COVID-19 OHIO MINORITY HEALTH STRIKE FORCE
BLUEPRINT

#MORE THAN A MASK.

Acknowledgments

Governor Mike DeWine formed the COVID-19 Minority Health Strike Force on April 20, 2020, in response to the disproportionate impact of COVID-19 on minorities in Ohio. The strike force contracted with the Health Policy Institute of Ohio (HPIO) to develop this "COVID-19 Ohio Minority Health Strike Force Blueprint." The "More than a Mask" campaign (www.coronavirus.ohio.gov/more) was created to engage communities of color in efforts to prevent and stop the spread of COVID-19 and mitigate the disparate impacts of the pandemic on Ohioans of color. The Education and Outreach Subcommittee of the Minority Health Strike Force provided guidance on development of the campaign and the campaigns' branding is used in the layout of this report.

Governor DeWine, the Strike Force and HPIO are grateful to all the community members and organizations who contributed ideas and expertise to this blueprint through virtual community forums, town hall meetings, and a community needs assessment, which gathered feedback from hundreds of community stakeholders facilitated by the Ohio State University College of Public Health and other stakeholder conversations.

COVID-19 Minority Health Strike Force

Subcommittee Chairs

Melba Moore, Ph.D., MS, CPHA, City of Cincinnati (Data and Research Subcommittee)

Charles Modlin, MD, MBA, FACS, Cleveland Clinic (Education and Outreach Subcommittee)

Charleta B. Tavares, PrimaryOne Health (Health Care Subcommittee)

June Taylor, Western Reserve Area Agency on Aging (Resources Subcommittee)

The full COVID-19 Minority Health Strike Force member list is included in Appendix A.

Table of Contents

This document includes the opinions of the Minority Health Strike Force and is not intended to endorse any pending legislation.

Crisis Facing Ohio

On April 20, 2020, Governor Mike DeWine launched the COVID-19 Minority Health Strike Force. This group of advisers has worked with state leadership to provide feedback on the immediate action necessary to address COVID-19 and its disproportionate impact on Ohioans of color. Once convened, the Strike Force collectively agreed that the roots of these disparities are deep and require a steadfast commitment to eliminate racism and advance equity to ensure the promotion of healthy communities.

This blueprint was developed during an exceptional time in history. The COVID-19 pandemic exposed and amplified the health disparities and inequities facing Ohioans of color. At the same time, Ohio and the rest of the nation are grappling with instances of unjust use of violence and the lives of people of color taken too soon. This led to widespread recognition that racism must be addressed throughout our country.

The events of past months present a unique opportunity to shine the spotlight on the challenges faced by Ohioans of color and propel policy action toward change. There is an urgency to move swiftly, strategically, and with strong leadership, building on past work, reports, and community input from many organizations and members who shared their perspectives through testimony, correspondence, and conversations.

Ohio can combat the crisis facing communities of color by taking a comprehensive and systemic approach. This blueprint provides a path forward.

Purpose of This Report

The purpose of this blueprint is to provide actionable recommendations to both eliminate racial and ethnic disparities in COVID-19 and other health outcomes and improve overall well-being for communities of color in Ohio. Prompted by the deep-seated health inequities exposed by the COVID-19 pandemic, this blueprint goes beyond the current crisis to establish a vision of Ohio as a model of justice, equity, opportunity, and resilience to withstand future challenges.

Developed by the COVID-19 Minority Health Strike Force with input from many community members around the state, the 35 actionable recommendations in this blueprint serve as a roadmap for the administration of Governor Mike DeWine to advance health equity in partnership with state, local and community officials in Ohio.

COVID-19 Minority Health Strike Force Interim Report

Released in May 2020, the Strike Force's interim report provided recommendations for state, local, and community officials to act immediately to:

- Stop the progression of COVID-19.
- Evaluate and document the impact of COVID-19.
- Remedy factors that contribute to the spread.
- Procure resources to prevent a resurgence of COVID-19.

The Governor's Office is working to implement the recommendations in the interim report.
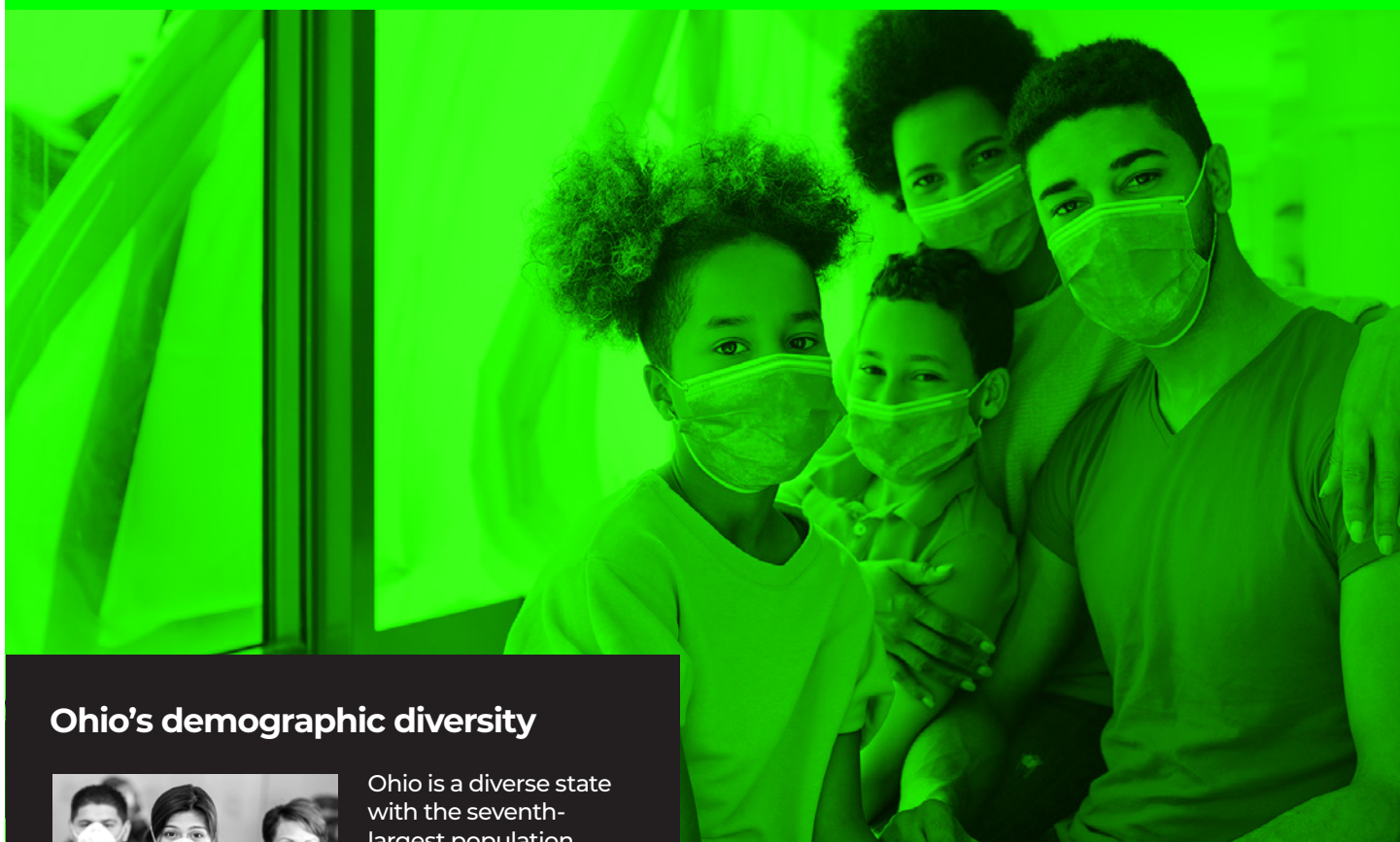
Ohio's demographic diversity

Ohio is a diverse state with the seventh-largest population in the U.S.[1] As of 2018, Black/African American, Latino, Asian American Ohioans and Ohioans who are members of other racial and ethnic groups with smaller populations, such as immigrants and refugees, comprised 21% of the state's population.[2] In addition, farms in Ohio employ about 5,700 migrant workers according to an estimate from the Ohio Department of Job and Family Services.[3] Ohio is also an aging state, it is estimated by 2025, more than 1 in 4 Ohioans will be age 60 and older. Ohio is also home to more than 1.6 million people (14%) who live with a disability.[4]

While diversity is a state strength, many Ohioans — including communities of color, people who are older and/or living with disabilities, residents of rural and Appalachian counties, immigrants, refugees, migrant workers and Ohioans who identify as LGBTQ, among others — are at risk for poor health outcomes.

Social drivers of health and health disparities

Research estimates that health is shaped by several modifiable factors, including health care or clinical care (20%); health behaviors (30%); and a person's social, economic, and physical environment (50%). These factors are often referred to as the "social determinants" or "social drivers" of health.

Differences in access to, and the allocation of, resources across the modifiable factors that shape health result in inequities, such as housing segregation, poverty, living in high-density neighborhoods, attending high-poverty schools, and incarceration. Health behaviors are also shaped by the environments in which a person lives, including the inequities they face.

Racism, other forms of discrimination, and the inequities they create are well documented as drivers of health disparities and poor overall health and well-being in communities of color.[5] Health disparities are avoidable differences in health outcomes among groups.

Figure 1 illustrates how racism and other forms of discrimination contribute to racial and ethnic disparities in COVID-19 and other health outcomes, including specific examples of inequities driving COVID-19 disparities that were prioritized by Minority Health Strike Force members (see Appendix C for a complete list of factors).

Figure 1 reflects that racism and other forms of discrimination permeate societal beliefs, interactions, organizations, and systems leading to inequities in health care and the social, economic, and physical environment. These inequities, in turn, directly and indirectly lead to poorer health outcomes and shortened lifespans for Ohioans of color.

Racism and other forms of discrimination also lead to trauma and toxic stress. The persistent stress of racism or extreme poverty causes changes to the neurological, endocrine, and immune systems that contribute to co-morbidities such as hypertension and heart disease.[6] Comorbidities render communities of color more vulnerable to COVID-19 complications and death. While protective factors, such as supportive family and caregiver relationships, social connections, and economic security can mitigate these risks, the impact of trauma and toxic stress often persists.[7]

Figure 1. **Factors driving COVID-19 and other disparities**

Primary drivers of inequity

Policy and system inequities
Examples related to COVID-19 and other health outcomes, prioritized by Strike Force members. Not an exhaustive list.**

Disparities in outcomes

Racism* and discrimination

- Toxic and persistent stress
- Trauma
- Exposure to violence
- Stigma

Health care access and quality
- Implicit bias, discrimination and lack of diversity in healthcare workforce
- Limited access to testing, treatment, personal protective equipment (PPE) and vaccine (when available)
- Lack of trust of medical professionals
- Lack of access to insurance coverage

Social and economic environment
- Poverty and disinvestment
- Unhealthy working conditions
- Incarceration
- Lack of access to business capital
- Limited access to education

Physical environment
- Crowded housing conditions
- Transportation barriers
- Digital divide

Disparities in co-morbidities
- Hypertension and heart disease
- Diabetes
- COPD, asthma, etc.

Overall health outcomes
- Premature death
- Health status

Disparities in COVID-19
- Cases
- Hospitalizations
- Deaths

Disparate impact of shutdown and recession
COVID-19 specific examples. Not an exhaustive list.**
- Unemployment
- Eviction and housing instability
- Anxiety, stress, depression, suicide and substance use disorders
- K-12 education disruption and learning loss

Cumulative impact across the life course and generations

* Structural, institutional, interpersonal and internalized racism
** See appendix for complete list of examples in rank order as prioritized by Strike Force members.

Disparities in COVID-19 cases, hospitalizations, and deaths in Ohio

As of June 24, 2020, there were a total of 46,759 COVID-19 cases, 7,447 hospitalizations and 2,755 deaths in Ohio. For a breakdown by race and ethnicity, see Figure 2.
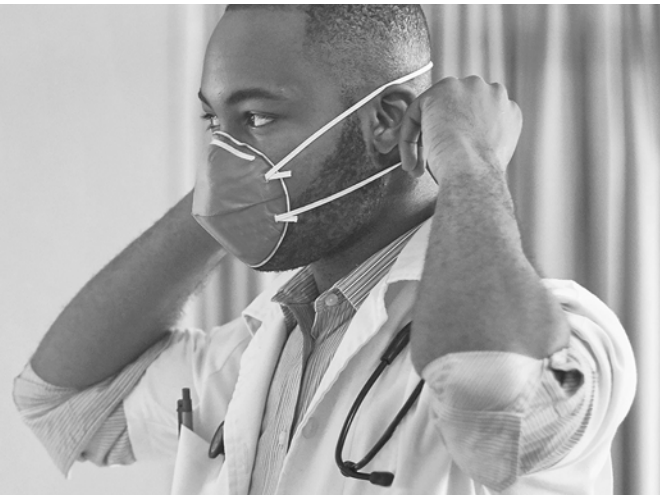
Figure 2. **COVID-19 cases, hospitalizations, and deaths in Ohio by race and ethnicity as reported through June 24, 2020**

	Percent of Ohio population	Cases (% of total)	Hospitalizations (% of total)	Deaths (% of total)
Race*				
White	82%	23,208 (50%)	4,104 (55%)	2,150 (78%)
Black	13%	11,985 (26%)	2,313 (31%)	510 (19%)
Multiracial	2%	1,800 (4%)	279 (4%)	33 (1%)
Asian	3%	1,503 (3%)	178 (2%)	29 (1%)
Hawaiian Native – Pacific Islander	0%	102 (0%)	21 (0%)	1 (0%)
American Indian – Alaskan Native	0%	51 (0%)	6 (0%)	1 (0%)
Other	—	3,599 (8%)	347 (5%)	16 (1%)
Unknown	—	4,511 (10%)	192 (3%)	15 (1%)
Refused to answer	—	None reported	7 (0%)	None reported
Ethnicity*				
Non Hispanic or Non Latino	96%	32,987 (71%)	6,337 (85%)	2,673 (97%)
Hispanic or Latino	4%	3,810 (8%)	508 (7%)	58 (2%)
Unknown	—	9,962 (21%)	594 (8%)	24 (1%)
Refused to answer	—	None reported	8 (0%)	None reported

*Labels for racial and ethnic groups in this table come from the source.
Source: Ohio Department of Health Coronavirus (COVID-19) Dashboard. Accessed on June 25, 2020. Last update listed on website was June 24, 2020.

Figure 3 compares COVID-19 outcomes for Black and white Ohioans relative to the percent of the state's total population. Black/African American Ohioans are overrepresented in COVID-19 cases (25.6%), hospitalizations (31%), and deaths (18.5%) compared to the percent of the state population that is Black/African American (13%).[8]

Latino Ohioans are also overrepresented in COVID-19 cases (8.1%) and hospitalizations (6.8%) compared to the percent of the state population that is Hispanic or Latino (3.9%).[9] As of July 14th, data indicate that these disparities have worsened.
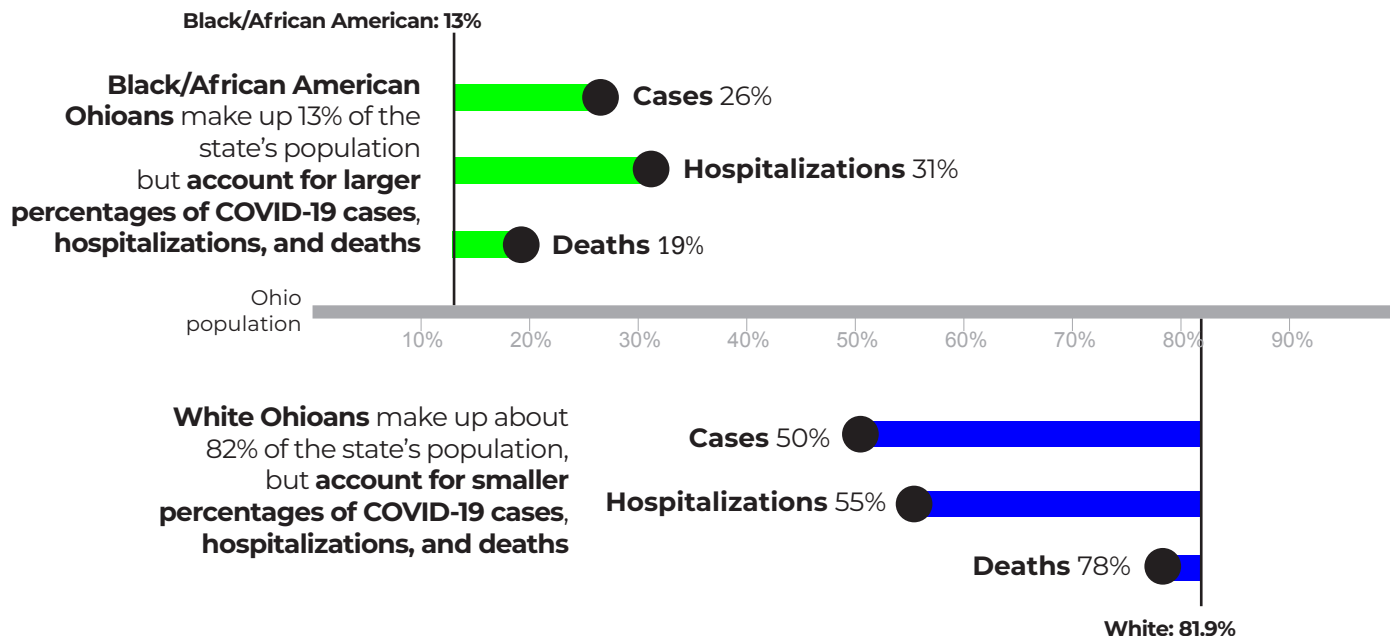
Figure 3. **COVID-19 cases, hospitalizations, and deaths through June 24, 2020, compared to population estimates, by race**

Black/African American: 13%

Black/African American Ohioans make up 13% of the state's population but **account for larger percentages of COVID-19 cases, hospitalizations, and deaths**

Cases 26%

Hospitalizations 31%

Deaths 19%

Ohio population

10%   20%   30%   40%   50%   60%   70%   80%   90%

White Ohioans make up about 82% of the state's population, but **account for smaller percentages of COVID-19 cases, hospitalizations, and deaths**

Cases 50%

Hospitalizations 55%

Deaths 78%

White: 81.9%

Source: Ohio Department of Health Coronavirus (COVID-19) Dashboard. Accessed June 25, 2020 at 8:30 AM. The last update noted on the website was June 24, 2020.

As of July 14, 2020, aggregated data on Asian American Ohioans do not indicate overrepresentation in COVID-19 cases, hospitalizations, and deaths. However, aggregating data for all Asian American populations may mask disparities experienced by groups with smaller populations, such as Bhutanese-Nepali refugees and other immigrant communities.

Age, race, and COVID-19

Research indicates that older adults are more vulnerable to hospitalization and death due to COVID-19. Nearly 26% of the white population in Ohio is over the age of 60, compared to 17.4% of the Black/African American population.[10] Through July 14, 2020, 91.1% of Ohioans who died with COVID-19 were older than 60.

Given this, it is expected that white Ohioans would be overrepresented in COVID-19 deaths. However, according to data from the Ohio Department of Health, Black/African American Ohioans are overrepresented in COVID-19 mortality, and white Ohioans are slightly underrepresented.

Disparities in other health outcomes in Ohio

While COVID-19 disparities are alarming, health disparities experienced by communities of color existed long before the pandemic. Ohioans of color often experience health problems at higher rates, including diabetes, hypertension, and heart disease.[11] These preexisting disparities have contributed to the increased vulnerability of Ohioans of color to COVID-19. Historical and contemporary racism, trauma, and the resulting inequities that drive health disparities have only exacerbated the impact of the pandemic on communities of color. This includes the remnants of slavery, Jim Crow laws and residential redlining (historical racism) and current racist and discriminatory practices such as racial profiling and predatory lending targeted in low-income communities of color (contemporary racism).

The Ohio Department of Health Online State Health Assessment (SHA) highlights racial and ethnic disparities in infant mortality and average life expectancy, which are key indicators of a population's overall well-being. According to the SHA:

- The infant mortality rate for Black/African American Ohioans (13.9 deaths per 1,000 live births) was double the state's overall rate (6.9) in 2018 (Figure 4).
- In 2017, the average life expectancy for Ohioans who are Black/African American (72.8) was 3.7 years less than the average life expectancy for all Ohioans (76.5) (Figure 5).

For these indicators, communities of color experience substantially worse outcomes than the population overall. The disparities that exist across these and other outcomes signal troubling inequities in the community conditions that support health.

Figure 4. **Ohio infant mortality rate by race, 2018**
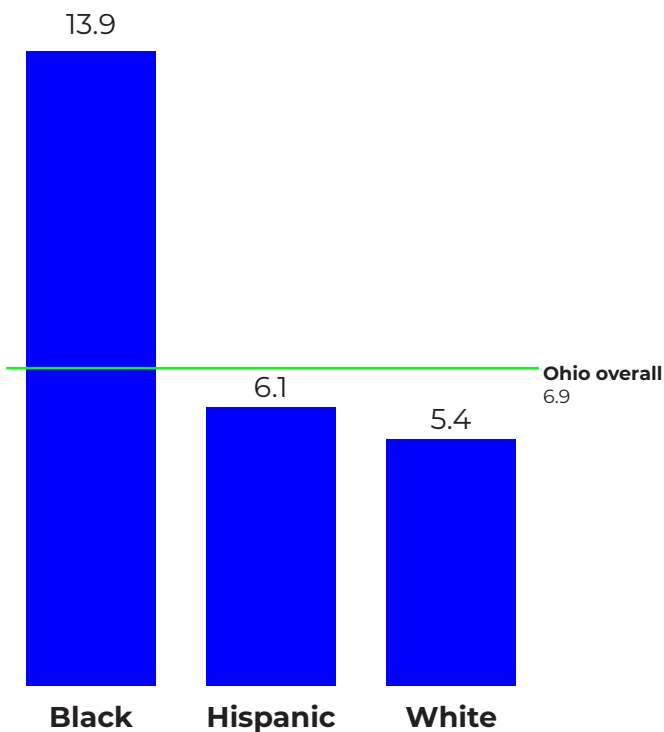
Source: 2018 Infant Mortality Annual Report. Ohio Department of Health, Feb. 25, 2020.

Inequities and community conditions

Healthy behaviors — such as physical activity, good nutrition, not smoking, and the appropriate use of primary care — can help to prevent many of the chronic conditions that put people at greater risk for severe COVID-19 complications. However, racism and other forms of discrimination, both historical and contemporary, have created inequities for groups of Ohioans, such as people of color, people living
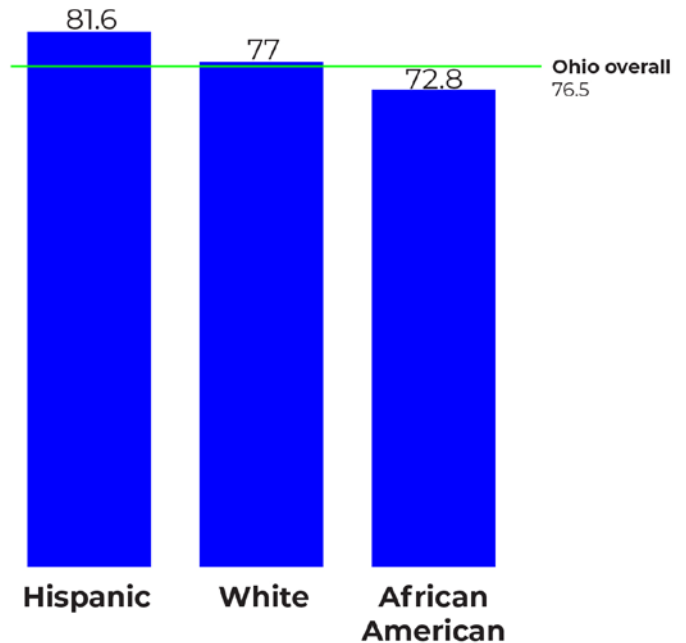
Figure 5. **Average life expectancy at birth by race in Ohio, 2017**

Source: "2019 Online State Health Assessment." Ohio Department of Health. Accessed June 22, 2020.

with disabilities, and people with low incomes that present substantial obstacles to making healthy choices.

For example, community conditions in many neighborhoods do not support healthy behaviors. Targeted advertising of tobacco products to people who are low-income, Black, and/or LGBTQ, and the higher saturation of tobacco retailers in lower-income neighborhoods, contribute to higher rates of smoking among these groups. In addition, chronic and persistent stress and a lack of access to healthy food and places for physical activity make healthy eating and active living more difficult.

COVID-19 data limitations

More specific data is necessary to understand the full extent of racial and ethnic disparities related to COVID-19. For example, collecting and reporting testing rates by race, ethnicity, county, and ZIP code would enable policymakers to identify gaps in testing for vulnerable populations and target resources to those communities.

Updates to the Ohio Department of Health's Coronavirus Dashboard in early June 2020 allowed for access to county-level data broken down by race. Interpreting this data, however, is difficult because it is not presented in context. For example, providing the percentage of cases, hospitalizations, and deaths by race without providing population size by race does not give users of the dashboard enough information to identify disparities, even at the most basic level. The dashboard also does not include summary statistics that put data in context, such as age-adjusted cases, hospitalizations, and death rates by race. These summary statistics would help stakeholders to compare outcomes between groups, understand disparities in COVID-19, and take action to eliminate those disparities.

Achieving equity for at-risk Ohioans

The purpose of this blueprint is to eliminate inequities and disparities faced by Ohioans of color. However, equity can only be achieved when inequities and disparities and racism and discrimination in all its forms are eliminated and all Ohioans are able to achieve their full potential.

Other at-risk communities in Ohio also experience health inequities and disparities, such as people living with disabilities, people in rural and/or Appalachian areas, migrant workers, immigrants, refugees, and people who identify as LGBTQ. Furthermore, Ohioans who are members of more than one at-risk population, such as Ohioans of color with a disability, often experience even more disparate outcomes.

Each recommendation identified in this blueprint can be implemented or adapted to eliminate inequities and disparities experienced by other at-risk communities.

Action framework and vision

The recommendations in this blueprint are designed to achieve the outcomes and vision in the action framework (Figure 6). The framework emphasizes that racism must be dismantled to advance equity and identifies three policy categories that contribute to health outcomes and disparities: health care and public health, the social and economic environment, and the physical environment. Collectively, these categories are also referred to as the social determinants of health or social drivers of health.

Figure 6. **COVID-19 Minority Health Strikeforce action framework**

Dismantle racism to advance health equity

Racism and other forms of discrimination are root causes of the inequities that lead to poor health outcomes for people of color. The historical and contemporary trauma caused by racism has affected generations of people of color and continues to this day. Dismantling racism is critical to advance equity and must be accomplished through public and private partnerships and multi-sector collaboration that builds community trust and empowers culturally and linguistically specific community efforts.

Improve outcomes for Ohioans of color*

Health care and public health
- Reduce discrimination and increase workforce diversity
- Increase access to COVID-19 testing, treatment, personal protective equipment (PPE) and vaccine (when available)
- Increase access to health care

Social and economic environment
- Improve access to high-quality education
- Reduce poverty and increase investment and employment
- Improve working conditions
- Decrease arrest and incarceration rates

Physical environment
- Increase safe and affordable housing
- Increase access to transportation
- Decrease the digital divide
- Ensure safe access to voting

Improve health outcomes and eliminate disparities

- COVID-19 and other diseases
- Premature death
- Health status

Vision
Ohio is a model of justice, equity, opportunity and resilience to withstand future challenges

* Examples prioritized by Strike Force members. Not an exhaustive list.

Data, implementation and accountability

From recommendations to action

Every person, organization, institution, and system in Ohio has a specific and distinct role to play in dismantling racism and moving the recommendations in this blueprint forward.

Achieving the vision in Figure 6 requires a comprehensive and coordinated approach across all levels of society. In addition to entities that can directly fund or implement change, action can be taken by others through increased education on the recommendations and issues addressed in this blueprint, serving as an ally to communities of color and advocating for implementation of these recommendations and other changes.

For Ohioans of color, thinking about the issues highlighted in this blueprint is not a choice. It is critical to engage in self-care and take action.

Dismantling Racism to Advance Health Equity

The historical and contemporary trauma caused by racism has affected generations of people of color and continues to this day. Dismantling racism is critical to advance health equity and must be accomplished through public and private partnerships and multi-sector collaboration that builds community trust and empowers culturally and linguistically specific community efforts. The following recommendations lay the groundwork for dismantling racism and advancing equity.

Understanding racism

There is a false perception in society that racism is only a direct act of prejudice initiated by one individual toward another because of race. However, racism plays out across multiple levels of society.

Race Forward's "Four Levels of Racism Framework," describes racism occurring at the individual and systemic level. At the individual level, racism can take the form of privately held racial beliefs of prejudice, oppression, and privilege about one's own race or other races or "internalized racism." Also, at the individual level is the more commonly understood display of "interpersonal racism," when individuals interacting with one another act upon their racial beliefs. This can manifest indirectly or directly through bias, violence, or hate.

At the systemic level, racism occurs within institutions "institutional racism" and across institutions and society "structural racism". Systemic racism is pervasive, far-reaching and manifests in the inequities experienced by communities of color. Systemic racism can be seen in the racial wealth gap and inequitable opportunities afforded to communities of color. This racism framework can be applied to other "isms" including ableism, sexism, and ageism.

To achieve equity, racism and discrimination in all its forms must be eliminated.

Dismantling Racism to Advance Health Equity

■ 1. Acknowledge racism as a public health crisis and commit to swift action to dismantle racism, which is a driving force of the social determinants of health.

State and local government leadership, publicly funded entities, and community partners across sectors — including health care, education, employment, housing, food, and criminal justice — should acknowledge racism as a public health crisis and dismantle racism and other forms of discrimination through a review of internal and external policies and procedures. This includes a review of administrative policies; leadership appointments; hiring and other human resource practices; vendor selection and contracting; and grant management, funding and other resource allocations.

■ 2. Apply a health equity lens to policy.

State and local government leaders and cross-sector partners should apply a health equity lens to evaluate and inform policy, including legislation, rules, codes, and organizational policies and procedures. This could include (1) prioritizing equitable outcomes in policy agendas for communities of color, (2) conducting impact assessments of proposed policy to ensure equitable outcomes for communities of color, (3) tailoring policies to meet the needs of communities of color, and (4) strategically allocating resources and funds to advance equity.

■ 3. Ensure equitable representation of Ohioans of color in government and private sector leadership.

State and local government and private sector leadership should develop and implement plans to ensure equitable representation of Ohioans of color in leadership positions across all branches of government as well as for-profit and nonprofit organizations, including governing and advisory boards and C-suites.

■ 4. Develop community understanding, health literacy, and trust.

State government leaders should work with influential leaders and members of communities of color to develop a cross-agency and sector outreach campaign to increase health literacy and educate all Ohioans on (1) the multiple factors that shape health (social drivers of health); (2) the impact of historical and contemporary racism, trauma, and other forms of discrimination on communities of color; (3) the severity of racial and ethnic inequities and disparities; (4) steps that can be taken individually to improve health; and (5) actions that can be taken by public and private entities to build and develop trust and partnership with communities of color through authentic engagement.

■ 5. Require cross-sector cultural and linguistic competency and implicit bias trainings.

State and local government leadership and Ohio's professional licensing boards should require trainings for policymakers and licensed professionals on cultural and linguistic competency, cultural humility, and implicit bias. This includes, but is not limited to, elected officials, government leadership and staff, and licensed professionals. Trainings should be considered as part of licensed professional continuing education requirements and should be aligned with National Standards for Culturally and Linguistically Appropriate Services (CLAS) or other national standards in health and health care. Trainings and CLAS alignment should also be considered for other cross-sector partners including Ohio's health care and public workforce, (i.e., hospitals, health systems, service providers and contract tracers), education, corrections, and other health and human service organizations.

■ 6. Develop cultural competency and language access plans.

State government leadership should work closely with leadership from state agencies, boards, and commissions and community partners to develop and implement cultural competency and language access plans to deliver multilingual and community-tailored delivery of programs, services, and resources. This could include quality interpretation, translation, visual aids, print materials in multiple languages, public service announcements, and social media content.

■ 7. Develop a plan for future emergency response efforts.

State government leadership should work with influential leaders and members of communities of color to develop a plan to ensure equity is considered in all aspects of emergency response efforts for future public health emergencies and disaster responses. The plan should ensure the rapid mobilization of communities of color during emergency responses to mitigate the adverse and disparate impact on Ohioans of color.

Health Care and Public Health

The following recommendations provide initial steps to remove the historical and contemporary obstacles that communities of color face in accessing high-quality health care and public health services.

Our recommendations

Reduce discrimination and increase diversity in the health workforce

■ 8. Recruit and retain people of color in health professions.

The state of Ohio should support the recruitment and retention of an equitable representation of Ohioans of color in health care and public health professions in all established workforce development programs. This could include providing academic and financial support, connecting with health and career preparation programs, professional experiences, and mentoring opportunities for high school, college, or post-baccalaureate students. The plan should also focus on retention, advancement, and education opportunities, including providing guidance and upper management (c-suite) training for Ohioans of color currently in the health care workforce.

■ 9. Consider internal reviews as a tool to address racism and other discrimination in health care.

State government leadership should work with, and consider requiring, all health care organizations, including hospitals, behavioral health providers, long-term care facilities, and others, to collect complete and accurate patient demographic data (i.e., race, ethnicity, language, disability) through electronic medical records to track differences in outcomes among their patient populations and develop a plan to mitigate any disparities, including performing internal reviews of the provider organization's policies and practices.

■ 10. Expand opportunities for Ohioans to receive trauma-informed interventions by enhancing efforts for practitioners, facilities, and agencies to become competent in trauma-informed practices.

State and local government leadership should continue, and expand the reach of, trauma-informed care practices and evidenced-based trauma interventions, including collaboration across provider disciplines and streamlined referral pathways when caring for patients who have experienced trauma.

■ 11. Consider and seek out sustainable funding sources to community-based health initiatives.

State agencies, including the Ohio Department of Health, along with philanthropy and other private-sector partners, should increase, or find sustainable funding for, evidence-based and promising community-based health initiatives that employ, and are overseen by, individuals who are representative of, and trusted by, communities of color, including community navigators and coordinators.

Increase access to health care

■ 12. Bolster health insurance enrollment support.

State government leadership should increase and enhance health insurance enrollment outreach and support programs to assist Ohioans of color who do not have access to affordable employer-sponsored health insurance.

■ 13. Integrate behavioral health into primary care

In order to increase access to mental health and addiction services for communities of color, state agencies including the Ohio Departments of Mental Health & Addiction Services, Medicaid, Insurance, Health, and Rehabilitation and Corrections should work together and with local communities to increase culturally meaningful screening, early intervention, and linkage to treatment in primary health care, community settings, and Ohio's institutions.

Increase access to COVID-19 testing, treatment, personal protective equipment (PPE), and a vaccine (when available)

Note: Recommendations to increase culturally appropriate and accessible testing and treatment for COVID-19, including the availability of adequate PPE, are provided in the "COVID-19 Minority Health Strike Force Interim Report." (See recommendations 2, 3, 4 and 5 of the interim report.)

Social and Economic Environment

Because health disparities are shaped by community conditions, improvements to the social and economic environment are critical to achieve equity. Historical divestment and residential segregation, higher poverty and unemployment rates, mass incarceration, employment in jobs with fewer benefits and telecommuting opportunities, and inequities in the criminal justice and education systems have kept many Ohioans of color from reaching their full potential.

Our recommendations

Improve access to high-quality education

■ 14. Strengthen early childhood education.

State and local policymakers and private philanthropy should look for ways to increase the number of Ohio children served by high-quality childcare and preschool/pre-K and review funding for early learning programs.

■ 15. Ensure K-12 chronic absenteeism reduction efforts meet the needs of children of color.

State government leadership should tailor efforts to decrease K-12 chronic absenteeism and increase graduation rates to meet the needs of students of color and students with disabilities and consider providing support to local school districts to ensure that future online learning successfully engages all Ohio families.

■ 16. Build pathways to higher education.

State government leadership and private philanthropy should consider investments in initiatives that increase the number of Ohioans of color who attend and obtain degrees in higher education, such as pipeline programs that transition K-12 students into college and retention interventions to help first-generation college students complete their degrees.

Reduce poverty and increase investment and employment

■ 17. Consider the implementation of one or more of the poverty-reduction strategies from the 2020-2022 State Health Improvement Plan (SHIP)

State and local leaders should consider the implementation of the evidence-based poverty reduction strategies in the SHIP, such as adult employment and high school equivalency programs. In addition, state government leadership should work together to identify additional strategies to decrease poverty and increase investment in communities of color.

■ 18. Encourage nonprofit hospitals in high-poverty communities to make "place-based" investments and implement inclusive local hiring, purchasing, and vendor contracting practices.

State and local policymakers should consider encouraging tax-exempt hospitals and others to review models like Healthcare Anchor Network; request that hospitals include specific documentation regarding local hiring, purchasing, vendor contracting, and place-based investment in communities of color as part of their annual reporting of community benefit to the Ohio Department of Health; and, publicly report this information, showcasing examples of hospitals that make measurable changes to investments and practices.

Improve working conditions

■ 19. Enhance job connections and workplace protections for essential workers by linking people of color to job training and other employment supports.

Employers should work with state and local governments to set standards that improve and ensure workplace safety. The standards should consider the provision of supplies for personal protection and cleaning, the possibility of hazard pay or paid leave, and the availability of career advancement training and job placement support to alleviate the impact of existing inequities.

Decrease arrest and incarceration rates

■ **20. Develop a health and criminal justice partnership.**

State government leadership should formalize a partnership to identify policy reforms to reduce community violence; police brutality; and bias in policing, sentencing, and other aspects of the criminal justice system. This, in turn, will reduce the incarceration rate of people of color.

■ **21. Reform law enforcement practices.**

State government leadership should monitor and evaluate the implementation of law enforcement reforms announced by Governor DeWine and Attorney General Dave Yost on June 17, 2020. The reforms include an Oversight and Accountability Board.

■ **22. Collect and report consistent, disaggregated police and court data.**

State government leadership should issue guidance to all local law enforcement agencies and courts asking that they report data on race, ethnicity, and income in a consistent way in order to assess the impact of law enforcement and criminal justice policies on various groups of Ohioans and to identify opportunities to reduce disparities and inequities in the criminal justice system.

In June, Governor DeWine developed a plan for meaningful law enforcement reform in Ohio by promoting widespread adoption of Ohio's use-of-force standards, as well as ordering the development of a standard for law enforcement's response to mass protests. Governor DeWine also created a new Ohio Office of Law Enforcement Recruitment to focus on improving the representation of minorities and women as peace officers and offered reimbursement to law enforcement agencies that have yet to provide training on use-of-force, de-escalation, and implicit bias in 2020. Chokeholds by law enforcement officers employed by state agencies are now prohibited unless the officer is justified in using deadly force, and Governor DeWine directed the Ohio State Highway Patrol to begin outfitting their troopers with body cameras and to refer all trooper-involved shootings and in-custody deaths for investigation by the Ohio Bureau of Criminal Investigation.

Both Governor DeWine and Attorney General Dave Yost also made a number of recommendations to the Ohio General Assembly requesting that the legislature:

1) Create a law enforcement oversight and accountability board within the Ohio Attorney General's Office.
2) Mandate independent investigations and prosecutions for all officer-involved shootings and in-custody deaths.
3) Mandate that all law enforcement basic training applicants pass a psychological exam prior to admittance into a police academy.
4) Identify a permanent funding stream for annual law enforcement training.
5) Mandate the reporting of use-of-force incidents to the state.
6) Examine what financial assistance is available to increase the use of body cameras.
7) Ban the use of chokeholds, unless deadly force is justified.

Physical Environment

Because health disparities are shaped by community conditions, improvements to the physical environment are critical to achieve equity.

Our recommendations

Increase safe and affordable housing

■ **23. Review the number of Ohioans in congregate settings.**

State agencies should review the use of congregate settings to reduce unnecessary use (nursing homes, residential care facilities for people with disabilities, group homes, and correctional facilities) and consider policy changes that allow people to receive the supports or treatment they need at home and/or for justice to be served in the community.

■ **24. Implement services and policies to prevent eviction.**

State and local policymakers can reduce disparities in evictions by increasing rapid access to legal representation, landlord-tenant mediation, and other supportive services, including emergency financial assistance.

■ **25. Continue support of the Ohio Housing Trust Fund.**

State policymakers should improve the availability of safe, accessible, and affordable housing for low-income and other at-risk Ohioans by supporting the Ohio Housing Trust Fund and finding ways to support home ownership in communities of color.

Increase access to transportation

■ **26. Improve access to public transportation.**

State policymakers should look for strategies to support and improve access to public transportation, prioritizing transit strategies that improve accessibility and better connect communities of color to health care, jobs, and education.

Decrease the digital divide

■ **27. Explore options to expand broadband funding to ensure that Ohioans of color have sufficient internet access and bandwidth for education and telehealth activities.**

The state should fully implement Innovate Ohio's Broadband Strategy and examine expansion of the InnovateOhio statewide grant program to target resources to low-income communities.

Data, Implementation, and Accountability

Comprehensive, disaggregated, and actionable data is critical to inform and evaluate Ohio's policy decisions and to track progress on eliminating disparities and inequities. The recommendations below strengthen Ohio's data collecting and reporting infrastructure and increase public access to data.

Our recommendations

■ 28. Improve data collection and reporting.

State and local governmental leadership and cross-sector partners should improve the collection of comprehensive and complete data from the communities they serve. The data should provide information about residents' race, ethnicity, primary language, and country of origin. This data should be publicly reported to identify health inequities and disparities and measure population-specific outcomes of interventions and policies on Ohioans of color. Additionally, state agencies and health professional licensure boards should consider routinely collecting, and making publicly available, data regarding the race/ethnicity of graduates of health care professional programs and licensed health care providers.

■ 29. Increase public access to data and support research.

State government leadership should make cross-sector, racially and ethnically identified health and social services data publicly available to researchers and community-serving organizations by leveraging existing contracts and projects through the InnovateOhio platform. Data should be used for health equity research, program design, and evaluation at the community level. Research using this data should be adequately funded and should consider targeting resources to communities with the greatest need.

■ 30. Build organizational capacity.

State government leadership and other cross-sector partners should build organizational capacity to advance health equity by considering: (1) health equity positions in organizational leadership, (2) the establishment of specialized external advisory panels on health equity, (3) ongoing training to improve data collection of race, ethnicity, primary language, and other demographic factors, as well as qualitative data from communities of color, and (4) engaging equity experts in all phases of the response to public health crises and regular health planning and improvement efforts.

■ 31. Develop dashboards to monitor inequities and disparities.

State agencies should develop and continuously update online dashboards that track health inequities and disparities using data from state agencies and other publicly available data. Dashboards should provide data in context, so that policymakers and the public can easily understand the inequities and disparities that exist between groups (e.g., age-adjusted rates by race, comparisons of prevalence to population size, etc.).

■ 32. Consider the need for sufficient samples to identify disparities in groups with small population sizes.

State government leadership should consider the importance of sufficient sample sizes to allow precise subpopulation estimates to comprehensively describe prevalence and outcomes in different racial and ethnic groups and subpopulations with smaller population sizes, such as Bhutanese-Nepali refugees and other immigrant communities and people who are part of more than one at-risk community.

■ 33. Implement the blueprint and interim report and monitor success.

Cross-agency statewide equity plans, led by state government leadership, equity experts, and community members of color, should be developed to set measurable objectives and monitor implementation of all blueprint and interim report recommendations. Action taken to implement blueprint recommendations should be tracked and reported annually. Progress on interim report recommendations should be tracked and reported on the website of the Ohio Department of Health or state website.

State Health Improvement Plan equity objectives

The 2020-2022 State Health Improvement Plan (SHIP) is a tool to strengthen state and local efforts to improve health, well-being, and economic vitality in Ohio. Equity is a central focus of the SHIP, which includes strategies to decrease inequities and measurable objectives to eliminate disparities in outcomes, such as overall health status, premature death, maternal morbidity, diabetes, heart disease, poverty, and lead poisoning. The Ohio Department of Health is responsible for reporting progress on these objectives on an annual basis, including disaggregated data for priority populations such as Black/African American and Hispanic/Latino Ohioans.

■ **34. Strengthen cross-agency implementation of SHIP and monitor success.**

The State Health Improvement Plan (SHIP) Steering Committee will remain intact to lead statewide implementation of 2020-2022 strategies. The Ohio Department of Health should convene the Steering Committee, including representation of relevant state agencies and produce a public report of progress on strategies and objectives on at least an annual basis, including data disaggregated for priority populations.

How Were These Recommendations Developed?

Leadership

Governor Mike DeWine formed the COVID-19 Minority Health Strike Force on April 20, 2020 in response to the disproportionate impact of COVID-19 on minorities in Ohio. The strike force is co-chaired and facilitated by Ohio Department of Aging Director Ursel McElroy and the Governor's RecoveryOhio Initiative Director Alisha Nelson. Ronald Todd, Governor DeWine's Minority Liaison, is the community relations chair of the strike force.

The Minority Health Strike Force includes 52 members from the public and private sectors. Four subcommittees were created as part of the strike force, with chairs designated to facilitate dialogue.

Over the course of the past two months there have been:

- Eight meetings of the full Minority Health Strike Force.
- Over 20 subcommittee meetings of the strike force.
- A virtual community forum hosted by the strike force.
- Three focus-groups to gain community insight on education and outreach approaches hosted by the strike force.

The strike force received more than 500 phone calls, letters, and emails from people and groups across Ohio. Also, individuals and organizations shared feedback during seven community discussions to help members of the strike force prepare this report.

Purpose of the "COVID-19 Minority Health Strike Force: Interim Report"

The interim report included 18 recommendations in four key areas: data, health care, education and outreach, and resources. It was created with input gathered through subcommittee discussions. The interim report was made available following a press conference on May 21, 2020, during which Governor DeWine discussed the report's findings.

Blueprint report process

Figure 7 outlines the process used to engage the strike force and develop the blueprint. In addition to building from the interim report, the final blueprint was also informed by full task force and subcommittee discussions, as well as the following:

• **Recommendations survey:** Recommendations for this blueprint were gathered through an online survey completed by members of the Minority Health Strike Force. First, members were asked to prioritize factors that drive health disparities related to health care access and quality, the social and economic environment, the physical environment, and the shutdowns and recession brought on by COVID-19. Next, members were asked to suggest three recommendations for inclusion in the final report that address inequities and were specific and actionable, directed at the decision-making authority that can implement the change, and supported by best practices, evidence, or data.

• **Virtual public meetings:** Input was gathered through several virtual platforms. The strike force hosted a virtual community meeting on June 16, 2020, to gather thoughts and suggestions for consideration for the final blueprint. There were 12 presentations and about 125 attendees during the virtual meeting.

The nonprofit Advocates for Ohio's Future, Children's Defense Fund-Ohio, and Policy Matters Ohio hosted three virtual town hall meetings that members of the strike force attended.

Throughout these public meetings, experts and community residents from across Ohio provided their unique perspectives on the impact of COVID-19 and other health disparities. The communities represented by the speakers included people experiencing homelessness, low-income families, people with disabilities, immigrants and refugees, Ohioans from Appalachia, and members of the Hispanic/Latino and the LGBTQ communities. Organizations expressed concerns about housing, air quality, income inequality, mental health and addiction, infant mortality, transportation, education, internet access, voting, and access to health care.

• **Ohio's COVID-19 Populations Needs Assessment:** The Ohio State University College of Public Health, in partnership with the Ohio Department of Health, conducted a needs assessment survey from May 2020 through early June to gather feedback on community needs in response to COVID-19. The assessment was completed by 363 community stakeholders representing six at-risk populations (people with disabilities and people who are immigrants/refugees, Black/African American, Asian American, Hispanic/Latino, or who live in rural areas). Expert panels representing each of the six populations targeted by the needs assessment were convened to validate survey findings and provide context and supplementary information to inform final recommendations.

• **Additional feedback:** The co-chairs of the Minority Health Strike Force, as well as the subcommittee chairs, had many additional communications with stakeholders from around the state that informed the work of the strike force.

Figure 7. **Minority Health Strike Force process**
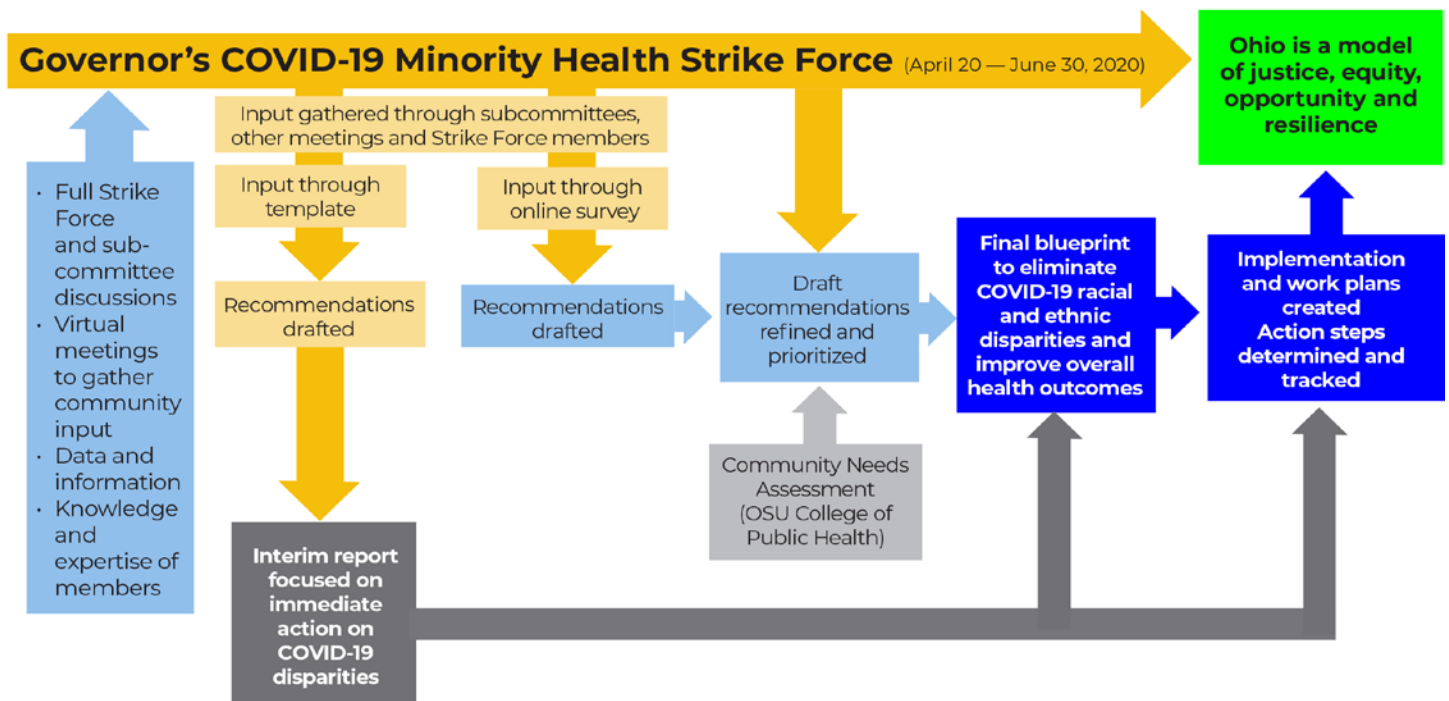
Recommendations were prioritized for inclusion in the blueprint based on the following criteria:

• **Specific and actionable.** Recommendation includes a specific policy lever and identifies the decision-making entity that can make the change.

• **Ability to track progress.** Data and information can be compiled to assess and report progress on this recommendation in a meaningful way.

• **Ability to impact.** Extent to which state government and other stakeholders can make progress implementing this recommendation within the next two years.

• **Strength of evidence of effectiveness.** Extent to which there is research-based evidence for the effectiveness of this approach to reduce disparities in COVID-19 (cases, hospitalizations and deaths), as well as overall health outcomes such as premature death and overall health status.

• **Continuity and alignment.** The recommendation is included in another report and/or the extent to which it aligns with other priorities and initiatives in Ohio.

(Appendix D includes a list of the sources consulted to provide additional detail and context to these recommendations.)

APPENDIX

Minority Health Strike Force Member List

COVID-19 Minority Health Strike Force Members

Name	Organization and Title
Alisha Nelson (Co-Chair)	Office of Governor Mike DeWine – RecoveryOhio, Director
Ursel McElroy (Co-Chair)	Ohio Department of Aging, Director
Ronald C. Todd II (Community Relations Chair)	Office of Ohio Governor Mike DeWine, Minority Liaison
Healthcare Subcommittee	
Charleta B. Tavares (Subcommittee Chair)	PrimaryOne Health, CEO
Anthony Armstrong, MD	Ohio State Medical Association, President
Andrew Jackson	Elson International Inc., Owner and CEO
Chezré Willoughby	Ohio Department of Medicaid
David Ellsworth	Ohio Department of Health
Donna James	Lardon & Associates, Managing Director – Center for Healthy Families, Founder
Lolita McDavid, MD, MPA	Child Advocacy & Protection at Rainbow Babies and Children's Hospital
Tiffany Huber	Ohio Department of Health
Traci Bell-Thomas	Ohio Department of Medicaid
Education and Outreach Subcommittee	
Charles Modlin, MD, MBA, FACS (Subcommittee Chair)	Cleveland Clinic
Breann González Almos	Office of Governor Mike DeWine
Cora Munoz, Ph.D., RN	Ohio Asian American Health Coalition
Dawn Thomas	Ohio Department of Mental Health and Addiction Services
Guadalupe A. Velasquez	Welcome City, Managing Director
Jamie Carmichael	Ohio Department of Mental Health and Addiction Services
Pastor John Coats	Columbus NAACP, 2nd Vice President
John H. Gregory	National Center for Urban Solutions
Lilleana Cavanaugh	Ohio Latino Affairs Commission, Executive Director
Robert Jennings	National Public Health Information Coalition, Executive Director
Ron Ponder	Pondersystem Media and Marketing, Owner and CEO
Tracee Garrett	Global Insight Productions, President and CEO
Yaves Ellis	Sling Shot Media Group, Owner – Radio One, Director of Public Affairs

Resources Subcommittee	
June Taylor (Subcommittee Chair)	Western Reserve Area Agency on Aging, Chief, Performance and Strategy
Alisia Clark	Ohio Department of Mental Health and Addiction Services
Christopher Smitherman	City of Cincinnati, Vice Mayor
Earnika Pitts	Ohio Department of Medicaid
Representative Emilia Strong Sykes	Ohio House of Representatives, Minority Leader, 34th District
Mayor Jamael Tito Brown	City of Youngstown
Joseph Hill	Ohio Department of Mental Health and Addiction Services
Congresswoman Joyce Beatty	U.S. House of Representatives, Ohio 3rd Congressional District
Pastor Jeffrey Dennis	Minority Behavioral Health Group
Michael B. Colman	Ice Miller Legal Counsel, Partner-in-Charge of Government Law
Michele Reynolds, Ph.D.	Governor's Office of Faith Based and Community Initiatives, Director
Stephen Massey, MS	Trauma Recovery Center, Chief Operating Officer, RecoveryOhio Advisory Council Member
Thomas Banks	IAP Government Services Group, President and CEO
Tiffany Bryant	Ohio Department of Job and Family Services
Bishop Timothy J. Clarke	First Church, Senior Pastor
Data and Research Subcommittee	
Melba Moore, Ph.D., MS, CPHA (Subcommittee Chair)	City of Cincinnati, Health Commissioner
Annette Chambers-Smith	Ohio Department of Rehabilitation and Corrections
Alisha Brown	Ohio Department of Medicaid
Angela C. Dawson, MS, MRC, LPC	Ohio Commission on Minority Health, Executive Director
Deena J. Chisholm, Ph.D.	Center for Innovation in Pediatric Practice at the Abigail Wexner Research Institute at Nationwide Children's Hospital, Director
Johnnie Allen	Ohio Department of Health
Mike Davis	Ohio Department of Rehabilitation and Corrections
O'dell M. Owens, MD, MPH	Interact for Health, President and CEO
Reina Sims	Ohio Commission on Minority Health
Renee Mahaffey Harris	Closing The Health Gap, President and CEO
Renee Tolliver	Ohio Department of Mental Health and Addiction Services
Ronnie Dunn, Ph.D.	Cleveland State University, Interim Chief Diversity Officer, Associate Professor

Appendix B:

Implementation Plan

Minority Health Strike Force implementation plan TEMPLATE

Recommendation	Specific action step	State agency(ies) responsible	Person(s) responsible	Timeframe	Community representation	Indicator of success	External communication plan
Insert recommendation from Minority Health Strike Force Blueprint report	If necessary, identify and specify action steps to complete recommendation; insert action steps here	List state agency(ies) or other entities responsible for taking action; include agencies with ancillary but critical functions, such as institutional review boards, Controlling Board, the General Assembly, JCARR, etc.	List people responsible for taking action	Provide a specific deadline for when action should be taken and communicated to internal and external stakeholders	Provide a brief description for how the community(ies) most impacted by the recommendation will be engaged in completing action steps	Provide a brief statement of how the people responsible will know when they have completed assigned action steps. Whenever possible, assign quantifiable indicators.	Provide details on when and how both internal and external stakeholders will be notified about progress toward completing action steps and fully implementing recommendations

Minority Health Strike Force Recommendation Survey: Prioritization Question Results

Total number of participants: 31
Response rate: 58.5%

Figure C.1. **Which of the following health care access and quality factors are the most important to prioritize for the final Minority Health Strike Force report?** (N=31)

Health care access and quality factors	Responses
Implicit bias, discrimination, and lack of diversity in health care workforce	87% (N=27)
Limited access to testing, treatment, personal protective equipment (PPE), and vaccine	65% (N=20)
Lack of trust of medical professionals	52% (N=16)
Limited access to health insurance coverage	48% (N=15)
Language barriers	26% (N=8)
Lack of health literacy	19% (N=6)

Figure C.2. **Which of the following social and economic environment factors are the most important to prioritize for the final Minority Health Strike Force report?** (N=31)

Social and economic environment factors	Responses
Poverty and disinvestment	100% (N=31)
Unhealthy working conditions	39% (N=12)
Incarceration	32% (N=10)
Lack of access to business capital	32% (N=10)
Limited access to education	32% (N=10)
Limited food access	29% (N=9)
Language barriers	23% (N=7)
Barriers to physical activity	0% (N=0)

Figure C.3. **Which of the following physical environment factors are the most important to prioritize for the final Minority Health Strike Force report?** (N=31)

Physical environment factors	Responses
Crowded housing conditions	**90% (N=28)**
Transportation barriers	**90% (N=28)**
Digital divide	**81% (N=25)**
Virus transmission on city buses	13% (N=4)
Air pollution	10% (N=3)
Tobacco marketing and tobacco retail density	6% (N=2)

Figure C.4. **Which of the following disparate impacts of the shutdown and recession due to COVID-19 are the most important to prioritize for the final Minority Health Strike Force report?** (N=31)

Disparate impacts of the shutdown and recession	Responses
Unemployment	**71% (N=22)**
Eviction and housing instability	**65% (N=20)**
Anxiety, stress, depression, suicide and substance use disorders	**55% (N=17)**
K-12 education disruption and learning loss	**48% (N=15)**
Loss of minority-owned businesses	29 % (N=9)
Disrupted child care	19% (N=6)
Disrupted access to behavioral health care	10% (N=3)

Appendix D:

Additional Sources Consulted

The following sources were consulted to provide detail and context to the recommendations included in this Blueprint.

1. "A new approach to reduce infant mortality and achieve equity: Policy recommendations to improve housing, transportation, education and employment," Health Policy Institute of Ohio, prepared for the Ohio Legislative Services Commission. December 2017. https://www.lsc.ohio.gov/documents/reference/current/SDOIM_FinalCombined.pdf

2. "Addiction Evidence Project." Health Policy Institute of Ohio, 2018-2020. https://www.healthpolicyohio.org/tools/addiction-evidence-project/

3. Blueprint for Changemakers: Achieving health equity through law & policy. ChangeLab Solutions, 2019. https://www.changelabsolutions.org/sites/default/files/2019-04/Blueprint-For-Changemakers_FINAL_201904.pdf

4. "Chronic Absenteeism." Ohio Department of Education. http://education.ohio.gov/Topics/Student-Supports/Chronic-Absenteeism

5. "Closing Ohio's health gaps: Moving towards equity," Health Policy Institute of Ohio, October 2018. https://www.healthpolicyohio.org/closing-ohios-health-gaps-moving-towards-equity/

6. Countering the production of health inequities: A Framework of Emerging Systems to Achieve an Equitable Culture of Health. Oakland, CA: The Prevention Institute, 2016. https://www.preventioninstitute.org/publications/countering-production-health-inequities-extended-summary

7. "COVID-19 response to prevent evictions." Housing Stabilization Coalition, 2020. Provided directly to HPIO.

8. Culturally Speaking - Insights into COVID-19: Understanding the Disparities in Black and Hispanic American Communities in Ohio. Singleton & Partners, 2020.

9. "Health Disparities and Stress Fact Sheet." American Psychological Association, 2012. https://www.apa.org/topics/health-disparities/fact-sheet-stress

10. "Governor should use $4 million CARES Act discretionary funds to boost internet access for families, education leaders say." Bamforth, Emily. Cleveland.com, June 22, 2020. https://www.cleveland.com/news/2020/06/governor-should-use-4-million-cares-act-discretionary-funds-to-boost-internet-access-for-families-education-leaders-say.html

11. Governor's Task Force Report on Black and Minority Health. Ohio Department of Health, 1987. https://mih.ohio.gov/Portals/0/Documents/Governor's%20Task%20Force%20Report.pdf

12. Ohio Broadband Strategy. InnovateOhio, 2019. https://innovateohio.gov/wps/wcm/connect/gov/bde9a8ce-5f93-4a04-b937-102788469bdb/OhioBroadbandStrategy_121919.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-bde9a8ce-5f93-4a04-b937-102788469bdb-mYuKib6

13. Policy Memo: Expanding Broadband to Underserved Areas. The Buckeye Institute, 2020. https://www.buckeyeinstitute.org/library/docLib/2020-05-04-The-Buckeye-Institute-Ohio-Needs-to-Expand-High-Speed-Internet-Service-to-Underserved-Areas-policy-memo.pdf

14. Race Reporting Guide: A Race Forward media reference. Race Forward, 2015. https://www.raceforward.org/reporting-guide

15. Rise Together: A blueprint for reducing poverty in Franklin County. Franklin County Board of Commissioners, 2019. https://commissioners.franklincountyohio.gov/poverty

16. State Health Improvement Plan, Ohio 2020-2022. Health Policy Institute of Ohio prepared for the Ohio Department of Health. April 2020. https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship

17. "What Works to Increase Self-Sufficient Employment." Health Policy Institute of Ohio, August 2018. https://www.healthpolicyohio.org/what-works-to-increase-self-sufficient-employment/

18. "Why African-Americans may be especially vulnerable to COVID-19." Gupta, Sujata. Science News, April 10, 2020. https://www.sciencenews.org/article/coronavirus-why-african-americans-vulnerable-covid-19-health-race

Appendix E:

Potential Indicators to Track Progress

Overall health

Goal	Indicator	Source
Improve overall health	**Health status.** Percent of adults, ages 18 and older, with fair or poor health, by race/ethnicity	Behavioral Risk Factor Surveillance System
	Premature death. Years of potential life lost before age 75, per 100,000 population (age adjusted), by race/ethnicity	Ohio Department of Health, Vital Statistics
	Life expectancy. Average life expectancy at birth based on current mortality rates, by race and ethnicity	Ohio Department of Health, Vital Statistics

Health care and public health

Goal	Indicator	Source
Increase access to insurance coverage for people of color	**Uninsured adults.** Percent of adults, ages 19-64, who are uninsured, by race/ethnicity	U.S. Census Bureau, American Community Survey
	Without a usual source of care. Percent of adults, ages 18 and older, who do not have at least one person they think of as their personal healthcare provider, by race/ethnicity	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance Survey
	State public health funding. Total state funding for public health, per capita	State Health Access Data Assistance Center, State Health Compare

Social and economic environment

Goal	Indicator	Source
Improve access to high-quality education for people of color	**Kindergarten readiness.** Percent of kindergarten students demonstrating readiness (entered kindergarten with sufficient skills, knowledge and abilities to engage with kindergarten-level instruction), by race/ethnicity	Ohio Department of Education
	Chronic absenteeism. Percent of students, grades K-12, who are chronically absent, by race/ethnicity	Ohio Department of Education
	Post-secondary attainment. Percent of adults, ages 25-44, with some post-secondary education, such as enrollment in vocational/technical schools, junior colleges, or four-year colleges, including individuals who pursued education following high school but did not receive a degree, by race/ethnicity	U.S. Census Bureau, American Community Survey
Reduce poverty and increase investment and employment in communities of color	**Adult poverty.** Percent of adults, ages 18 and older, who live in households at or below the federal poverty threshold, by race/ethnicity	U.S. Census Bureau, American Community Survey
	Child poverty. Percent of children, ages 17 and under, who live in households at or below the federal poverty threshold, by race/ethnicity	U.S. Census Bureau, American Community Survey
	Neighborhood poverty. Percent of residents living in high-poverty neighborhoods, by race/ethnicity	National Equity Atlas
	Wages $15/hour or more. Share of workers earning at least $15/hour, by race/ethnicity	U.S. Census Bureau, American Community Survey. Analysis of Integrated Public Use Microdata Series
	Unemployment rate. Percent of adults who do not have a job, have actively looked for work in the past four weeks, and are currently available for work, by race/ethnicity	U.S. Department of Labor, Bureau of Labor Statistics
Decrease arrest and incarceration rates for people of color	**Incarceration rate.** Number of people imprisoned under the jurisdiction of state or federal correctional authorities, per 100,000 population, by race/ethnicity	Bureau of Justice Statistics and the U.S. Census Bureau, Population Division
	Arrest rate. Arrest rate per 100,000 population, by race	Ohio Department of Rehabilitation and Correction

Physical environment

Goal	Indicator	Source
Increase safe and affordable housing	**Severe housing problems.** Percent of households that have one or more of the following problems: 1. Lack of complete kitchen facilities; 2. Lack of complete plumbing facilities; 3. Severe overcrowding; 4. Monthly housing costs, including utilities, exceed 50% of monthly income, by race/ethnicity	U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy Data
Increase access to transportation	**Transit time to work.** Average travel time to work (minutes), by race/ethnicity	National Equity Atlas
Decrease the digital divide	**Computer and broadband access.** Percent of households with a computer and a broadband internet subscription, by race/ethnicity	U.S. Census Bureau, American Community Survey
Ensure safe access to voting	**Voter turnout.** Percent of adults who vote in the 2020 general election, by race/ethnicity	U.S. Census Bureau

FOOTNOTE RESOURCES

[1] *Ohio Population*. Ohio Development Services Agency, September 2019. https://development.ohio.gov/files/research/P7001.pdf

[2] Ibid.

[3] Data provided by the Ohio Department of Job and Family Services via Ohio Latino Affairs Commission. E-mail communication. Provided June 30, 2020.

[4] *Ohio Population*. Ohio Development Services Agency, September 2019. https://development.ohio.gov/files/research/P7001.pdf

[5] *Countering the production of health inequities: A Framework of Emerging Systems to Achieve an Equitable Culture of Health*. Oakland, CA: The Prevention Institute, 2016. https://www.preventioninstitute.org/publications/countering-production-health-inequities-extended-summary

[6] "Toxic stress: Effects, Prevention and Treatment." Franke, Hillary A. "Toxic stress: Effects, Prevention and Treatment." *Children* 1, no. 3 (2014): 390-402. doi: 10.3390/children1030390; See also *The Impact of Toxic Stress on Individuals and Communities: A Review of the Literature*. Shern, David L., Andrea K. Blanch and Sarah M. Steverman. Mental Health America, 2014.

7 *Vibrant and healthy kids: Aligning science, practice, and policy to advance health equity*. National Academies of Sciences, Engineering, and Medicine. Washington, DC: The National Academies Press, 2019. https://doi.org/10.17226/25466.

8 HPIO analysis of data from CDC WONDER, Single-race population estimates accessed May 13, 2020, and data from the Ohio Department of Health Coronavirus (COVID-19) Dashboard accessed June 25, 2020; last updated June 24, 2020.

9 Ibid.

10 Single-race Population Estimates, United States, 2010-2018. July 1st resident population by state, county, age, sex, single-race, and Hispanic origin, on CDC WONDER Online Database. 2018 estimates. Accessed May 14, 2020.

11 *2019 Health Value Dashboard*. Health Policy Institute of Ohio, April 2019; See also "2019 State Health Assessment Summary Report." Health Policy Institute of Ohio, September 2019.

COVID-19 OHIO
MINORITY HEALTH
STRIKE FORCE
BLUEPRINT

#MORE

INFORMED · INVOLVED · INSPIRED