ACCESS TO CARE

Cleveland, Ohio
2019 Report

Cleveland Department of Public Health

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Special Thanks to

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- Division of Environment
- Division of Air Quality
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- Office of HIV/AIDS Services
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Sisters Charity Foundation
City of Cleveland
Care Alliance
Frontline Services

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Executive Summary

Historically, the Cleveland Department of Public Health (CDPH) has worked to understand and address the health needs of Clevelanders through a county-wide health assessment and improvement planning process convened through the Health Improvement Partnership of Cuyahoga County (HIP-Cuyahoga). In early 2018, we created an opportunity to expound upon HIP-Cuyahoga Community Health Status Assessment indicators by comprehensively assessing the access to care within the City of Cleveland, which contains one-quarter of the county population. To understand the unique and vastly different needs of Cleveland residents, CDPH convened a broad range of individuals representing various sectors including academic institutions, hospitals, community clinics, healthcare providers, neighboring health departments, social service, philanthropy, non-profits, policy makers, and residents. Employing a collaborative approach, CDPH and these community partners convened over the course of several months to identify un/underserved populations, assess the availability of health care services and capacity of the healthcare system to meet community needs, determine the causes of gaps and barriers to care, and to uncover any emerging issues.

Key findings summarized within this Access to Care Report include:

1. Significant disparities exist based on geographic, economic, and demographic factors. Key health indicator data reveal significant differences in life expectancy based on where an individual lives (geographic); two to three times more African-American and Hispanic residents experience poverty as whites in the City of Cleveland (economic); and African American babies are three times as likely to die compared to white babies (demographic).

2. Considering the capacity of the health care system, data reveal that while resources exist to meet community needs, services are un/under-utilized. This suggests opportunities exist to create awareness of resources as well as education and navigation assistance. An opportunity exists to establish an ongoing partnership across health, social, and other sectors of organizations to more effectively leverage community assets and to continue collaborative work towards meeting community needs.

3. Emerging issues facing Cleveland residents include changes to health care service delivery methods (e.g., new technologies, such as telehealth), state/federal budget and policy implications, shifting priorities and funding among philanthropic organizations, and healthcare system capacity changes (specifically, a need to recruit, train, and retain a qualified community health workforce).

Throughout this journey, CDPH is grateful for the support and collaborative engagement of many partner organizations and community members who contributed towards understanding the needs of our most disparate populations.

Background

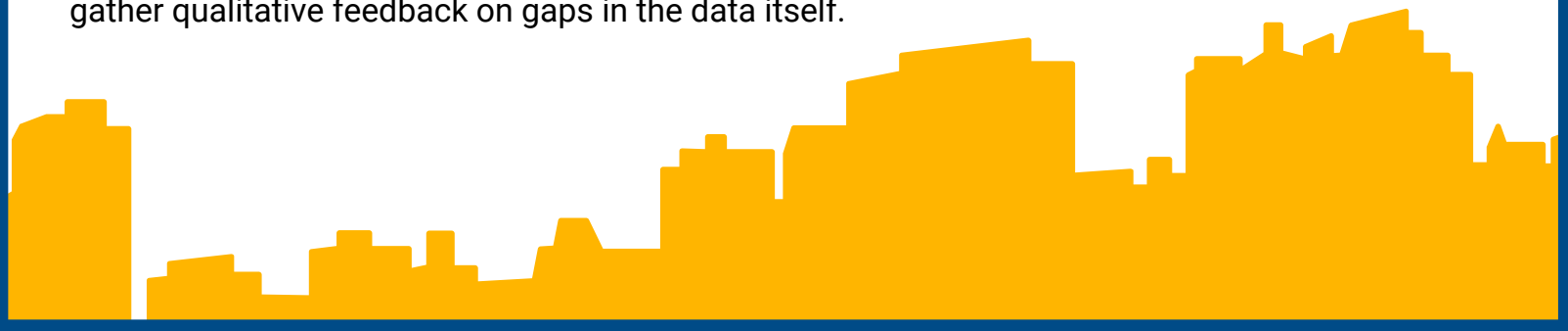
In June 2018, the Cleveland Department of Public Health (CDPH) identified an opportunity to examine access to care within the City of Cleveland. CDPH engaged an internal planning team consisting of the City of Cleveland's Chief of Public Affairs, the CDPH Director, CDPH administrative staff, the Commissioners of Air Quality, Environment, and Health, as well as other staff to assess access to care needs among Cleveland residents. This internal planning team was charged with systematically reviewing existing access to care-related data, primarily contained within the 2013 Community Health Needs Assessment, as well as various community, hospital, and programmatic reports to understand resident needs. Additionally, the planning team developed a list of potential community partner organizations that could contribute towards understanding the community and assessing the gaps in access to quality, affordable, and accessible care and developing strategies to address them.

This Access to Care Report is the product of a collaborative process to comprehensively assess access to care needs among un/underserved populations within the City of Cleveland, as well as the capacity and resources available to meet those needs using both quantitative and qualitative data sources.

Stakeholder Engagement

Evaluating access to care in the City of Cleveland began by engaging a small group of internal stakeholders within CDPH to identify the structure and necessary components that would guide this process and the data evaluated in the report. Following this meeting, the team engaged with several other programs within the Health Department to identify other opportunities for evaluating data as it pertained to care access.

External stakeholders were engaged in a two-step mixed-methods approach in an attempt to highlight and capture both quantitative and qualitative data to best understand issues surrounding access to care. Using preliminary analyses of secondary data (quantitative), the team presented to data experts, epidemiologists, and researchers from the City of Cleveland to gather input on several indicators. These analyses were tweaked based on feedback and then summarized and presented to a group of community stakeholders to foster discussion and gather qualitative feedback on gaps in the data itself.



Internal Stakeholders

Attendees: CDPH Office of Communicable Disease Surveillance and Epidemiology, Commissioners of Health, Environment, and Air Quality, Communications, Department Director.

Purpose: Identify report needs and highlight available data sources.

Follow-up meetings were held with several programs and offices within CDPH including MomsFirst, the Office of HIV/AIDS, and the Office on Minority Health.

Data Experts

Attendees: Health Data Matters, Better Health Partnership, Cuyahoga County Board of Health, Baldwin Wallace University, and CDPH.

Purpose: Convene key data analysts contributors to review and refresh Cleveland-specific datasets.

Community Stakeholders

Attendees: Over 20 local community partner organizations within the City of Cleveland.

Purpose: Share the preliminary Access to Care Report with local partners in the community that work in key indicator areas. Develop a shared definition of 'access to care'. Identify and discuss access to care needs identified and possible strategies to address gaps/barriers to care. Gather input to refine the Community Resource Guide.

Defining Access to Care

Since the 1980s, characteristics that traditionally define access to care have been summarized into five main groupings described below.

The 5 A's of Access

Affordability — Can the patient pay for insurance or afford out-of-pocket expenses?

Availabilty — Do those providing care have the resources and capacity to perform essential services?

Accessibility — Is the provider or facility in a location that can be reached easily?

Accomodation — Is the provider operated in a way that meets the needs of the patient (e.g., hours of operation, communication, scheduling)?

Acceptability — Is the patient comfortable with the characteristics of their provider (e.g., age, sex, race/ethnicity, social class)?

Developing a mutual understanding and definition of access to care allows community partners to converge around a clear vision and strategy for the City of Cleveland. During the convening, partners discussed the applicability of the five A's to assess aspects of access to care among residents. One key theme emerged based on a comparison of 5's among partners: that while healthcare facilities and other resources are available, oftentimes within less than a mile of their homes, individuals are either unaware or not utilizing them. Partners discussed the need for insurance and patient assistance, health literacy, and translation services to identify available resources and/or help to navigate the health care system may be significant opportunities. An examination of the 5 A's also led to a robust discussion among partner organizations on ways to more effectively leverage existing resources by working together to build capacity and provide a roadmap to help individuals navigate the health care system, as well as social, behavioral health, and other needs across sectors.

"You want to see if all of the effort that the City is putting in is making an impact. The data will tell the story."
-Community Partner of CDPH

Un/Underserved Populations

This report highlights disparities which exist among City of Cleveland residents, whether they are geographic, demographic, economic, or other variables. Concepts of health equity are fundamental to understanding and working towards establishing equitable living environments.

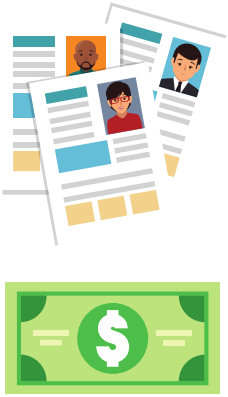
In order to understand health disparities that currently exist as they relate to an individual's ability to access or obtain health services, this report examines several health outcomes and indicators to focus specifically on how different populations may experience health and health care in disparate ways.

Economic equality is one significant disparity identified which shows poorer health status among those residing in lower-income neighborhoods. In research from Kramer MR, Neighborhoods and Health, wealthier communities benefit the health of their residents, whereas poorer communities pose increased risks to their residents' health.

Employment Inequality

23.5%

of black residents report unemployment versus 9.1% for white residents



Income Inequality

$20,937

median income of black residents versus **$38,614** for white residents

"The goal is to identify local health disparity needs with an emphasis on informing, educating and empowering at risk communities. The office is responsible for activating efforts to educate citizens and professionals on imperative health care issues and seeks to provide minority health data and technical assistance to local agencies working to improve the health status of minority populations."

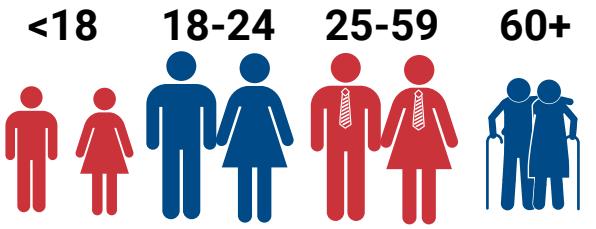
-Cleveland Department of Public Health, Office of Minority Health

Data and sources available in Data Sources & Tables Section

The City of Cleveland

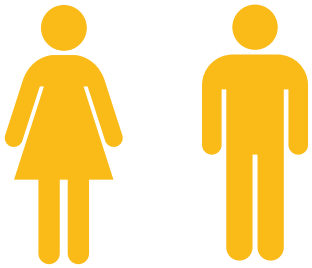
Cleveland is a unique city with a rich history. Peaking at a population of 914,000 in 1950, the City of Cleveland has seen a decline in population since the 1960s to nearly 390,000 in 2017. Cleveland has experienced a great transition from an industrial economy to a knowledge-based economy which has moved the City out of the recession. It is also experiencing a migration in of younger, higher net worth individuals.

Age



23% 11% 47% 19%

Sex*



52% 48%

*Indicates sex at birth

Race

50% Black or African American

40% White or Caucasian

2% Asian

1% American Indian or Alaska Native

4% Multiracial

3% Other

Ethnicity

Hispanic or Latino

11% Hispanic or Latino

89% Not Hispanic or Latino

AND

Asian

37% Chinese

24% Asian Indian

9% Nepalese

30% Other Asian

Data and sources available in Data Sources & Tables Section

Poverty

Poverty affects a third of the City of Cleveland's residents. In the span of five years, the rate of poverty remains relatively unchanged across the City. However, during this same time, the gaps in income have grown. The mean income deficit, or the average number of dollars it would take an individual to reach the poverty threshold, has grown from $6,525 to $6,768 which suggests that overcoming poverty may be getting further out of reach for many Cleveland residents.

Populations Experiencing Poverty

1 in 3 families
1 in 2 children under 18
1 in 5 seniors
2 in 5 persons with a disability

Black	Multiracial	Hispanic	Asian	Other	White
43%	40%	36%	35%	34%	25%

Poverty and Life Expectancy

"The relationship between health and socioeconomic factors has been well documented and these data show that average life expectancy in the City of Cleveland is four years less... compared to the Cuyahoga County overall."
-2013 Community Health Status Assessment for Cuyahoga County, Ohio

2016 Life Expectancy Comparison in Years

City of Cleveland	Cuyahoga County	Ohio	U.S.
72.2	76.5	76.6	78.7

In the City of Cleveland, life expectancy can differ in the Cleveland zipcodes by about 13 years, with the largest disparities observed among those with lower socioeconomic status. Of growing concern is also that life expectancy in the City is declining, with those born in 2016 being expected to live **1.5 fewer years** than those born in 2010.

Data and sources available in Data Sources & Tables Section

Housing & Living

Coupled with the abundance of poverty, basic necessities such as stable, healthy, safe and affordable housing, access to nutritious foods, and reliable transportation are out of reach for a substantial amount of the population. Many residents may be forced to make trade-offs between basic necessities and their health care.

Housing

20%

of residents do not live in the same house they did 12 months ago

74 hours

The number of hours a resident making minimum wage has to work each week to afford a standard two-bedroom apartment

Food

35%

of residents receive Supplemental Nutrition Assistance Program Benefits (SNAP) or food stamps

62%

of those using emergency food assistance had to choose between paying for food or paying for medicine

Transportation

24%

of households do not have access to a vehicle

2x

Patients who rely on the bus are 2x as likely to miss an appointment than those with their own vehicle

Data and sources available in Data Sources & Tables Section

Health Literacy

Health literacy refers to the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions. Low health literacy may contribute to a number of challenges, including a patient being unable to fully understand consent forms or other written education information, having difficulty filling out forms, not understanding how and when to take prescribed medicine, not being able to decipher their health problem, not understanding their insurance benefit information, not able to process what their healthcare provider is recommending, and general difficulties in navigating the healthcare system.

Up to **80%** of medical information provided by healthcare providers is forgotten immediately by patients; **half** of the information that is remembered is **incorrect**. Approximately **20%** of American adults read at or below the **fifth grade level**. However, most health information materials are written at the **tenth grade level** or above.

Literacy

66%

of Cleveland adults are functionally illiterate with some neighborhoods having rates as high as 97%

Cost

$106-$238

Billion

is lost every year on health care costs due to a disconnect in the delivery of health information

Ways to Improve Health Literacy

1

Conduct patient-centered visits to engage a person/patient in dialogue where there is more listening and asking specific questions around understanding.

2

Explain items using simple and plain language and use analogies and non-medical language can assist with conversations. Use of translation services to assist conversations.

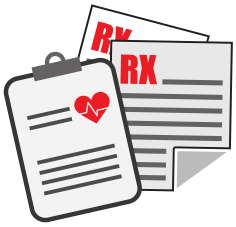
3

Use key messages and use them repetitively to help patients remember the information they are being given.

Data and sources available in Data Sources & Tables Section

Health Insurance

Individuals who do not have health insurance have difficulty accessing needed clinical care, prevention services, and/or may choose not to seek medical care because of financial concerns. Not obtaining needed or timely health care can lead to poorer health outcomes and potentially greater long-term medical needs and financial debt. Medicaid expansion in Ohio and the implementation of the Affordable Care Act have increased individuals ability to access insurance and healthcare resources. Additionally, community clinics have expanded services, yet a large portion of the City of Cleveland's population continues to be uninsured.



10% **of residents are still uninsured. This is a decrease from 2016 when 12% of the population was uninsured**

In 2017, it was estimated that **15%** of men and women between the ages of 18-64 reported they did not have health insurance. That is over **36,000** City of Cleveland residents **without** health insurance.

39% are covered by employer coverage

43% are covered by Medicaid

17% are covered by Medicare

8% are covered by other private insurance

1% are covered by Military or VA

Uninsured Populations

13% MEN

AND

8% WOMEN

11% of the white population is uninsured

12% of the Hispanic population is uninsured

10% of the black population is uninsured

Data and sources available in Data Sources & Tables Section

Capacity of the Health Care System

The City of Cleveland has four major hospital systems: University Hospitals, MetroHealth, Cleveland Clinic, and St. Vincent Charity Hospitals. In the 2013 Community Health Needs Assessment, the ratio of physician to population in Cleveland was shown to be higher than the national ratio. Despite this, most of the City is described as being within a Health Professional Shortage Area (HPSA) by the Health Resources and Services Administration. HPSA designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. There are three categories of HPSA designation based on the health discipline that is experiencing a shortage:

Primary Health

26 %

of residents are estimated to be under-served by primary health practitioners

Dental Health

39 %

of residents are estimated to be under-served by dental health practitioners

Mental Health

There is a lack of data highlighting those who are served and under-served by mental health practitioners

Care Utilization and Need

Primary Health

24.5%

of adults report not having visited doctor for routine checkup within the past year

Dental Health

48.6%

of adults report not having visited a dentist or dental clinic within the past year

Mental Health

16.5%

Adults reported having mental health that was not good for ≥14 days in the past 30 days

Data and sources available in Data Sources & Tables Section

Mental Health & Substance Abuse

Substance abuse and mental health can cause a rippling effect on a person, families, and the community. Stigma may prevent someone from accessing the care they need, so identifying and treating an illness early on can be the best prevention method.

Mental Health

26.6

children out of every 1,000 have substantiated reports of maltreatment which is **2x** higher than the rate in Cuyahoga County

32.3-36.6%

of CMSD high school students said they felt sad or hopeless almost every day for 2 weeks or more in a row in the past 12 months

Suicide

12.2

residents per 100,000 died from suicide

20.9

men per 100,000 died from suicide

Substance Abuse Disorder

61.8

per 100,000 died of opiate-related causes

2.4x

Men were 2x as likely to die of opiate-related causes than women

Data and sources available in Data Sources & Tables Section

Violence & Crime

Experiencing violence and crime can impact the quality of life and health status of an individual. Many residents experience violence or crime within their own families or neighborhoods. It can contribute to a high level of stress and impact physcial health and lead to unhealthy behaviors.

Violent Crimes in 2017 were

6,285

number of violent crimes reported that include offenses of homicide, rape, robbery, and aggrevated assualt

compared to

6,565

number of violent crimes reported that include offenses of homicide, rape, robbery, and aggrevated assualt in **2016**

Homicide

121

number of homicides

Rape

551

number of rapes

Property Crime in 2017 were

20,070

number of property crimes reported that include offenses of burglary, larceny-theft, motor vehicle theft, and arson

compared to

21,763

number of property crimes reported that include offenses of burglary, larceny-theft, motor vehicle theft, and arson in **2016**

Burglary

6,068

number of burglaries reported

Motor Vehicle Theft

3,389

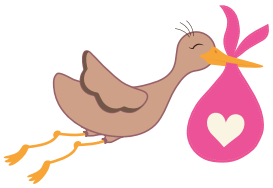
number of motor vehicle thefts reported

Data and sources available in Data Sources & Tables Section

Maternal, Infant, & Child Health

Maternal (mother) care is directly related to the birth of the child and how a mother takes care of herself before, during, and after the pregnancy. One of the most important areas for monitoring and assessing relates to the health of a most vulnerable population: infants and children.

In 2017, there were



13.7
births per 1,000 people

BUT

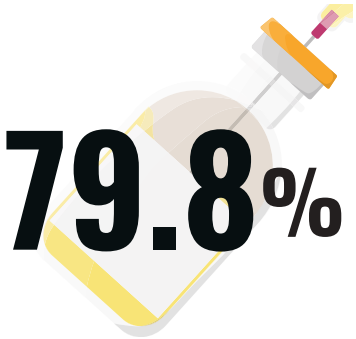
13.9
infants died out of every 1,000 born

Deaths

10.2
infants out of every 1,000 live births died within the first 28 days

24.9
children (aged 1-14 years) died out of every 100,000 children

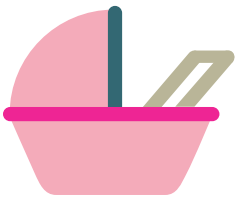
Vaccination



79.8%
almost 80% of children in the City of Cleveland were up-to-date on their vaccination series by kindergarten

Births

3.5%
of infants born were very preterm (less than 32 weeks)



33
number of teen births (aged 15-19) per 1,000 females

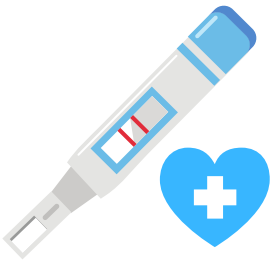
14%
of live births were low birthweight (less than 2500 grams)

Data and sources available in Data Sources & Tables Section

Prenatal Care

Access to early and high quality prenatal care allows mothers to maintain their own health and the health of their babies. By getting prenatal care early on, doctors have more opportunity to spot and treat unexpected problems, increase safe deliveries, and promote good health in the first few days of life.

In 2017, there were



64 %

of mothers receiving prenatal care in the first trimester

compared to

61%

of mothers receiving prenatal care in the first trimester in 2010

Insurance Matters

4.4x

Uninsured pregnant women are 4.4 times as likely to receive inadequate prenatal care compared to those with private insurance

Race Matters

Black women are 60% more likely to receive inadequate prenatal care compared to white women

3x

Black infants are 3 times more likely to die before their 1st birthday than white infants

Geographic Accessibilty

On average, pregnant women live 1.1 miles away with some as far as 3.2 miles from a OB/GYN facility

Tobacco Use

40%

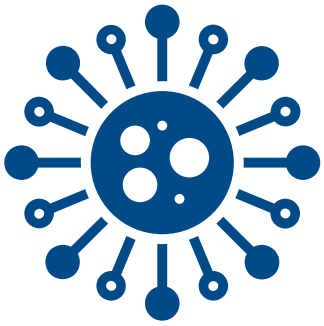
Women with inadequate prenatal care were 40% more likely to have smoked during their last trimester than women with high quality care

Data and sources available in Data Sources & Tables Section

Sexually Transmitted Infections

In the City of Cleveland, there has been a steady rise in sexually transmitted infections (STIs). Since 2013, the incidence of **chlamydia has increased by 1%**, **gonorrhea has increased by 30%**, and **syphilis has increased by 270%**. STIs are a common, preventable, and treatable health condition, but access to good information, testing, partner notification, and treatment options are critical in reducing the spread of infection.

In 2017, there were



Chlamydia

1938

new cases of Chlamydia diagnosed per 100,000 residents

Gonorrhea

988

new cases of Gonorrhea diagnosed per 100,000 residents

Syphilis

74

new cases of Syphilis diagnosed per 100,000 residents

Age Matters

1 IN 10

youth aged 15-19 was diagnosed with Chlamydia in 2017

77%

of Gonorrhea cases occur among those that are younger than 30 years of age

Race Matters

7.5
4.7
2.6

Black populations are 7.5, 4.7, and 2.6 times as likely to be diagnosed with Gonorrhea, Chlamydia, and Syphilis, respectively, compared to white populations

Risky Behaviors Among Youth

1/3 of high school students are currently sexually active

of those who are sexually active only half report condom use during last intercourse

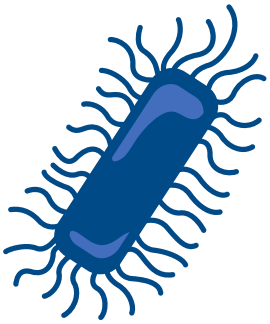
14% to 16% of students report having had sex with 4 or more people

Data and sources available in Data Sources & Tables Section

HIV & AIDS

Individuals with HIV or AIDS need high quality health care to mitigate complications related to the disease to ensure and extend quality of life, and to help prevent the spread of infection. Since 2010, the rate of new HIV infections diagnosed per 100,000 people in the city has **increased by 15%.**

In 2017, there were



964.4

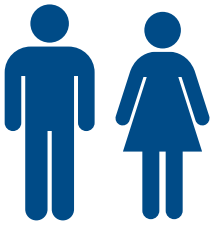
persons living with HIV or AIDS per 100,000 residents

AND

27.2

new cases of HIV diagnosed per 100,000 residents

Age Matters



4.7x

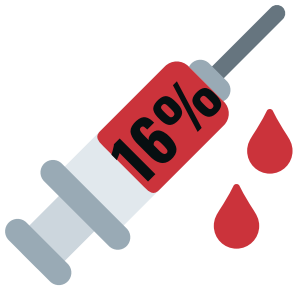
Individuals between the ages of 20 and 29 are 4.7 times as likely to be diagnosed with HIV than those 30 years and older

HIV Education Among Youth

2 IN 3

Only 2 out of 3 high school students report ever having been taught about AIDS or HIV infection in school

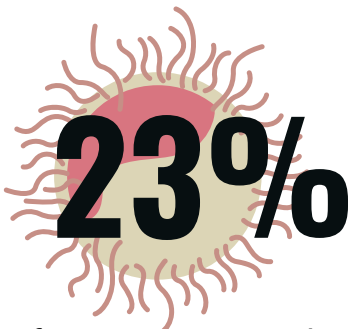
High Risk Populations



Of the population living with AIDS, 16% report intravenous drug use

2 IN 3

Roughly 2 out of every 3 new cases of HIV diagnosed were among men who had sex with other men



23%

of new HIV cases who were also tested for syphilis were co-infected with the bacteria

Data and sources available in Data Sources & Tables Section

Chronic Disease

In the City of Cleveland, chronic conditions contributed to nearly **75%** of all deaths that occurred between 2008 and 2017. There are numerous disparities observed among these conditions including diagnosis, screening behaviors, and mechanisms to control the disease.

Commonly Linked Chronic Diseases

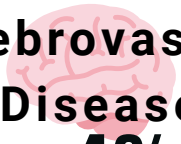
Heart Diseases

26%

of deaths are from heart diseases

8%

of adults say they've been diagnosed



Cerebrovascular Diseases

4%

of deaths are from cerebrovascular diseases (e.g., stroke)

5%

of adults report having had a stroke

Diabetes

3%

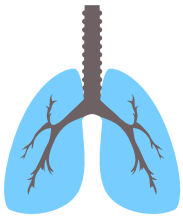
of deaths are from diabetes

16%

of adults report having been diagnosed

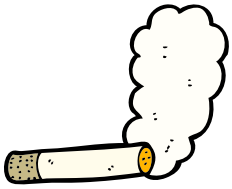
More than **one-third** (39%) adults report being **obese**. Nearly the same proportion (40%) report having **high blood pressure** but only 69% of those with high blood pressure said they take medicine to control it. Only **70%** of adults report having been screened for high cholesterol in the past 5 years, but of those, 31% report having been **diagnosed with high cholesterol**.

Chronic Lower Respiratory Diseases



5%

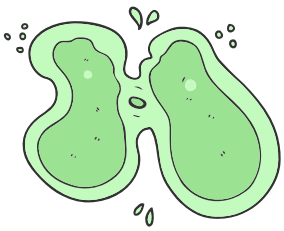
of deaths are from chronic lower respiratory diseases while 10% say they've been diagnosed with COPD and 12% currently have asthma



29%

Cleveland adults say they currently smoke

Cancers



22%

of deaths are from cancers but only 6% say they've been diagnosed

55%

adults age 50-75 have been screened for Colorectal Cancer

70%

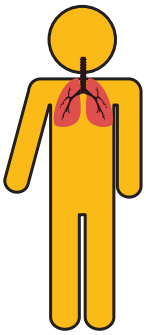
women age 50-74 have had a mammogram

Data and sources available in Data Sources & Tables Section

Leading Forms of Cancer

Lung, breast, prostate, and colorectal cancers are the most common cancers. They account for nearly half of all cancers diagnosed and the greatest number of cancer-related deaths. Early detection through routine screenings coupled with timely, high quality treatment and care may improve prognosis and survival.

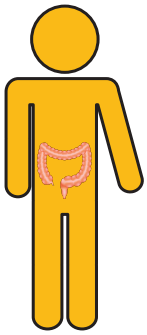
Between 2008 and 2017*, there were



907 new cases of lung cancer diagnosed per 100,000 people

AND

510 new cases of colorectal cancer diagnosed per 100,000 people



Late Stage Diagnoses

50% lung cancers diagnosed in late stage

20% colorectal cancers diagnosed in late stage

Deaths

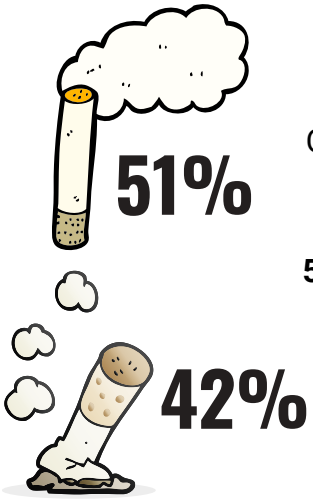
662 lung cancer deaths per 100,000 people

201 colorectal cancer deaths per 100,000 people

Lung | Colorectal

Lung | Colorectal

Tobacco Use



51%

42%

Of those newly diagnosed with lung cancer with a known tobacco history, **55% were current tobacco users** and **40% had used tobacco previously**

Race Matters

Black residents are **less likely** to be diagnosed with colorectal cancer but **more likely** to die from it than white residents

1 IN 4 colorectal cancer diagnosed among Asian residents is in the late or distant stage

**2017 data are preliminary*

Data and sources available in Data Sources & Tables Section

Between 2008 and 2017*, there were

1411 new cases of breast cancer diagnosed per 100,000 women

AND

1428 new cases of prostate cancer diagnosed per 100,000 men

Late Stage Diagnoses

7% breast cancers diagnosed in late stage — Breast

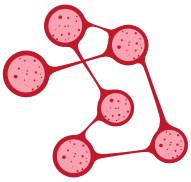
10% prostate cancers diagnosed in late stage — Prostate

Deaths

251 breast cancer deaths per 100,000 women — Breast

339 prostate cancer deaths per 100,000 men — Prostate

Tobacco Use



5.5x

Women who currently use tobacco are **5.5 times as likely** to be diagnosed with breast cancer in the late or distant stages than women who have never smoked

Race Matters

Black men are nearly **2 x** as likely as white men to be diagnosed with prostate cancer

Asian men & women are **2 - 3 x** more likely to not have insurance when diagnosed with **prostate** or **breast** cancer

**2017 data are preliminary*

Data and sources available in Data Sources & Tables Section

Emerging Issues

Over the course of several meetings, including a large community gathering to review the draft Access to Care Report as well as Cleveland-specific data and trends, partners and CDPH staff identified emerging issues which impact – both positively and negatively – health and access to care among Cleveland residents.

Common themes arose around necessary changes to the healthcare system and availability of primary care, translation services within the clinical setting as well as the types of health messaging both oral and written to ensure individuals understand their health. Technology needs to be addressed, particularly since many neighborhoods in Cleveland have low connectivity or access to the internet, therefore cannot utilize technology tools for chronic care management or making and keeping appointments. There were concerns around disturbing trends in fatal and non-fatal drug overdose rates, rising rates of sexually transmitted infections particularly among youth, rising rates of vaccine-preventable conditions, most notably Hepatitis A which is currently an outbreak within Ohio. Robust discussion took place around the changing demographics in Cleveland including gentrification of some neighborhoods while others are witnessing their neighborhood declining, becoming poorer with fewer resources. Health and social service organizations need to find ways to adapt the types and delivery methods of their programs and services.

Generally, partners were appreciative of Cleveland-specific data and called for more real/close to real time data collection through data sharing platforms including Health Data Matters to ensure the entire community can understand and address shifting population health needs and commit to working together. Key emerging issues identified by partners are summarized by topic area below.

CHANGES TO THE STRUCTURE AND DELIVERY OF SERVICES

The Community Health Worker (CHW) framework provides a culturally-competent framework to reduce barriers to care and has been successfully implemented in neighboring communities. At present, CHWs are not reimbursed under Medicaid or any other insurance. Obtaining funding to employ CHWs as part of a HUB model could assist individuals with enrollment and navigation services to meet their needs.

Telehealth provides an excellent opportunity to leverage technology to efficiently meet health needs; although Ohio is behind most states, Cleveland has an opportunity to explore this new technology. Partners also discussed the Behavioral Health Redesign and Behavior 3 Design theory which would provide an opportunity to more systematically assess aspects of behavioral health.

“We have two CHW programs and no way to bill these folks. We charge them to have background checks to be in the clinics. Places all over the world are using CHWs and we aren’t doing it”

- Community partner of CDPH

Emerging Issues

STATE BUDGET & POLICY IMPLICATIONS

Ohio's Governor, Mike DeWine, along with the new Ohio Department of Health Director, Dr. Amy Acton, have proposed potential increased funding for home-visiting programs, maternal and child health, behavioral health, and social determinants of health; Cleveland partners need to be prepared with data to support the need for additional funding. Additional policies under consideration which could impact health include changes to the Affordable Care Act (ACA), Heartbeat Bill, or defunding of Planned Parenthood, Lead Safe Cleveland Legislation). Other social and political causes with access implications include immigration reform and the anti-vaccination movement.

HEALTHCARE SYSTEM CAPACITY SHIFTS

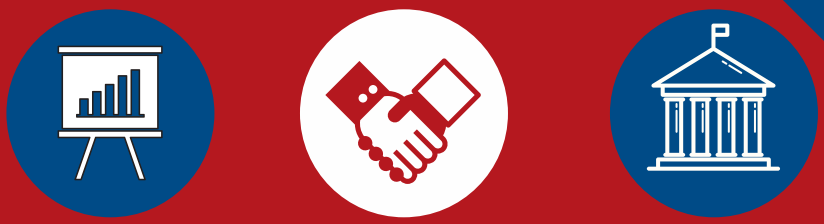
Workforce shortages exist across sectors to recruit, train, and retain qualified health professionals. Additional training is needed to ensure the workforce remains current in areas in which the field is advancing, such as, use of technology (telehealth) and changing policies (for example, police officers are not accepting "pink slips" which are designed to transport people who have a Consent Decree for mental health issues. Confusion exists among officers due to policy changes of what is mandated of them).

DEMOGRAPHIC SHIFTS

Many neighborhoods are becoming more gentrified with fewer (perceived) resources allocated to impoverished areas. Partners also noted that an excessive amount of advertising for alcohol, cigarettes, and flavored tobacco products are intentionally targeting youth and minority neighborhoods. With more minority populations migrating to Cleveland, translations services are needed for languages other than Spanish, including Asian, Eastern European, and African languages.

SHIFTING PRIORITIES & FUNDING

Philanthropic funding priorities seem to be shifting away from the delivery of primary care services to focus more on social determinants of health.



Implications & Future Direction

This report highlights several important directions to inform future efforts based on the highlighted data and stakeholder discussions. Key findings and opportunities to address disparities and barriers to care are provided below.

KEY FINDING #1

Resources exist to address many of the communities needs though individuals are not accessing services. Data suggest the City has the capacity to meet community needs: Cleveland is home to four major hospital systems and has a higher physician to population ratio than the national average, but services are under-utilized. For example, data also reveal on average, pregnant women live a maximum of 3.2 miles from an OB/GYN facility, yet only 64% of mothers receive prenatal care within the first trimester.

OPPORTUNITY/FUTURE STRATEGY #1

Opportunities exist to create awareness, provide education, and help individuals navigate resources. CDPH and its partners developed an updated Resource Guide of basic health, housing, educational, and other services available across the City.

KEY FINDING #2

While numerous partnerships exist to address specific health topics and/or populations, no partnership exists to comprehensively assess access to care issues. According to evaluation forms collected among partners during the July 25, 2019 access to care meeting, partners appreciated the opportunity to discuss access to care issues, emerging issues, and potential strategies. They found working in this way with other community organizations to be very informative and helpful towards achieving their individual organizational goals. Should additional partners/organizations be included in the future, partners suggested including the Ohio Department of Health (ODH)/legislators, AIDS Taskforce Foundation, schools/daycare centers, American Cancer Society, County government, and more community-based organizations mainly to collect data from populations with whom they have already built trust, among others.

OPPORTUNITY/FUTURE STRATEGY #2

Future convenings would be helpful to identify community-wide issues and share information across sectors.

Continued on this page are the additional key findings and opportunities/future strategies proposed to the findings.

KEY FINDING #3

Partners reinforced the need for real-time local data to be used for decision-making and an opportunity to more effectively leverage resources community-wide by working together as opposed to in silos.

OPPORTUNITY/FUTURE STRATEGY #3

Leverage existing city-specific data-sets available, including United Way 211 and Health Data Matters, during future convenings.

KEY FINDING #4

When asked about CDPH's role in the community, partners valued CDPH's contributions as a mobilizer and convener as well as data partner/contributor. Partners also felt CDPH should focus efforts on health promotion and education. CDPH's role in the delivery of direct services was not discussed.

OPPORTUNITY/FUTURE STRATEGY #4

Assess opportunities for future data needs and potential partnerships to address health issues across sectors.

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Data Tables & Sources

Unemployment	2010 (n=319,367)	2017 (n=310,022)
Unemployment* by Race and Ethnicity		
Black or African American	23.1%	23.5%
American Indian or Alaskan Native	21.6%	15.1%
White or Caucasian	12.6%	9.1%
Asian	7.1%	7.1%
Multiracial	23.9%	15.6%
Other	13.8%	10.4%
Hispanic or Latino	17.4%	12.8%
2010 data come from the 2006-2010 American Community Survey; 2017 data come from the 2013-2017 American Community Survey		

Household Income	2010 (n=170,464)	2017 (n=168,496)
Median Income		
Black or African American	$21,662	$20,937
Asian	$39,790	$30,927
American Indian or Alaskan Native	$26,016	$35,337
White or Caucasian	$35,238	$38,614
Multiracial	$25,870	$24,277
Other	$28,526	$29,898
*GINI Index***	0.4740	0.5045
*Employment rates are calculated for the population that is 16 years and over **GINI Index values range from 0-1 with 0 representing total income equality where everyone is receiving an equal share and 1 representing perfect inequality where one group of recipients receives all of the income 2010 data come from the 2006-2010 American Community Survey; 2017 data come from the 2013-2017 American Community Survey		

Demographic	2010 (n=409,221)	2017 (n=388,812)
Age		
<18	25.2%	22.9%
18-24	10.1%	11.2%
25-59	47.5%	46.6%
60+	17.2%	19.3%
Gender		
Male	47.4%	47.9%
Female	52.6%	52.1%
Race		
Black or African American	53.1%	50.4%
White or Caucasian	40.2%	39.8%
Asian	1.7%	2.1%
Multiracial	2.2%	4.0%
Other	2.8%	3.7%
Hispanic or Latino Ethnicity		
Hispanic or Latino	9.2%	11.2%
Not Hispanic or Latino	90.8%	88.8%

Asian Ethnicity		
Chinese	N/A	37.2%
Asian Indian	N/A	24.3%
Nepalese	N/A	8.7%
Other Asian	N/A	29.8%
Educational Attainment*		
Less than High School	24.5%	20.8%
High School or Equivalent	37.1%	33.1%
Some College or Associate's Degree	26.8%	29.7%
Bachelor's Degree	8.2%	10.3%
Graduate or Professional Degree	4.7%	6.1%

*Educational attainment is among those 25 years of age and older
2010 data come from the 2006-2010 American Community Survey; 2017 data come from the 2013-2017 American Community Survey

Poverty	2012 (n=388,144)	2017 (n=377,997)
Overall		
Total Population	34.2%	35.2%
Families	29.5%	30.7%
Poverty by Age		
<18	50.8%	51.6%
18-64	30.5%	32.3%
65+	20.2%	20.6%
Poverty by Race and Ethnicity		
Black or African American	41.4%	42.9%
White or Caucasian	24.4%	25.0%
Asian	26.4%	35.0%
Multiracial	42.8%	39.9%
Other	37.9%	33.7%
Hispanic or Latino	41.3%	35.7%

2012 data come from the 2009-2012 American Community Survey; 2017 data come from the 2013-2017 American Community Survey

Life Expectancy	2010	2016
Average Life Expectancy in Years		
City of Cleveland	73.6	72.2
Cuyahoga County	77.9	76.5
Ohio	N/A	77.8*
U.S.	N/A	78.6

2010 data come from the 2013 Community Health Status Assessment for Cuyahoga County, Ohio (2013); 2016 data come from the 2018 Cuyahoga County Community Health Assessment (2018)

Housing & Living	2017
Housing Instability	
Population who live in same house 1 year ago	79.5%
Population who moved within Cuyahoga County	16.1%
Population who moved from within Ohio	1.8%
Population who moved from outside Ohio	1.7%
Population who moved from abroad	0.9%
Access to Food	
Households receiving food stamps/SNAP	35.0%
Tranpsortation	
Households with no vehicle	24.4%
Households with 1 vehicle	44.5%
Households with 2 vehicles	23.0%
Households with 3+ vehicles	8.0%

2017 data come from the 2013-2017 American Community Survey

Other literature cited:

1. 74 hours: The number of hours a resident making minimum wage has to work each week to afford a standard two-bedroom apartment-Shields, M. (2017). Clevelanders face housing insecurity: A higher minimum wage would help. Policy Matters Ohio. Available at https://www.policymattersohio.org/blog/2017/06/30/clevelanders-face-housing-insecurity-a-higher-minimum-wage-would-help

2. 62%: of those using emergency food assistance had to choose between paying for food or paying for medicine-Greater Cleveland Food Bank. Hunger Facts for Northeast Ohio. Available at https://www.greaterclevelandfoodbank.org/about/hunger-facts

3. 2x: Patients who rely on the bus are 2x as likely to miss an appointment than those with their own vehicle-Silver, D, Blustein, J, & Weitzman B.C. (2012). Transportation to clinic: Findings from a pilot clinic-based survey of low-income suburbanites. Journal of Immigrant and Minority Health, 14(2):350-355.

Health Literacy

Other literature cited:

1. Health literacy refers to the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.-Plain Writing Act, ACA, 2010

2. Up to 80% of medical information provided by healthcare providers is forgotten immediately by patients; and half of the information that is remembered is incorrect. Approximately 20% of American adults read at or below the fifth grade level. However, most health information materials are written at the tenth grade level or above.- U.S. Department of Education, 2003

3. 66% of Cleveland adults are functionally illiterate with some neighborhoods having rates as high as 97%-Seeds of Literacy (2001). Estimates for the Percent at Level 1 or Level 2 Literacy. Data from this handout were originally published in 2000 by Case Western Reserve University Center on Urban Poverty and Community Development. Assessing Literacy Needs in Cuyahoga County - Preliminary Analysis.
4. $106-$238 Billion is lost every year on health care costs due to a disconnect in the delivery of health information-Vernon, J. (2007). Low Health Literacy: Implications for National Health Policy

Health Insurance	2015 (n=384,102)	2017 (n=382,641)
Insurance Type*		
Uninsured	14.2%	10.4%
Public	51.5%	55.4%
Private	43.4%	43.3%
Uninsured by Age Group		
<19	4.0%**	8.4%
19-25	24.8%	19.0%
26-34	23.0%**	16.9%
35-44	20.3%	14.7%
45-54	14.6%	15.1%
55-64	14.6%	10.4%
65+	0.8%	0.7%
Uninsured by Gender		
Male	17.4%	12.9%
Female	11.2%	8.1%
Uninsured by Race		
Black or African American	14.3%	10.3%
White or Caucasian	14.0%	10.6%
Asian	14.1%	10.7%
Multiracial	10.2%	7.7%
Other	21.4%	12.1%
Uninsured by Ethniciy		
Hispanic or Latino	16.3%	12.2%

Totals represent the proportion of civilian, non-institutionalized population

*Numbers may add up to greater than 100% because individuals can be insured by more than 1 entity

**2015 age group is <18 years of age and 25-34 years of age

2015 data come from the 2011-2015 American Community Survey; 2017 data come from the 2013-2017 American Community Survey

Violence and Crime	2015	2017
Violent Crime		
Total Number of Violent Crimes	6032	6285
Homicides	111	121
Rape	547	551
Property Crime		
Total Number of Property Crimes	20265	20070
Burglaries	6185	6068
Motor Vehicle Theft	3414	3389

Data are from Cleveland Police, Cleveland, violent crime, property crime, homicide, rape, burglary, motor vehicle theft, 2016-2017. Analysis by Center on Urban Poverty and Community Development, Jack, Joseph and Morton Mandel School of Applied Social Sciences, Case Western Reserve University. Accessed through the Neighborhood Data Warehouse, NEOCANDO, system, accessed August 21, 2019. http://neocando.case.edu

Maternal, Infant and Child Health	2010	2017
Birth*		
Birth Rate	15.4	13.7
Adolescent Birth Rate (15-19 years)	35.4	33.0
% Low Birth Weight (<2500 grams)	13.3	14.0%
% Very Preterm (<32 weeks gestation)	3.7	3.5%
% Premature	14.4	14.3%
Mortality		
Neonatal Mortality Rate (<28 days)**	8.2	10.2
Infant Mortality Rate (<1 year)**	12.5	13.9
Child Mortality Rate (age 1-14 years)^	n/a	24.9
Vaccination		
Children who are up-to-date on vaccines	n/a	79.8%

*Rates calculated are per 1,000 using 2010 and 2017 American Community Survey population estimates

**Rate is calculated per 1,000 live births using data from Ohio Department of Health Office of Vital Statistics. 2010 and 2017 Birth Records

^Rate is calculated per 100,000 children ages 1-14 using 2010 and 2017 American Community Survey population estimates

^^Are up-to-date on the 4+DTaP, 3+Polio, 1+MMR, 3+Hib, 3+HepB, 1+Varicella. Vaccination Series by Kindergarten^^. Data are from the Ohio Department of Health. School Immunization Status Assessment and represent the 2017-2018 school year

Prenatal Care*	2010	2017
% Receiving Prenatal Care in First Trimester		
All Women	60.6%	64.3%
% Receiving High Quality Prenatal Care by Insurance Status		

Uninsured	Not Captured	57.3%
Public Insurance		69.4%
Private Insurance		85.4%
% Receiving High Quality Prenatal Care by Race		
Non-Hispanic Black	Not Captured	68.4%
Non-Hispanic White		78.0%
Non-Hispanic Other		73.0%
Hispanic		78.1%

*The Kotelchuck Index is used to quantify prenatal care quality
2010 data are from the Community Health Status Assessment for Cuyahoga County, Ohio (2013); 2017 data are from Ohio Department of Health Office of Vital Statistics. 2017 Birth Records

Sexually Transmitted Infections*	Chlamydia	Gonorrhea	Syphilis
Age Group			
<15	140.8	38.3	--
15-19	10070.7	3573.7	68.3
20-24	8940.2	4122.7	197.5
25-29	4089.8	2655.6	200.5
30-34	1893.4	1256.1	161.1
35-39	936.1	784.7	123.5
40-44	491.3	535.5	88.4
45-49	312.9	406.8	116.2
50-54	173.4	224.6	47.3
55+	33.6	68.3	13.2
Race			
Black	2485.6	1434.8	97.5
White	526.5	189.9	41.2
Multiracial	1337.4	792.7	--
Other	973.4	349.5	84.8
Hispanic	398.2	156.4	135.3
Non-Hispanic	1400.2	743.8	18.7
Overall	**1937.5**	**987.7**	**73.9**
% Change Since 2013	**+1%**	**+30%**	**+270%**

*Rates are calculated per 100,000 population using 2017 American
--Data are suppressed when fewer than 10 cases are observed
Data are from the: Ohio Disease Reporting System. Cases presented represent all incident cases per 100,000 population using 2017 American Community Survey Estimates. Please note that data may be subject to change as additional information is provided.

Other literature cited:

1.Data for risky behaviours among youth are from -2017 Cuyahoga County Youth Risk Behavior Survey: Regional Prevalence. (2018). Prevention Research Center for Healthy Neighborhoods. Case Western Reserve University.

HIV/AIDS	2017 Prevalence		2017 Incidence
	HIV	AIDS	HIV
Age*			
<20	19.4	--	--
20-24	377.4	81.1	88.2
25-29	660.0	240.6	89.4
30-34	659.2	318.6	54.9
35-44	690.7	545.5	22.0
45-54	911.1	1112.2	23.0
55-64	630.9	899.3	--
65-74	319.2	433.8	--
Race & Ethnicity*			
Non-Hispanic Black	508.1	463.0	35.1
Non-Hispanic White	266.0	253.9	13.6
Hispanic or Latino	511.0	594.4	--
Gender*			
Male	738.3	673.6	50.4
Female	180.8	178.4	6.4
Overall*	**444.8**	**412.9**	**27.2**
Priority Populations			
Men Who Have Sex Wi	78.7%	60.8%	65.2%
Intravenous Drug Use	7.7%	16.1%	5.7%

*Rates are calculated per 100,000 population using 2017 American

--Data are suppressed when fewer than 10 cases are observed

Prevalence data were provided by the Ohio Department of Health HIV/AIDS Surveillance Program for 2017; Incidence data are from the: Ohio Disease Reporting System. Cases presented represent all incident cases per 100,000 population using 2017 American Community Survey Estimates. Please note that data may be subject to change as additional information is provided.

Other literature cited:

1.Data for HIV/AIDS education among youth are from -2017 Cuyahoga County Youth Risk Behavior Survey: Regional Prevalence. (2018). Prevention Research Center for Healthy Neighborhoods. Case Western Reserve University.

Chronic Disease	2015-2016
Diagnoses*	
Diabetes	15.8%
Asthma (Current)	11.7%
COPD	10.3%
Coronary Heart Disease	8.3%
Cancer (Excluding Skin)	5.6%
Stroke	5.4%
Chronic Kidney Disease	4.2%
Conditions that Lead to Disease	
High Blood Pressure	40.7%
Take Blood Pressure Medication	81.0%
Cholesterol Screening	69.4%
High Cholesterol	36.1%
Obesity	39.2%
Cancer Screenings*	
Colorectal Cancer Screening (ages 50-75)	54.5%
Mammogram (women ages 50-74)	70.0%
Health Behaviors	
Sleep <7 hours	42.5%
Physical Inactivity	36.2%
Smoke (Currently)	29.3%
Binge Drink	13.8%

*Age-adjusted prevalence among adults 18+ (unless otherwise specified)
Data are from Centers for Disease Control and Prevention Division of Population Health. 500 Cities Project: Local Data for Better Health (2018).

Lung Cancer Rates*	2008-2017
Incidence Rate	**906.5**
Black or African American	886.9
White or Caucasian	1009.0
Asian	371.1
Hispanic or Latino	340.4
Male	1102.0
Female	743.3
% Uninsured	**5.4%**
Black or African American	4.8%
White or Caucasian	5.8%
Asian	11.8%
Hispanic or Latino	9.8%
% Late Stage Diagnoses	**50.0%**
Black or African American	51.5%
White or Caucasian	48.2%
Asian	47.4%
Hispanic or Latino	42.0%
Mortality Rate	**662.1**
Black or African American	676.3
White or Caucasian	701.4
Asian	429.6
Hispanic or Latino	302.2

*Rates are direct age-adjusted to the 2000 U.S. Standard population and use the 2010 Decennial Census data as the denominator and are calculated per 100,000 population
Incidence, insurance, late-stage diagnosis data are from the Ohio Cancer Incidence Surveillance System, 2008-2017; Mortality data are from the Ohio Department of Health Office of Vital Statistics Death Records, 2008-2017

Colorectal Cancer Rates	2008-2017
Incidence Rate	**510.1**
Black or African American	485.1
White or Caucasian	525.3
Asian	269.1
Hispanic or Latino	283.6
% Uninsured	**6.2%**
Black or African American	6.8%
White or Caucasian	5.5%
Asian	16.7%
Hispanic or Latino	7.8%
% Late Stage Diagnoses	**19.9%**
Black or African American	22.2%
White or Caucasian	18.9%
Asian	27.8%
Hispanic or Latino	18.5%
Mortality Rate	**200.7**
Black or African American	214.6
White or Caucasian	199.9
Asian	--
Hispanic or Latino	149.6

*Rates are direct age-adjusted to the 2000 U.S. Standard population and use the 2010 Decennial Census data as the denominator and are calculated per 100,000 population
Incidence, insurance, late-stage diagnosis data are from the Ohio Cancer Incidence Surveillance System, 2008-2017; Mortality data are from the Ohio Department of Health Office of Vital Statistics Death Records, 2008-2017

Breast Cancer Rates	2008-2017
Incidence Rate	**1410.5**
Black or African American	1448.0
White or Caucasian	1444.0
Asian	1053.7
Hispanic or Latino	898.8
% Uninsured	**3.4%**
Black or African American	2.8%
White or Caucasian	4.0%
Asian	14.7%
Hispanic or Latino	7.3%
% Late Stage Diagnoses	**7.0%**
Black or African American	6.8%
White or Caucasian	7.7%
Asian	2.3%
Hispanic or Latino	5.6%

Mortality Rate	**251.2**
Black or African American	283.9
White or Caucasian	233.4
Asian	--
Hispanic or Latino	156.3

*Rates are direct age-adjusted to the 2000 U.S. Standard population and use the 2010 Decennial Census data as the denominator and are calculated per 100,000 population
Incidence, insurance, late-stage diagnosis data are from the Ohio Cancer Incidence Surveillance System, 2008-2017; Mortality data are from the Ohio Department of Health Office of Vital Statistics Death Records, 2008-2017

Prostate Cancer Rates	2008-2017
Incidence Rate	**1427.5**
Black or African American	1810.6
White or Caucasian	1053.9
Asian	507.0
Hispanic or Latino	1016.8
% Uninsured	**5.3%**
Black or African American	5.5%
White or Caucasian	4.7%
Asian	15.4%
Hispanic or Latino	6.6%
% Late Stage Diagnoses	**9.7%**
Black or African American	9.2%
White or Caucasian	10.9%
Asian	15.4%
Hispanic or Latino	12.4%
Mortality Rate	**339**
Black or African American	442.0
White or Caucasian	248.3
Asian	--
Hispanic or Latino	242.7

*Rates are direct age-adjusted to the 2000 U.S. Standard population and use the 2010 Decennial Census data as the denominator and are calculated per 100,000 population
Incidence, insurance, late-stage diagnosis data are from the Ohio Cancer Incidence Surveillance System, 2008-2017; Mortality data are from the Ohio Department of Health Office of Vital Statistics Death Records, 2008-2017

10 Leading Causes of Death by Age Group, Cleveland, OH 2008-2017

	Age Groups								
Rank	<1	1-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Short Gestation 209	Homicide 37	Homicide 266	Accidental 313	Accidental 362	Diseases of the Heart 966	Malignant Neoplasms 2269	Diseases of the Heart 7311	Diseases of the Heart 10616
2	Congenital Malformations 99	Accidental 34	Accidental 104	Homicide 264	Diseases of the Heart 268	Malignant Neoplasms 953	Diseases of the Heart 1955	Malignant Neoplasms 5790	Malignant Neoplasms 9293
3	SIDS 84	Malignant Neoplasms 13	Suicide 55	Suicide 95	Malignant Neoplasms 190	Accidental 617	Accidental 522	Chronic Lower Respiratory Diseases 1533	Accidental 2507
4	Maternal Pregnancy Complications 62	Congenital Malformations 13	Malignant Neoplasms 30	Diseases of the Heart 80	Homicide 129	Chronic Liver Disease & Cirrhosis 219	Chronic Lower Respiratory Diseases 362	Cerebrovascular Diseases 1384	Chronic Lower Respiratory Diseases 2090
5	Newborn Complications 55	Suppressed	Diseases of the Heart 22	Malignant Neoplasms 46	Suicide 80	Cerebrovascular Diseases 146	Chronic Liver Disease & Cirrhosis 333	Diabetes Mellitus 863	Cerebrovascular Diseases 1848
6	Accidental 36		Suppressed	HIV 19	Diabetes Mellitus 62	Chronic Lower Respiratory Diseases 142	Diabetes Mellitus 284	Alzheimer's Disease 820	Diabetes Mellitus 1370
7	Respiratory Distress 21			Diabetes Mellitus 16	Chronic Liver Disease & Cirrhosis 50	Diabetes Mellitus 138	Cerebrovascular Diseases 260	Septicemia 627	Homicide 894
8	Bacterial Sepsis 12			Cerebrovascular Diseases 11	Cerebrovascular Diseases 36	Homicide 97	Septicemia 144	Nephritis 605	Septicemia 872
9	Homicide 12			Suppress	HIV 33	Suicide 91	Nephritis 121	Accidental 519	Alzheimer's Disease 831
10	Circulatory System Diseases 10				Chronic Lower Respiratory Diseases 27	Septicemia 68	Viral Hepatitis 92	Hypertension 464	Nephritis 807

*Data are suppressed when fewer than 10 deaths are observed within cause of death category

Mortality data are from the Ohio Department of Health Office of Vital Statistics Death Records, 2008-2017

City of Cleveland