




**PRESCRIPTIONS  
FOR CHANGE**

**A COORDINATED  
STRATEGY  
TO ELIMINATE**

**APRIL 2006**

**HEALTH  
DISPARITIES  
IN NORTHEAST  
OHIO**



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**The Roundtable Community Council,**  
**a program of the Greater Cleveland Partnership,**  
**and**

**The Center For Reducing Health Disparities,**  
**a collaboration between the The MetroHealth Medical Center**  
**and Case Western Reserve University**

**April 2006**

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Dear Community Leader:

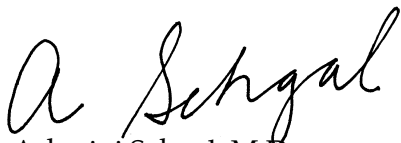
In the fall of 2003, the Center for Reducing Health Disparities, a collaboration between MetroHealth Center and Case Western Reserve University, and the Greater Cleveland Roundtable, (now the Roundtable Community Council), a program of the Greater Cleveland Partnership, began discussions about hosting a series of events to raise awareness about and develop solutions for the longstanding challenge of health disparities affecting Northeast Ohio. It quickly became apparent that such an important effort would require the support and cooperation of a broad range of community partners. In addition, we decided that the effort would be best served by a year-long series of programs, hosted at different locations, with national and local thought leaders addressing the range of issues related to this complicated health care issue.

We were heartened by the response we received from key stakeholders in the community. A list of our contributors is set forth in the appendix to this report. However, we owe special thanks to the Center for Community Solutions, and George Weiner in particular, for the research they have conducted in this area over the last several years and for the specific support they provided in completing this report. In addition, the City Club of Cleveland provided special accommodations to make our program series more accessible to a broad audience, as did our media partner Adelphia. Most significantly, however, the entire series was made possible by generous support we received by two of the region's leading health-focused foundations, The Mt. Sinai Health Care Foundation, and the Saint Luke's Foundation.

What follows is a synthesis of the data and information and perspectives gathered from the lecture series and several community forums, as well as new research that has been conducted over the last several years. This report also contains recommendations of local healthcare and community leaders aimed at creating a broad-based strategy to attack this problem.

We hope that, as you read this report, you will find the basis – whether economic, academic, or ethical – to embrace this issue as a high community priority, and that your organization will take upon itself a meaningful role in our call to action to eliminate health disparities in Northeast Ohio.

Sincerely yours,



Ashwini Sehgal, M.D.  
Director,  
Center for Reducing Health Disparities  
A Collaboration between MetroHealth Center  
and Case Western Reserve University



Danny R. Williams, Esq.  
Executive Director,  
Roundtable Community Council  
Senior Vice President & General Counsel  
Greater Cleveland Partnership



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*“One of the greatest challenges facing the nation is reducing and eliminating the profound disparity in health status that exists for many of its populations. Without decisive action now, the health challenges of the 21st century will expand along with the increasing number of racial and ethnic minorities, inhabitants of rural areas, and low socioeconomic populations.”*

John Ruffin, Ph.D., Director, National Center on Minority Health and Health Disparities  
Testimony before the Senate Subcommittee on Labor-HHS-Education Appropriations, April 2004

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(left to right) Danny R. Williams, Greater Cleveland Partnership, John Ruffin, Ph.D., National Center on Minority Health and Health Disparities, and Ashwini Sehgal, M.D., MetroHealth Medical Center



*Prescriptions for Change: Eliminating Health Disparities in Northeast Ohio* reflects the vision, enthusiasm and dedication of our region's community, government and philanthropic leaders, health care professionals, policy makers and educators in pursuing the elimination of health disparities in Northeast Ohio.

The *Prescriptions for Change* initiative was developed and implemented with generous funding and support from The Mt. Sinai Health Care Foundation, the Saint Luke's Foundation and others. In October 2004, the Roundtable Community Council, a program of the Greater Cleveland Partnership, and the Center for Reducing Health Disparities, a collaboration between The MetroHealth System and Case Western Reserve University, facilitated a lecture series as part of an effort to raise awareness about the causes of health disparities, provide examples of model interventions, identify funding opportunities to support innovative programs, and serve as a forum for regional collaboration. In addition to speakers of national prominence, many of the programs featured local experts and advocates who discussed health disparity issues unique to Greater Cleveland.

Lecturers and participants emphasized the need for community-focused interventions that achieve measurable reductions in health disparities. There was also a general appreciation that meaningful progress would require sustained, collaborative effort and consensus around goals and strategies.

# ELIMINATING HEALTH DISPARITIES IN NORTHEAST OHIO

## SUMMARY

This publication offers insight into the nature and extent of disparities in the Greater Cleveland area and describes economic and ethical reasons for expeditiously eliminating the injustice of health disparities. The publication outlines the causes of disparities, both nationally and in our region – personal and behavioral variables, lack of cultural competence, a disproportionately low number of minority health care professionals, financial barriers, lack of a “medical home,” provider bias and inadequate access to quality health care. Insight into the effective use of health information technologies, which can help regional health care providers and health insurance companies identify factors that contribute to disparities in Northeast Ohio, is also provided.

*Prescriptions for Change* includes examples of ongoing regional efforts to eliminate disparities that can be expanded and replicated and provides recommendations for accelerating efforts to eliminate health disparities in Northeast Ohio. The recommendations are provided in sections, targeted to health care providers, researchers, insurance providers, local elected officials, grant makers and funders, secondary schools, colleges and universities, community organizations and regional business leaders.

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*“... in too many areas, our nation is still two nations, divided when it comes to health. Simply put: America suffers from racial and ethnic disparities in health.”*

Vice Admiral Richard H. Carmona , United States Surgeon General  
U.S. Department of Health and Human Services

Remarks prepared for 2004 National Medical Association conference, San Diego, August 2, 2004

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**W**HILE living in the shadows of some of the world's most renowned health care institutions, minorities in the Greater Cleveland area experience consistently higher morbidity and mortality rates than non-minorities. In December 2003, the Federation for Community Planning (now known as the Center for Community Solutions) and United Way Services issued a landmark report, *Social Indicators 2003: Community Health*, as part of a series that depicts social, economic, housing, safety and health conditions in Northeast Ohio.<sup>1</sup>

### **STRIKING FINDINGS RELATED TO HEALTH DISPARITIES INCLUDE:**

- ◆ The average age-adjusted death rate for African-Americans in Northeast Ohio was 20 percent higher than that of whites.
- ◆ Heart disease accounted for about one-third of all deaths in the region. The heart disease death rate was higher for African-Americans than whites, with 331 deaths per 100,000 for African-Americans versus 289 deaths per 100,000 for whites.
- ◆ The cancer death rate in Northeast Ohio was higher than the national average. The cancer death rate was higher for African-Americans than whites, with 266 deaths per 100,000 for African-Americans versus 211 deaths per 100,000 for whites.
- ◆ In Northeast Ohio, the death rate from stroke was higher for African-Americans than for whites. The death rate from stroke for African-Americans was 66 deaths per 100,000 for African-Americans versus 57 per 100,000 for whites.
- ◆ In Cuyahoga County, more than a quarter of African-American mothers received inadequate prenatal care – almost two-and-a-half times the rate for white mothers.
- ◆ Over 17 percent of African-American mothers in the region gave birth prematurely, compared to ten percent of white mothers.
- ◆ The infant mortality rate among babies born to African-American mothers in the region was more than two-and-a-half times that for white mothers.

A report released in June 2005, *Cuyahoga County's Uninsured Adults and the Problems They Face*,<sup>2</sup> prepared by the Center for Community Solutions in cooperation with the Ohio Department of Job and Family Services, presented these additional disturbing findings:

- ◆ Minority children and adults in Cuyahoga County were more than twice as likely to lack health insurance as whites. Nearly a quarter of African-Americans in Cuyahoga County had no health insurance, compared to just over one in ten whites.
- ◆ Hispanic adults were more likely to lack insurance than their non-Hispanic counterparts. About one in six Hispanic adults in Cuyahoga County lacked health insurance, compared to just over one in 10 non-Hispanic whites.

Low birth weight, a precursor of later health problems, provides further evidence of the existence of health disparities among Cleveland's poor and minority populations. In 2002, the average rate for low birth weight babies in the City of Cleveland was 121.2 per 1,000 live births, as compared to 99.2 per 1,000 live births in Cuyahoga County overall.<sup>3</sup> However, in the ten Cleveland wards with the highest rates of low birth weight, the average rate was 146.4 per 1,000 live births. These neighborhoods are also among those with the highest poverty rates in Cleveland, and they have an average African-American population of 78.8 percent.<sup>4</sup>

In addition, as of June 30, 2005, 2,294 Cleveland residents were reported as living with HIV or AIDS, a prevalence rate of 479.5 per 100,000 residents. This is 3.6 times the rate in Ohio (as of June 30, 2004). Prevalence rates of Cleveland Hispanics living with HIV/AIDS were the highest among Cleveland residents (869.6 cases per 100,000 Hispanic residents), followed by Black/non-Hispanic (567.7 per 100,000) and White non-Hispanic Clevelanders (302.2 per 100,000).<sup>5</sup>

Although Cleveland-specific data are not available, it is important to note that African-Americans and Hispanics in Ohio are significantly more likely than whites to be overweight or obese – which can be a contributing factor to the development of many chronic health conditions. While just over one in five (20.6 percent) white adults<sup>6</sup> in Ohio were reported as obese,<sup>7</sup> 29.6 percent of African-American and 25.1 percent of Hispanic adults are obese.<sup>8</sup> Data for children<sup>9</sup> in Ohio show that 29.5

percent of white children were overweight, while 40.7 percent of African-American and 39.6 percent of Hispanic children were overweight. In addition, overweight and obesity in Ohio is significantly more prevalent among those with family

incomes below 100 percent of poverty.<sup>10</sup>

Based on 2001 data, Cleveland has also been found to have the highest rate of lead poisoning among tested children in the United States.<sup>11</sup> High poverty rates, which reduce the ability to undertake preventative maintenance, including lead paint abatement, tend to correlate with high lead poisoning rates.

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*“Eliminating health disparities in Cleveland will require us to address not only what happens in health care settings, but also the root causes of health disparities, including poverty, segregation, and racism.”*

Ashwini Sehgal, MD  
Director, Center for Reducing Health Disparities  
Case Western Reserve University and MetroHealth Medical Center

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## REGIONAL RESPONSE

**I**N response to these and other findings about the magnitude of health disparities in Northeast Ohio, the Roundtable Community Council,<sup>12</sup> a program of the Greater Cleveland Partnership (GCP),<sup>13</sup> and the Center for Reducing Health Disparities,<sup>14</sup> a partnership between Case Western Reserve University and MetroHealth Medical Center, facilitated a lecture series to accelerate efforts to reduce, and eventually eliminate, regional health disparities. The series was funded by The Mt. Sinai Health Care Foundation and the Saint Luke's Foundation. Invaluable in-kind services and support were also provided by the City Club of Cleveland and Adelphia Cable.

The series of seven lectures, held from October 2004 through August 2005, addressed a wide spectrum of individual and systemic issues contributing to disparities in health status and health care access for minority populations in Northeast Ohio. The series consisted of the following presentations (see Appendix Section A for a list of presenters):

- ◆ Unequal Health Outcomes: National Challenges and Progress Toward Reducing Health Disparities
- ◆ The Color Line: Why Race Matters in the Elimination of Health Disparities
- ◆ Identifying Barriers: Access and Quality Issues that Contribute to Health Disparities
- ◆ The Impact of the Rising Complexity of Health Care and Self Care on Challenged Consumers
- ◆ The Economic Cost of Health Disparities
- ◆ Responding to Cultural Differences: New Approaches for Multicultural Health Care
- ◆ Remedies for Change: Developing Effective Strategies to Eliminate Disparities

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*“The City of Cleveland is committed to providing health information, resources and direct care services to all of our residents. We must work even harder to eliminate health disparities in Cleveland.”*

Matt Carroll  
Interim Director, Department of Public Health, City of Cleveland

The audience consisted of health care providers, researchers, representatives of a variety of community organizations, government agencies, the business community, the general public and the media. The lectures were presented to: (1) raise regional awareness of the significance and fundamental causes of health disparities; (2) provide examples of successful interventions for reducing disparities; (3) provide a forum for health care stakeholders to collaborate on concepts for developing regional, interdisciplinary strategies; and (4) provide insight into grant and other funding opportunities that may

support initiatives to alleviate health disparities.<sup>15</sup>

Lectures were led by national experts on health, health care, economics and disparities. Many sessions also featured local experts and advocates who discussed health disparity issues unique to Greater Cleveland and identified resources for developing solutions. Together, these dedicated professionals provided information about the social, policy and individual factors that contribute to disparate health outcomes at the national and regional level and discussed the economic and social consequences of failing to address these inequities.

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*“The lecture series emphasized the need for a level of community and financial support commensurate with the magnitude of the long-standing challenge of health disparities. Closing the gap in health outcomes experienced by our region’s poor and minority citizens must include supporting health promotion and disease prevention activities beginning with very young children and extending into adulthood. Focusing on innovative solutions must continue to be a key priority for all funders interested in the health and economic well-being of our community.”*

Mitchell Balk, President, The Mt. Sinai Health Care Foundation

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## WHY ADDRESS HEALTH DISPARITIES?

**T**HE *Prescriptions for Change* initiative focused on a multitude of economic, legal and ethical reasons for addressing health disparities at the community level. The need for community-focused interventions that achieve real, measurable reductions in health disparities was emphasized throughout the lecture series.

*Prescriptions for Change* investigated and discussed economic issues related to regional health disparities. For example, many Greater Cleveland employers are seeking short-term financial relief from rising health insurance costs by eliminating benefits for their workers or reducing insurance subsidies. While this may help increase profits in the short run, the practice is having a significant impact on minority employees who hold a disproportionate share of low-wage, low-benefit jobs in Northeast Ohio. While limiting access to malpractice remedies (tort reform) may stem the out-migration of some medical specialists, it may not significantly reduce health insurance costs for employers or their workers. The Congressional Budget Office has reported that malpractice accounts for less than two percent of health care spending.<sup>16</sup>

While many studies have addressed the overall cost to society of various medical conditions, analysis of the economic impact of the “health gap” between minority and non-minority populations has only recently begun. At the national level, the cost of the diabetes, hypertension and HIV/AIDS health gap of African-Americans and Hispanics compared to whites was estimated at \$35.8 billion in 2002.<sup>17</sup> Almost two-thirds of this amount was for direct medical expenditures (*e.g.*, physician visits, medication and hospitalization), while the remaining costs were the result of lost productivity.

Minorities in Greater Cleveland may be dispro-

portionate contributors to rising health care costs associated with obesity, which can be a contributing factor to the development of many chronic health conditions. Research has shown that nationally, African-American and Hispanic women had obesity rates of 49.6 percent and 38.9 percent, respectively, compared to white women at 31.3 percent in 2002. Higher incidences of obesity correspond to higher rates of diabetes and hypertension.<sup>18</sup> Considering the overall rise in the prevalence of obesity between 1987 and 2002, and associated health care costs for treating obese versus non-obese individuals, costs may have risen as much as 27 percent due to obesity-related health factors.<sup>19</sup>

Higher rates of diabetes and hypertension that result from obesity could have a significant long-term economic impact on Northeast Ohio’s economy. *The New York Times*, in a January 2006 article<sup>20</sup> detailing the social and economic toll of diabetes, noted:

The Caro Research Institute, a consulting firm that evaluates the burden of diseases, estimates that a diabetic without complications will incur medical costs of \$1,600 a year – unpleasant, but not especially punishing. But the price tag ratchets up quickly as related ailments set in: and average \$30,400 for a heart attack or amputation, \$40,200 for a stroke, \$37,000 for end-stage kidney disease.

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*“The health gap between minorities and non-minorities is having a profound impact on our region’s economic competitiveness. Employer health insurance costs and lost productivity due to illness can be reduced significantly by eliminating disparities.”*

Danny R. Williams  
Senior Vice President & General Counsel, Greater Cleveland Partnership

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In addition, when more individuals become disabled by these diseases and draw disability benefits, the costs of these benefits must be absorbed or passed on to consumers, thus reducing profits and impeding competitiveness.

Finally, the ethical impropriety of health disparities should also be recognized. Health disparities matter ethically because they reduce the prospects for a good life for a large segment of our region's population.<sup>21</sup>

## UNDERSTANDING HEALTH DISPARITIES

**A**LTHOUGH policy makers, researchers, health care professionals, educators, government officials, community leaders and others have become increasingly aware of the implications of health disparities,<sup>22</sup> different definitions have been developed to describe the situation. Two of the more widely recognized definitions are shown in the box on Page 8. While they differ somewhat in their scope and focus, *together* they provided the framework for the *Prescriptions for Change* initiative's key areas of focus. These and other definitions helped shape the initiative's agenda for: raising awareness of the regional causes of health disparities; seeking replicable examples of successful interventions; facilitating collaboration to identify regional strategies; and identifying funding opportunities to help to alleviate regional health disparities.

### CAUSES OF HEALTH DISPARITIES

#### OVERVIEW

Examples of health disparities, or inequitable health treatment or outcomes, have been documented dating back to our nation's founding. At that time, enslaved women were used as subjects for various medical procedures.<sup>23</sup> African-American soldiers were also used in studies devised to investigate their supposed inferiority.<sup>24</sup> The Tuskegee syphilis experiment, supported by the U.S. Public Health Services and conducted from 1932 to 1972, provided penicillin for white men who had contracted syphilis. African-American men were neither treated nor informed of the availability of the treatment. In addition, a variety of disparities result from cultural or personal behavioral patterns that put individuals at greater risk of negative health outcomes.

While health disparities are the result of many factors, ethnic and minority populations demonstrate patterns of disease occurrence, health care utilization and mortality that differ from the majority population. Social and cultural influences due to historical, political, environmental, hereditary and economic factors shape many of these differences.<sup>25</sup> One of the major predisposing factors contributing to health disparities is a lack of access to quality health care. Poverty is the leading cause of lack of health insurance for minorities.<sup>26</sup> However, even with more affluent African-Americans who have health insurance, health disparities persist.<sup>27</sup> Other contributing factors may include racial bias of health care providers, a lack of "cultural competency" on the part of health care providers and minority patients, poor communication, a lack of health literacy and a history of distrust of the health care establishment by minorities.

## Health Disparities are...

“...differences that occur by gender, race or ethnicity, education or income, disability, living in rural localities or sexual orientation.” [Department of Health and Human Services: *Healthy People 2010*]

“...differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.” [U.S. Department of Health and Human Services: *National Institutes of Health*]

One way to understand the nature of and reasons for health disparities is to categorize them into two groups – “upstream” and “downstream” factors. Upstream factors focus on forces affecting the health of individuals before they enter the health care system. They include broader socioeconomic contributors to poor health outcomes, such as poverty, safety, housing, environmental conditions, education and lifestyle choices.

Downstream factors focus on forces affecting individuals once they enter the health care system, such as access to quality care, insurance coverage, language barriers, cultural preferences, health literacy and diversity in the health care workforce. Downstream factors generally occur on three levels: (1) the institutional level; (2) the patient level; and (3) the physician level.<sup>28</sup> While disparities at the institutional level have been studied the least, it is clear that the current structure of today’s health care system is complex and challenging to navigate. Facilities and services can be difficult to access without adequate transportation, insurance, education, a good command of the English language and a private physician.

At the patient level, minorities have been shown to delay seeking care and, in some cases, to refuse medical treatment and recommendations.<sup>29</sup> Patient-level factors include language and literacy barriers,

cultural beliefs and mistrust of the medical system.

At the physician level, personal prejudices and other bias decreases cultural competency and influences the therapeutic relationship and medical decisions. Studies have documented that white patients are more likely to be offered and receive “standard of care” cardiac procedures than minority patients, even when the clinical scenario is identical.<sup>30</sup> Research has shown that developing computerized quality indicators and auditing protocols may be useful for improving consistency among population groups in the delivery of health care.<sup>31</sup> Furthermore, developing and deploying health information technologies (HITs) can help physicians and other health care providers determine when and where disparities occur.<sup>32</sup> Additionally, studies related to physician-patient communication have reported that minority patients are more satisfied with their visit and more likely to participate in their care if they are seeing a physician of the same race.<sup>33</sup>

A summary of selected studies on key causes and mechanisms for health disparities is provided in the next section. The studies, which are the result of growing national awareness of health disparities, provided valuable information about the seriousness of health disparities and helped describe specific disparities from a national perspective.

The following discussion focuses on the key factors identified through *Prescriptions for Change* that

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***“Eliminating racial and ethnic disparities in health will require enhanced efforts at preventing disease, promoting health, and delivering appropriate care. It will also require new knowledge about the determinants of disease, causes of health disparities, and effective interventions for prevention and treatment.”***

George Weiner, Ph.D.  
Acting Director, Center for Health Equity, Cleveland State University  
Biomedical and Health Institute Center for Health Equity

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appear to contribute the most to health disparities in Northeast Ohio. These include: (1) personal and behavioral variables; (2) lack of cultural competence; (3) an inadequate number of minority health care professionals; (4) financial barriers such as a lack of insurance and low income; and (5) structural barriers, such as the lack of a “medical home.” The effective use of health information technologies, which can help regional health care providers and health insurance companies identify factors that contribute to disparities in Northeast Ohio, is discussed further in a subsequent section of this publication.

## **SELECTED STUDIES ON KEY CAUSES AND MECHANISMS**

More than 26 years ago, the Surgeon General released a report on health promotion and disease prevention.<sup>34</sup> The publication, which focused on risk areas for morbidity and mortality in the general population, briefly described socioeconomic factors as potential obstacles to improving the health of all Americans. The document helped shape future federal public health agendas, including the U.S. Department of Health and Human Services’ Healthy People 2000 and Healthy People 2010 initiatives.

Healthy People 2010, an initiative of the U.S. Department of Health and Human Services’ (HHS) Office of Disease Prevention and Health Promotion, serves as a foundation for identifying and addressing health disparities. Healthy People 2010 centers around a statement of national health objectives designed to identify the most significant preventable threats to health. It also facilitated the establishment of national goals to reduce these threats. Two primary goals of Healthy People 2010 are to: (1) improve health, life expectancy and

*Matt Carroll, interim director, City of Cleveland Department of Public Health, participates in the Q&A portion of the program on the economic costs of health disparities.*

quality of life for all individuals; and (2) eliminate health disparities. The “Leading Health Indicators” established by Healthy People 2010 are being used to measure the health of the nation throughout the first decade of the 21<sup>st</sup> century. The indicators are: physical activity; overweight and obesity; tobacco use; substance abuse; responsible sexual behavior; mental health; injury and violence; environmental quality; immunization; and access to health care.

In 1985, the U.S. Department of Health and Human Services published the first comprehensive national study focusing on minority health. The report documented health disparities across race and socioeconomic status and resulted in the establishment of HHS Office of Minority Health Resource Center.<sup>35</sup> The Center continues to provide valuable information about health disparities by collecting and distributing information on a wide variety of health topics, including substance abuse, cancer, heart disease, violence, diabetes, HIV/AIDS and infant mortality. The Center is particularly helpful in understanding disparities at the local level by offering customized database searches, publications, mailing lists, and referrals regarding various population groups.

In 1998, researchers found that African-Americans, women and the poor were less likely to complete steps in the kidney transplant process than were whites, men and non-poor individuals.<sup>36</sup>



A report released in 1999 indicated that the rate of surgery for African-Americans diagnosed early with non-small-cell lung cancer was 12.7 percentage points lower than for whites and their five-year survival rate was lower than for whites.<sup>37</sup>

The following year, researchers conducted a study to determine if African-Americans were less likely to undergo lung cancer surgery.<sup>38</sup> Researchers found that culturally sensitive training and outreach education may help address lung cancer surgical intervention and survival disparities.

In 2003, the Institute of Medicine released findings related to health care inequalities.<sup>39</sup> The report, which states that minorities tend to receive lower quality health care compared to whites, cites cultural, linguistic and geographic barriers along with biases and the lack of workforce diversity as barriers to quality health care for minorities. The same year, Physicians for Human Rights released a publication about health care and the clinical experience.<sup>40</sup> The authors point out that health disparities are pervasive across various diseases. The document includes an annotated bibliography of studies on racial and ethnic health care disparities and their causes.

Also in 2003, an examination of the impact of quality improvement efforts on race and sex disparities in hemodialysis patients found that by targeting key barriers in the system of appropriate care, the gap between African-American and white patients decreased substantially; suggesting that im-

provements in monitoring patient outcomes, feedback of performance data and education of clinicians at dialysis centers may reduce disparities.<sup>41</sup>

A 2004 study of diagnostic cardiac catheterization found that African-Americans were less likely than whites to receive some standard medical interventions and that African-Americans had a higher death rate than whites one year after a myocardial infarction (heart attack).<sup>42</sup> The author suggests that fewer preventative health measures, among other factors, contribute to this outcome.

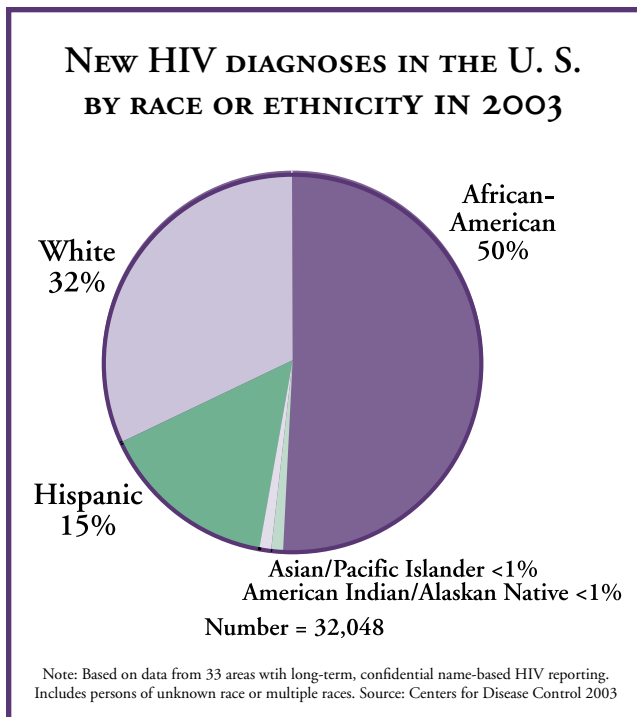
A report released in 2005 described project REACH (Racial and Ethnic Approaches to Community Health) which operated in Detroit.<sup>43</sup> REACH explored the effects of a community-based, patient-tailored diabetes lifestyle intervention on risk factors for diabetes. Findings suggest that this type of intervention, delivered by community participants, reduced risk factors associated with disease complications. The intervention is significant at the community level because it used educational materials targeted specifically toward African-Americans and Hispanics. Trained community residents, rather than health professionals, administered the intervention. African-American and Hispanic adults with serious impediments to health who lived in an urban area were included in the intervention. REACH brought about statistically significant improvements in post-intervention dietary knowledge and behaviors and physical activity knowledge.

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*“Disparities are often rooted in the poverty people grow up with, the unavailability of an adequate formal education, the diminished hope for a better future, and the lack of choices that are available to the more affluent in our community.”*

Earl Pike, Executive Director  
AIDS Taskforce of Greater Cleveland

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## **PERSONAL AND BEHAVIORAL VARIABLES**

Personal and behavioral variables associated with “choice” and “risk” have a significant impact on health disparities. Both “choice” and “risk” are subjective and volatile concepts and failure to recognize their multi-layered meanings and expressions can undermine health promotion and health care efforts.

For example, a major factor associated with “choice” and “risk,” Human Immunodeficiency Virus (HIV) infection and its late-stage manifestation, acquired immune deficiency syndrome (AIDS), form one of the most devastating global infection disease pandemics in history. While African-Americans make up about 12 percent of the U.S. population, they accounted for 50 percent of the new HIV cases diagnosed in the United States in 2003.<sup>44</sup> AIDS is the leading cause of death among African-American women 25 to 34 and African-American men 35 to 44.<sup>45</sup> Although Hispanics make up only about 14 percent of the population

of the United States and Puerto Rico, they account for 18 percent – almost 164,000 – of the more than 886,500 AIDS cases diagnosed since the beginning of the epidemic.<sup>46 47</sup>

African-Americans also suffer disproportionately from many chronic and preventable diseases associated with smoking.<sup>48</sup> Compared to white Americans, African-Americans are at increased risk for many lung conditions primarily caused or worsened by tobacco smoking.<sup>49</sup> Conditions include lung cancer, asthma, occupational lung disease, and acute lung infections. Furthermore, in 2002, 27.1 percent of non-Hispanic African-American men smoked compared to 25.5 percent of non-Hispanic white men.<sup>50</sup>

The *lack* of choice, for some low-income individuals can also result in health disparities. Those who live in more affluent neighborhoods may have easier access to fresh, nutritious, reasonably priced food than those who live in economically depressed neighborhoods. Furthermore, inner-city public housing and low-income residents are often surrounded by “fast-food” establishments that offer limited healthy food options.

Lack of nutritional awareness and options for nutritious food, along with other environmental and behavioral factors, contribute to a disproportionate obesity burden for some underserved and underrepresented populations. For example, African-American women have the highest rates of overweight and obesity and, as such, have substantial morbidity and mortality from diabetes, hypertension and cardiovascular disease.<sup>51</sup> The disproportionate obesity burden among African-American and poor women is well-documented; weight management has been particularly challenging in these high-risk population groups. A recent study that examined the weight-loss experiences of obese women reported that African-American obese women identified particular cultural factors such as cultural settings (*e.g.*, church), food types,

and beliefs about food which complicates successful weight management.<sup>52</sup> Although the low-income women in the study wanted to lose weight, they believed that affordability limited their weight management efforts. Furthermore, African-American obese women in the study identified food characteristics such as taste, texture and choice and critical components of their ideal weight loss method.

In the May 2005 *Prescriptions for Change* program, Emory University professor Kenneth E. Thorpe, Ph.D.<sup>53</sup> noted that most proposals targeting the rise in health care spending do not address the rise in treated disease prevalence. One contributing factor to the rise in treated disease prevalence is linked to rising population risk factors, in particular, obesity. Dr. Thorpe pointed out that the rise in treated disease prevalence linked to the rise in obesity is the single largest driver of health care spending over time, noting that from 1987 to 2002, treating diseases linked to the rise in obesity accounted for a 27 percent increase in health care spending.

Closely related to choice is the issue of “risk.” For example, many African-Americans in Greater Cleveland who live in poverty are continually exposed to risks associated with substandard and po-

tentially dangerous housing, including lead paint. Cleveland has been found to have the highest rate of lead poisoning among tested children in the United States.<sup>54</sup> Lead poisoning, primarily caused today through exposure to peeling lead paint or lead dust, is believed to be responsible for a host of developmental and behavioral abnormalities as well as the loss of IQ points in affected children.<sup>55</sup> In 2004, 11 percent of Cleveland children tested had blood lead levels that reached or exceeded ten micrograms per deciliter of blood, which is the action level, while the national rate is under two percent.<sup>56</sup>

Neighborhood-by-neighborhood statistical data reveal a significant disparity in lead poisoning rates across the City of Cleveland. The neighborhoods with the highest rates of lead poisoning are predominantly less affluent, African-American, east side locations – St. Clair-Superior, Glenville, Forest Hills, Fairfax, Woodland Hills, Hough, and Union-Miles – all of which were 23 percent or higher in 2001. The west-side Tremont and Detroit-Shoreway neighborhoods, while predominantly white with a Hispanic presence, are also less affluent. The fact that these neighborhoods fall in the top 11 clusters of lead poisoning in Cuyahoga County illustrates the predominant role of socioeconomic status as a predictor of health disparities.<sup>57</sup>

While the age of our housing stock is a primary factor causing our community’s lead poisoning problem, the level of housing maintenance is even more significant. Even though older housing is widespread on all sides of the City, the ability to undertake preventative maintenance, including lead paint abatement, varies with the ability to afford such maintenance. As such, high poverty rates tend to correlate with high lead poisoning rates in Cleveland.

Additional factors associated with lack of choice include poorly performing schools that make it difficult for the next generation to achieve self-reliance and stability and inadequate public transportation

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*“As a physician trained in Hungary, I recognize the importance of understanding a patient’s culture. Ninety-eight percent of our 6,000 patients are minorities, 88 percent are uninsured and many are homeless. We must go beyond addressing medical issues, looking at every individual as a whole person. Because lifestyle changes are vital to the health and wellbeing of our patients, we need to know how to communicate in a way they will understand.”*

Feyisayo Adeyina, M.D., Medical Director  
Family Practice Physician, Care Alliance of Cleveland, Ohio

that limits access to jobs and other resources needed for success.

The lack of choice for many Greater Cleveland residents is partially responsible for health disparities that are common to many urban environments. These variables, along with lack of “cultural competence” (bias and stereotyping on the part of health care providers, language barriers, and mistrust of the health care system by some minorities), a lack of minority health care professionals, financial barriers such as the lack of health insurance and/or poverty, the lack of a “medical home” and access to care undermine health promotion and contribute to health disparities throughout Northeast Ohio.

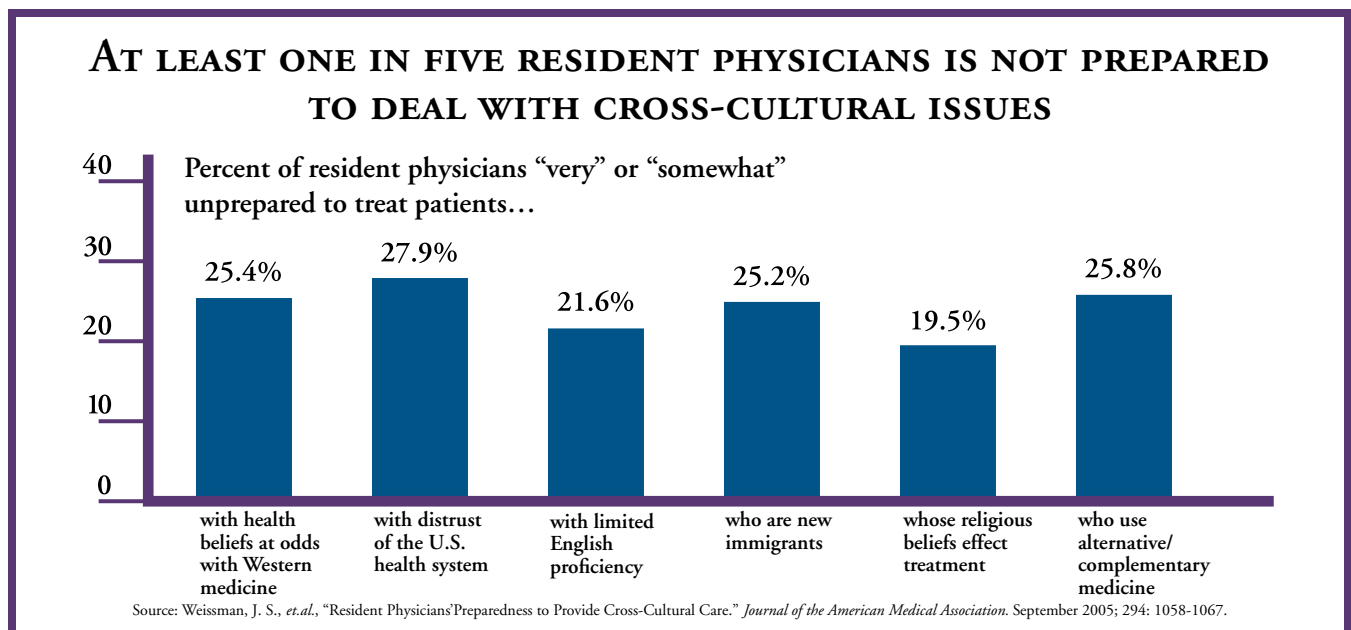
### **CULTURAL COMPETENCE**

Cultural competence plays an important role in medical diagnosis, prognosis, and treatment. Cultural competence is critical because lack of cultural proficiency results in racial and ethnic minorities receiving a lower quality of health care than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled.<sup>58</sup> “Cultural competence,” according to a Commonwealth Fund report, is defined as “*the ability of systems to provide care to patients with di-*

*verse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.*”<sup>59</sup>

Cultural competence can include issues related to bias and stereotyping. Research has shown that stereotypes are held even by people who believe that they do not judge others based on social categories. Most health care providers find prejudice morally at odds with their personal and professional values. However, like other members of society, they may not recognize the manifestations of prejudice in their own behavior.<sup>60</sup> While it is unrealistic to expect health care providers to be aware of the customs and practices of all the different ethnicities of the patients they serve, they must develop the skills to better understand the needs of patients and effectively serve those with different backgrounds.

Cultural competence includes linguistic barriers. Effective communication is vital to patient care. Linguistic competence can be defined as “the capacity for an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons with limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.”<sup>61</sup> An example

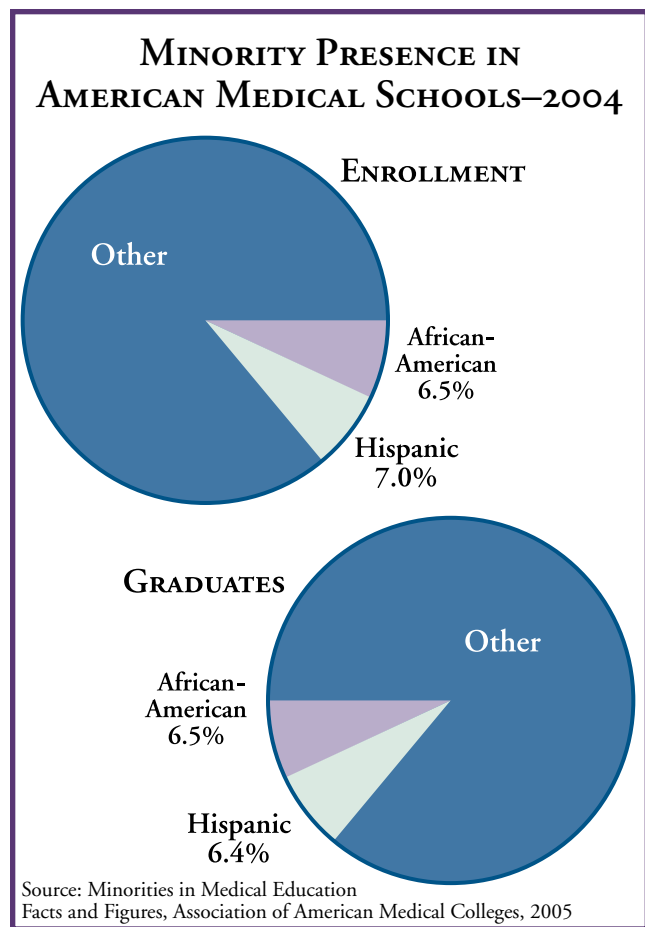


is the need to provide interpreters for non-English speaking patients, translated signs and other written material. This is particularly important because, in recent years, Cleveland has experienced growing numbers of immigrant residents and those with limited English proficiency, including about 40,000 Spanish speakers; 30,000 Arabic speakers; 10,000 Russian speakers; about 5,000 Vietnamese; and an expanding Somali community. A 2003 telephone survey of Cleveland area hospitals, conducted in Spanish, shows a general inability to communicate by telephone with Spanish speakers seeking health care.<sup>62</sup>

Cultural competence can have an impact on alleviating patient mistrust of the health care system brought about by years of discrimination and racism. When patients mistrust the health care system, they may refuse treatment or refuse to comply with treatment. Providers may become less engaged in the treatment process and patients may not be as likely to receive the necessary treatments and services.<sup>63</sup>

Because many health care professionals were educated at a time when cultural competence was less understood, training in this area will improve the skills needed to better assist various population groups. Characteristics exhibited by organizations that demonstrate cultural competence include: (1) articulating principles that support and enhance cross-cultural effectiveness in the health care setting; (2) adapting to the cultural norms of the communities and individuals they serve; (3) recognizing cultural competence as an institutionalized practice; and (4) holding individuals and departments accountable to the established standard.

Several challenges must be addressed in integrating cross-cultural training in the health professions. These include defining necessary core competencies, developing appropriate methodologies (and integrating them throughout the training process) and making the case for their importance in the training agenda.



## **LACK OF MINORITY HEALTH CARE PROFESSIONALS**

Another factor related to health disparities in Northeast Ohio is a paucity of minority health care professionals. A study citing data from the Commonwealth Fund's 1994 National Comparative Survey of Minority Health Care found that African-Americans and Hispanics, if given a choice, sought care from physicians of their own race. Although travel time played a role in physician choice, personal preference for seeing a doctor of a similar race and language was more important.<sup>64</sup>

A more recent study by the Commonwealth Fund found that when a physician and patient are of the same race, levels of patient satisfaction with care are higher, based on ratings of physicians' participatory styles.<sup>65</sup>

Research shows that patient and provider relationships are strengthened by greater racial and ethnic diversity in the health professions<sup>66</sup> and that racial concordance of patient and provider is associated with greater patient participation in care processes, greater adherence to treatment and greater patient satisfaction.<sup>67</sup> This is not to suggest that patients should only be treated by health professionals of the same race or ethnicity. Rather, for those minority patients who may have trust or language issues, having the option of being treated by someone with whom they believe they have a greater affinity may improve their outcomes.

While African-Americans make up about 12 percent of the nation's population, they only comprise about 6.5 percent of the students in medical schools. Hispanics currently comprise about 14 percent of the population and 7 percent of medical school students.<sup>68</sup> Only 6.5 percent of medical school graduates are African-American and 6.4 percent are Hispanic. As of December 2004, only 3.1 percent of the medical school faculty in the United States was African-American. Hispanics comprised 4 percent.

Attempts to increase the number of minority health care professionals can be traced back to the days of the Civil War. During the post-Reconstruction period, several "black" medical schools and hospitals emerged, although the number of these schools was quickly reduced, and by 1920 only Howard University and Meharry Medical College remained. It was not until 1969 that all of the nation's medical schools together enrolled more African-American students than did these two medical schools alone.<sup>69</sup>

Addressing the lack of minority health care professionals will require a conscious and collaborative effort at the local level to ensure that Northeast Ohio has an adequate ethnic and racial representation of medically competent health professionals who better match the racial and ethnic background

of the communities they serve. This effort should include interventions as early as K-12. Underrepresented minorities interested in pursuing health careers should receive early mentoring that includes assistance in gaining admittance to and subsequent graduation from medical training institutions. Incentives should be put in place for recruiting minority health care professionals when they complete their training.

Initiatives currently underway at University Hospitals Health System, University Hospitals of Cleveland (UHC) and Case Western Reserve University can serve as models for addressing this situation (see the section: Regional Assets for Addressing Health Disparities).

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*"In the Greater Cleveland area, early mentoring of minority students in various health care fields will help foster and secure their successful completion of training. This should happen as early as the junior and senior high school level."*

Carla M. Harwell, MD  
Medical Director, The Otis Moss, Jr.-University Hospitals Medical Center

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## **FINANCIAL BARRIERS**

Financial barriers to appropriate health care and access include not having health insurance, not having an adequate amount of insurance to cover needed services, or not having the money to cover services outside of insurance plans (e.g., not being able to afford prescription drugs). Health insurance coverage – whether provided by employers for their employees and their families or by government agencies for the elderly, poor or disabled – removes some of the financial barriers to health care for residents of Northeast Ohio. People without health insurance are less likely to have a regular source of care or receive preventive care. Several national-

level studies have shown that uninsured individuals reported more problems getting care, were diagnosed later and received less therapeutic care. They were sicker when hospitalized and more likely to have died during their hospital stay.<sup>70</sup>

Even though some health centers provide free, or low-cost care, uninsured individuals often delay seeking care until their conditions become more serious, resulting in more costly treatment, often in hospital emergency departments. Sometimes these individuals forego care entirely.

An analysis of the 2003-2004 Ohio Family Health Survey (OFHS) found that more than one in seven working-age adults (18 to 64 years of age) in Cuyahoga County had no health insurance.<sup>71</sup> The uninsured rate for working-age African-Americans, however, was over 23 percent – more than double the rate for their white counterparts. The uninsured rate for African-American males was even higher. Health insurance disparities for children exist, although they are not as great as adults because of government-sponsored health insurance programs like Medicaid and Ohio's Children's Health Insurance Program.<sup>72</sup>

Respondents to the OFHS were asked to assess their own health on a five-point scale, ranging from "poor" to "excellent." A third of uninsured adults in Cuyahoga County reported only "poor" or "fair" health, more than double the rate of their insured counterparts. People in poor health are often unable to work full-time, or at all. Some may not be able to afford health insurance because of high costs associated with pre-existing conditions. In addition to reporting "poor or fair" health more frequently

than insured counterparts, more than two-fifths of uninsured adults reported no health professional visits in the prior 12 months, more than two-and-a-half times the rate for "healthier" insured adults. Among those who used health care services, the uninsured were far more likely to have reported poor quality care.<sup>73</sup>

Although a lack of financial resources is a barrier to health care access for many Americans, particularly those who are uninsured and low-income, the impact on access appears to be greater for minority

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*"When I found out I had diabetes, the doctor gave me free samples and a prescription. The samples ran out. I couldn't afford to get the prescription filled. People who are homeless, jobless, or who can't afford care, need a place that can help them. Everyone should have guaranteed health care because everyone is guaranteed illness."*

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James Hardwick  
Patient

populations. According to a 1999 Commonwealth Fund study, nearly half of Hispanic adults, more than two-fifths of Asian American adults, and more than one-third of African-American adults report difficulty paying for medical care, compared to approximately one-quarter of white adults.<sup>74</sup> A recent national

survey by the Center for Health System Change found that 30 percent of African-Americans and 25 percent of Hispanics with chronic health conditions had to forgo prescription drug purchases due to the high cost; this compares to 17 percent of whites.<sup>75</sup>

At the local level, OFHS respondents were asked if there was any time during the past 12 months when they did not get needed health care such as a medical exam, medical supplies, mental health care, or eyeglasses. Uninsured adults in Cuyahoga County were more than five times as likely to report unmet health care needs than those with insurance. Among both adults with and without insurance, those with full-time employment were less likely to have unmet health care needs, presumably because they could cover the costs with their current in-

come. Poor and near-poor adults were more likely to have unmet needs, as were people who reported only poor or fair health, whose needs were greatest.<sup>76</sup>

OFHS respondents were asked if they had not had a prescription filled because of the cost in the past 12 months. Although not all health insurance plans cover prescription medications, people without insurance were almost four times as likely to have unmet prescription needs. People who reported their health as poor or fair (those whose needs were greatest) were more likely to have prescriptions unfilled.

The Free Medical Clinic of Greater Cleveland, the only totally free health care facility in Northeast Ohio, is an example of how health care costs can be addressed for the region's most-in-need population. In addition, as part of The MetroHealth System's mission, Cuyahoga County residents are eligible for treatment at MetroHealth facilities regardless of income. Financial counselors determine if patients qualify for any insurance programs; if not, they can use a "sliding scale" fee based on income. The sliding scale approach is a valuable option for the uninsured who may be able to afford discounted fees. The same sliding scale fee is available in MetroHealth pharmacy departments for prescription medications.

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*"As health insurance coverage rates go up for businesses, many are forced to increase their employees' co-payments. When an employee in a low-wage job is struggling with everyday bills, health coverage is often the last priority. All too often, these difficult choices are made to the detriment of the health of employees and their family members."*

Gail Bromley, Executive Director  
The Free Medical Clinic of Greater Cleveland

## **LACK OF A "MEDICAL HOME" AND ACCESS TO CARE**

While a lack of insurance or financial resources are major contributors to health disparities, there are a number of structural issues in the Greater Cleveland area that contribute as well. The location of providers and their hours of operation can be barriers to quality health care. While some area residents can schedule medical appointments in the middle of the day, many people, often in low-paying jobs, cannot leave work to visit a health care provider. In many cases, these individuals lack a "medical home," and must seek non-urgent care in hospital emergency departments, adding congestion, inefficiency, and cost to the region's health care system. More than 40 million Americans do not have a "medical home," a particular doctor's office, clinic, health center, or other place where they usually go to seek health care or health-related advice. The OFHS found that adults without insurance were four times as likely not to have a medical home. Both insured and uninsured males were more likely than their female counterparts to be without a medical home.<sup>77</sup>

The lack of a "medical home" for many Greater Cleveland residents is also related to regional demographics. Cleveland historically has been a racially segregated city. It is about two-thirds minority, with most being African-American. The majority of African-Americans live in Cleveland's east side and eastern Cuyahoga County suburbs where health care facilities are continually challenged to meet the demand for services. These are areas where health conditions are worst,<sup>78</sup> meaning that people most in need of regular primary care are least likely to receive it.<sup>79</sup>

People without a "medical home" report difficulties obtaining needed services and fewer preventive services, including blood pressure monitoring,

flu shots, prostate exams, Pap tests, and mammograms.<sup>80</sup> They make fewer doctor visits, and have more difficulty accessing prescription drugs. Lacking a regular source of care, particularly a primary care physician, can also limit access to referrals for specialty care.<sup>81</sup>

Lacking a “medical home” is further exacerbated by the scarcity of primary care practitioners, medical specialists, and diagnostic facilities in inner cities and rural areas – communities with high concentrations of minority populations. Thus, minor-

ity groups are more likely to report that they have little or no choice in where they obtain care compared to whites.<sup>82</sup>

The need to provide a “medical home” for all Greater Cleveland residents is heightened by the relatively recent closings of the Mount Sinai Hospital and Saint Luke’s Hospital urban health care facilities. MetroHealth has developed a strategy for increasing the number of area residents with “medical homes.” This strategy is described in the subsequent section: Regional Assets for Addressing Health Disparities.

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*“MetroHealth is committed to placing primary care practices in retail urban shopping centers located in Cleveland neighborhoods. The MetroHealth Center for Community Health can serve as a model for eliminating health disparities by providing access to quality health care in underserved neighborhoods, providing specialized services to targeted populations, and helping to improve and maintain the health status of patients regardless of their ability to pay.”*

E. Harry Walker, MD, Director  
MetroHealth Center for Community Health

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## EFFECTIVE USE OF HEALTH INFORMATION TECHNOLOGIES

One way to accelerate the elimination of health disparities in Northeast Ohio is to develop and deploy health information technologies that can help health care providers and insurance companies identify factors that contribute to regional disparities. Health information technology (HIT) is the application of computerized information processing that deals with the storage, retrieval, sharing and use of health care information, data, and knowledge for communication and decision making.<sup>83</sup> An important HIT application is the electronic health record (EHR) – a patient’s medical file. Electronic records held by patients are known as patient health records (PHR); those maintained by clinicians are known as electronic medical records (EMR).<sup>84</sup>

EMRs can be used to order prescriptions and tests, provide information to support clinical decisions, and create a historical record of events and decisions related to a patient’s care. They are also used for care management, analysis, and reporting on an individual or groups of patients. Data can be used to compare clinicians, provider groups and health plans by analyzing how well they serve patients after adjusting for race and economic status.

In October 2005, more than 100 health care leaders and stakeholders attended the “Ohio Health Information Symposium” to discuss how more responsive EMR systems could be developed and deployed. During the symposium, the Health Policy

Institute of Ohio released a paper entitled “Assessing Health Information Technology in Ohio,” which contains information about how HIT can be used to reduce health disparities in Ohio (see: <http://www.healthpolicyohio.org/publications/HIT.html>). The paper provides descriptions of statewide initiatives and models for collaboration. While many of the large clinical institutions in Greater Cleveland have adopted, or are in the process of adopting, EMR systems for their “internal” use, health care organizations and insurance carriers may want to consider forming a Regional Health Information Coalition that can provide leadership for designing and deploying health information technologies that can be used to reduce health disparities at the local level (see Recommendations section).

For example, Aetna, one of the nation’s leading providers of health insurance, continues to expand its program to address health disparities through data collection. In addition to research, education, customer service, and general awareness initiatives, Aetna is enhancing data collection efforts that will: (1) facilitate assistance to individuals with risk factors for certain health conditions who may benefit from disease management programs; (2) support linguistically and culturally appropriate communications; and (3) buttress quality improvement efforts that are designed to reduce disparities in care.<sup>85</sup>

# REGIONAL ASSETS FOR ADDRESSING HEALTH DISPARITIES

**T**HE community resources and partnerships described in this section represent some of the strongest assets available in the region's fight against health disparities. This listing does not presume to encompass the entire range of regional activities that aim to reduce gaps in health outcomes. These various programs were chosen, however, because of their capacity for expansion and replication and their high potential for improving the quality of life for thousands of residents and enhancing the competitive advantage of Northeast Ohio.

These successful initiatives appear to share a number of key characteristics: advocacy and activism; stable, committed and charismatic leadership; programmatic, organizational and financial stability; effective community communication and engagement; accessible and user-friendly health care services; and the proximity of the services to at-risk populations.

Many partnerships involve community- and faith-based organizations, health care institutions (especially teaching hospitals and academic centers), disease-specific health care-nonprofit organizations, and philanthropic associations. Most of the partnerships focus on attempts to discover the causes and origins of disease and disparities, education and individual empowerment, efforts to bring about lifestyle changes and cultural shifts, screening programs, health care advocacy and the provision of health care services.

## AIDS TASKFORCE OF GREATER CLEVELAND

With 75 staff and more than 1,800 clients, the AIDS Taskforce of Greater Cleveland is the oldest AIDS service organization in Ohio. The Taskforce is a primary provider of community-based HIV prevention education and non-medical services to people living with HIV and AIDS. Services include: comprehensive case management and client advocacy; housing services, individual and group counseling and support; chemical dependency and recovery services; Ryan White Care Act assistance<sup>86</sup>; social and recreational activities and referrals and linkages with other community and government sources of assistance. In addition to these services, the Taskforce offers a client nutrition program.

## BREAST CANCER COMMUNITY OUTREACH

Early breast cancer detection and screening in Cleveland is emphasized through a partnership with MetroHealth, the Thomas H. McCafferty Health Center, the American Cancer Society and the JD Breast Cancer Foundation. A recent breast cancer screening and health fair was held at La Segrada Familia Church; the majority of women served were Hispanic without medical insurance. The initiative was part of a larger outreach effort by MetroHealth's Cancer Center to help uninsured and low-income women receive breast cancer screenings. The program began in August 2005 and is funded by the Susan G. Komen Breast Cancer Foundation Northeast Ohio affiliate. Volunteer doctors, nurses

and social workers from MetroHealth and McCafferty staffed the clinical breast examinations and the American Cancer Society sponsored a “mamovan” (mobile unit) for women without health insurance. Bilingual volunteers were available on-site to interpret and help increase awareness. Future screenings will be held at various locations.

### CENTER FOR MINORITY PUBLIC HEALTH

Located in Cleveland’s west side, the Center for Minority Public Health, originating from Case Western Reserve University’s School of Medicine’s Department of Epidemiology and Biostatistics and supported by grants from the National Institutes of Health, The Cleveland Foundation and The Grossman Family Trust, focuses on health issues of concern to the African-American and Hispanic communities, particularly those involving mental illness and HIV risk. In addition to providing education, counseling and referral services, the Center trains and employs community members to help area residents navigate the health care system, especially in matters related to services for mental illnesses.

### CENTER FOR REDUCING HEALTH DISPARITIES

In January 2004, Case Western Reserve University and MetroHealth Medical Center created the Center for Reducing Health Disparities to reduce disparities through research on root causes, mechanisms, and interventions; education of students, providers, and policy makers; and the establishment of partnership with community organizations and government agencies. The Center’s long-term goals include creating a durable academic-community partnership to develop innovative interventions that achieve measurable reductions in health disparities in the Greater Cleveland area; promoting successful

intervention strategies that can be replicated in other regions; and training a new generation of health activists committed to eliminating health disparities. Ongoing research projects include a Medicare-funded effort to develop clinical performance measures on access to kidney transplantation. In the educational area, the Center organizes visits by local and national experts on health disparities. Ongoing community collaboration includes a joint effort with the AIDS Taskforce of Greater Cleveland to improve the delivery of services to Hispanics. The Center, in conjunction with the Greater Cleveland Partnership, conducted the *Prescriptions for Change* lecture series to educate the community about health disparities.

### CLEVELAND MUNICIPAL SCHOOL DISTRICT FITNESS PROGRAM

With a \$400,000 grant from the American Heart Association and Kaiser Permanente, the Cleveland Municipal School District is launching a “Physical Best” pilot program in 15 elementary schools in an effort to fight obesity in younger children. The program focuses on teaching proper nutrition and developing four fitness areas – aerobics, building muscles, body composition and flexibility. These activities will be integrated into existing fitness classes. Grant funds will be used to train teachers and purchase equipment.

### COMMUNITY-BASED FEDERALLY QUALIFIED HEALTH CENTERS

An effective approach for eliminating healthcare disparities at the local level is to bring health care services directly into local minority communities. In 1991, the federal government established a program to help fund community-based Federally Qualified Health Centers. Three of these centers have been established in Cleveland.

Northeast Ohio Neighborhood Health Services (NEON), which has operated since 1967, focuses on the health care needs of Cleveland's near east side African-American community. Care Alliance provides health care services for needy members of Cleveland's inner-city neighborhoods. Neighborhood Family Practices provides services for a significant portion of the Hispanic community on Cleveland's west side.

These organizations have formed partnerships with the Free Medical Clinic of Greater Cleveland, the City of Cleveland and Cuyahoga County Health Departments and faith-based organizations to establish the Safety Net Provider Strategic Alliance. The Alliance's mission is to take a systematic approach for eliminating health disparities and for improving access to health services. An initial Alliance project focused on improving diabetic care, establishing a diabetes education program and engaging patients in developing a chronic care model. The Alliance has started monitoring hemoglobin glycation as a measure of diabetic control and collaborates with other local health care organizations to provide necessary specialty care (*e.g.*, St. Vincent Charity Hospital provides examinations and treatment for diabetic retinopathy and other aspects of eye care).

## CMHA HEALTH EDUCATION AND LIFESTYLE CHANGES

The Cuyahoga Metropolitan Housing Authority (CMHA), together with the Health Museum of Cleveland (now known as HealthSpace) and the Case Western Reserve University School of Medicine's Office of Urban Health initiated a program to reduce health disparities by implementing a health prevention delivery model for residents of Cuyahoga County's public housing. With initial funding from the Robert Wood Johnson Foundation, supplemented by local funding from The

Cleveland Foundation, The Bruening Foundation, The Wean Foundation, The Murphy Foundation and The Mount Sinai Health Care Foundation, the program focuses on raising awareness, health education, lifestyle enhancement and cultural/environmental shifts. Interventions focus on exercise programs, helping public housing residents understand and improve cardiovascular health and assisting in improving general nutrition. Bridge funding from the Kaiser Permanente Foundation and subsequent support from the Ohio Commission on Minority Health has enabled the program to continue to provide health education and promote positive lifestyle changes for public housing residents. Continuation of the program will depend on the availability of long-term financial support.

## DAVID SATCHER CLERKSHIP

The David Satcher Clerkship<sup>87</sup> at University Hospitals of Cleveland, which began in 1991, exposes minority medical students to career opportunities available in academic medical centers. Participants attend seminars on issues related to health care for underserved populations and are mentored by two individuals – a minority physician who is a member of the CWRU medical school faculty and a minority member of the Cleveland lay community who involves the student in home and community activities. Each clerk receives a stipend to help defray the costs of travel and housing expenses.

## DENTAL SEALANT PROGRAM

An innovative approach for reducing disparities by bringing health care to individuals who need it most is a dental sealant program, known as "Bright Smile, Bright Future." The program is conducted by the Department of Community Dentistry at the Case Western Reserve University School of Dental Medicine. Each year, in cooperation with the Cleveland Municipal School District, all freshman

dental students visit almost 100 Cleveland public schools to provide oral health instruction and apply dental sealant to approximately 7,000 six- and 12-year-old students. The program, which is designed to protect teeth, prevent decay, avoid associated pain and loss of teeth and the need for dental extraction, was initially supported as a pilot study by the Saint Luke's Foundation, which continues to provide annual support to sustain the benefits of the program to the community. The School of Dental Medicine is committed to maintaining the program because it is an integral component of its education process and a vital public service.

### FACILITATING HEALTH CARE CONNECTIONS

The Greater Cleveland Service and Education Council, the Diabetes Association, the American Cancer Society and others have developed programs to provide physician referrals, help patients enter the healthcare system and conduct follow-up calls to encourage participation and compliance.

### FREE MEDICAL CLINIC OF GREATER CLEVELAND

The Free Medical Clinic of Greater Cleveland, which began operating in 1970, is the only totally free health care facility in Northeast Ohio. The Free Medical Clinic's mission is to provide quality health care and related services free of charge to those who lack appropriate alternatives and to advocate for policy changes that make health care available to all. The Free Medical Clinic serves more than 13,000 patients each year. Over 600 volunteers, including doctors, nurses, midlevel practitioners, lab technicians, dentists, psychiatrists, psychotherapists, and social workers support the Free Medical Clinic. Lay people are trained to work on the Clinic's hotline, perform medical and mental health intake,

and provide HIV counseling and other services to support the Clinic. Approximately 55 percent of the Clinic's funding comes from public sources, including federal, state, and local government funders. The balance is received from a combination of foundations, corporations, special events, and individual contributions.

### FREE VISION SCREENING AND GLASSES

Demonstrating another long-term commitment to eliminating health disparities in Cleveland, The Mt. Sinai Health Care Foundation has formed a partnership with the Cleveland Municipal School District to sustain the "Child Sight Cleveland" program, which provides free vision screening and corrective glasses for middle-school students throughout the school district.

### GREATER CLEVELAND HEALTH SERVICE AND EDUCATION COUNCIL

Beginning as the Greater Cleveland High Blood Pressure Coalition, with sponsorship by the Mt. Sinai Medical Center, the Greater Cleveland Health Service and Education Council capitalized on the power of the African-American church as a voice for health promotion and disease prevention. While continuing to focus on controlling high blood pressure, the Council has extended its efforts to include education, screening and referral for cardiovascular health, tobacco use prevention and other health issues of particular concern to Cleveland's African-American community. With funding from The Mt. Sinai Health Care Foundation and the Saint Luke's Foundation, supplemented by other short-term grants, the Council has expanded its outreach efforts beyond area African-American churches to include community health fairs, the Cleveland Municipal School District and Head Start programs.

Using a novel approach, the Council identified barbershops as settings for reaching African-American men, enlisting barbers as health care advocates and establishing on-site programs for cardiovascular health screening and education.

## HEALTH SCREENING

Several area organizations have established partnerships to provide health screening opportunities for members of Cleveland's minority communities. The Ireland Cancer Center of University Hospitals of Cleveland, together with CVS/pharmacy® and WKYC Channel 3, conducted multiple Fecal Occult Blood Testing programs to detect colorectal cancer. The Cleveland Clinic Foundation, together with the City of Cleveland and Medical Mutual of Ohio, conducted a "Healthy Hearts" program that included cholesterol and hypertension screening.

The Cuyahoga County Unit of the American Cancer Society, in cooperation with Cuyahoga County and in partnership with regional health-care providers, conducts breast cancer early detection programs in which over 700 highly vulnerable, elderly and minority women annually receive screening mammograms. The American Cancer Society, The Cleveland Clinic Foundation, University Hospitals of Cleveland, Huron Road Hospital, and other organizations worked together with 100 Black Men of America and area African-American churches to increase awareness of prostate cancer in African-American men and facilitate prostate cancer screenings.

In addition, through its community outreach programs, which are conducted in partnership with area churches, health fairs and food markets in urban commercial areas, the Diabetes Association of Greater Cleveland conducts risk assessments in Cleveland's minority communities. The association performs measurements of blood glucose, cholesterol and blood pressure, screening as many as 5,000 inner-city residents annually.

## HOSPITAL AND FAITH-BASED PARTNERSHIPS

Established in 1997, The Otis Moss, Jr.-University Hospitals Medical Center, located in Cleveland's Fairfax neighborhood and staffed by full-time primary care physicians, is a partnership between University Hospitals of Cleveland and Olivet Institutional Baptist Church. This clinic brings affordable, accessible high-quality health care services to the community in a setting of prayer and spirituality – an environment with an aura of familiarity and comfort that has a positive impact on the health of individuals in the neighborhood.

## *Mas Vida* ("MORE LIFE") INITIATIVE

The *Mas Vida* ("More Life") initiative – a partnership between the AIDS Taskforce of Greater Cleveland (ATGC) and the HIV Unit at MetroHealth Medical Center – was established in 2005 to provide greater medical access and education to Hispanics with HIV, with the ultimate goal of improving medical outcomes for Hispanics living with HIV/AIDS in northeast Ohio. The initiative provides HIV-positive Hispanics with bilingual services such as social workers in clinics and community programming and provides training in HIV/AIDS and HIV/AIDS care and treatment in bilingual training workshops designed for HIV-positive Hispanics not currently accessing HIV treatment services. *Mas Vida* also facilitates the development of community partnerships, including ATGC, the MetroHealth Medical Center and community organizations and groups serving the northeast Ohio Hispanic communities.

## MEDICAL TRAINING FOR MINORITY STUDENTS

Case Western Reserve University School of Medicine has a long history of commitment to expanding enrollment and training opportunities for minority students. With funding from The Robert Wood Johnson Foundation, the School of Medicine has conducted the Health Careers Enhancement for Minorities Summer Program (HCEM) for 16 years. The program helps prepare minority and disadvantaged undergraduate college students for admission and success in medical school. Over 65 percent of HCEM students who applied went to medical school, and 40 percent of the minority students at the CWRU School of Medicine were initially involved in this program. The program has been replaced by the Summer Medical and Dental Program, which is also funded by The Robert Wood Johnson Foundation. The program encourages and prepares students for medical or dental careers.

## METROHEALTH NEIGHBORHOOD “MEDICAL HOMES”

As part of its commitment to promote comprehensive health services to residents of Cuyahoga County, MetroHealth has located a series of highly accessible, multi-specialty care clinics at strategic locations in the inner city. MetroHealth has committed to placing primary care practices in retail urban shopping centers in Cleveland neighborhoods. Staffed by pediatricians, internists, obstetricians, family practitioners, dermatologists and rehabilitation experts, the clinics provide high-level specialty care for neighborhood residents. Since 1999, four health facilities have opened in Cleveland’s Brooklyn, Lee/Harvard, Broadway and Buckeye neighborhoods.<sup>88</sup> These modern facilities, developed with

input from neighborhood community leaders and residents, are easily accessible to public transportation and offer evening and Saturday hours. All of the neighborhood facilities are connected with the MetroHealth Medical Center via an electronic medical records system that allows sharing of treatment and outcome data.

The unique nature of these facilities has attracted grant funding to test management programs for chronic diseases such as asthma, obesity and diabetes. For example, the Buckeye Health Center received a grant from the Saint Luke’s Foundation to collaborate with local schools, libraries and other neighborhood resources to offer a broader range of community support. A program targeting pediatric asthma will monitor school absence rates, emergency room visits or workdays missed by a parent or caregiver to determine how well patients are managing their conditions.

## MINORITY FACULTY DEVELOPMENT AWARD

University Hospitals of Cleveland offers a Minority Faculty Development Award that provides financial assistance to underrepresented minorities with a job offer or new hire currently on faculty.

## MINORITY MEN’S HEALTH CENTER

The Minority Men’s Health Center of the Cleveland Clinic Foundation’s Glickman Urological Institute addresses health care disparities among minorities by focusing on prostate cancer and renal transplantation in African-American men. In cooperation with researchers at the Cleveland Clinic Lerner Research Institute, the Center pursues a wide variety of studies such as immunology, molecular genetics, behavioral research and clinical trials of new therapies and diagnostics.

## OUTREACH TO THE HISPANIC COMMUNITY

The *Creando Posibilidades / Creating Possibilities* program, developed and operated by *El Barrio*, a provider of social services for the Cleveland area's Hispanic community, is using innovative outreach and recruitment methods to better link the region's Hispanic population with health career awareness and exposure, training and job opportunities.

## PROYECTO LUZ AND PASANDO LA LUZ

*Proyecto Luz*, a Cleveland west-side, faith-based HIV/AIDS prevention, education and case management program, provides outreach and education services for Latinos and others infected and affected by HIV/AIDS. The program has been operating for six years. The *Pasando La Luz* (Passing the Light) prevention program specifically targets Latina women and youth. This is accomplished by focusing on places where Latinas gather (*e.g.*, faith groups, clubs, *etc.*).

## SCIENTIFIC ENRICHMENT AND OPPORTUNITY PROGRAM

To further encourage members of Cleveland's minority community to enter the health care professions, the Center for Science, Health and Society at Case Western Reserve University's School of Medicine, in collaboration with the Cleveland Municipal School District, and with support from the Saint Luke's Foundation and The Sam and Maria Miller Foundation, conducts the Scientific Enrichment and Opportunity Program. The program encourages high school students to enter the health care professions through summer research experiences and a series of motivational and educational seminars. The first cohort of students who started in the program after completing 10<sup>th</sup> grade has entered college and is expected to progress through the Sum-

mer Medical and Dental Education Program where efforts will continue to support their interests in medical and dental professions and encourage their return to practice in the Cleveland community.

## ST. VINCENT CHARITY HOSPITAL HEALTH ADVOCACY

St. Vincent Charity Hospital, with support from the Sisters of Charity Foundation of Cleveland, has established a unique health advocacy program. Two full-time and one part-time health advocate provide education and help community members, including CMHA residents, enter the healthcare system and obtain optimal benefits from the services available at St. Vincent Charity Hospital. In partnership with the Ireland Cancer Center of University Hospitals of Cleveland and Project TEMPLE (teaching, education, mentoring, prevention, learning and empowering), with funding from The Susan Komen Foundation, the St. Vincent Charity Hospital Health Advocacy program was expanded to include two additional advocates who educate hospital staff and community members in matters related to breast health and facilitate access to breast health services and oncology personnel.



(left) Gus Kiouss, M.D., senior vice president, medical management, Huron Hospital, talks with (right) Charles Modlin, M.D., founder and director of the Minority Men's Health Center at the Cleveland Clinic's Glickman Urological Institute, at the program on national challenges and progress toward reducing health disparities. John Ruffin, Ph.D., director, National Center for Minority Health and Health Disparities, (second from left) was the presenter.

# RECOMMENDATIONS FOR ELIMINATING HEALTH DISPARITIES IN NORTHEAST OHIO

THE following recommendations for eliminating health disparities in Northeast Ohio were developed by participants in the *Prescriptions for Change* initiative. They do not presume to be exhaustive or, in many cases, implementable without additional planning and dialogue with key community stakeholders. Instead, the recommendations represent an invitation to the community to undertake this long-term challenge as an important, coordinated priority. It is our hope that eliminating health disparities can be addressed as part of the overall efforts currently underway to improve the quality of life for all Greater Clevelanders and to maximize the economic capacity of the region.

Many of these recommendations were included in topical papers prepared by community leaders, health care professionals, policy makers, educators and others who contributed their experience and expertise to the initiative. Others are borrowed from research and suggestions of policy leaders who are giving increasing levels of attention to this issue. The recommendations are grouped into eight sections, targeted to health care providers, researchers, insurance providers, local elected officials, grant makers and funders, colleges and universities, community organizations and regional business leaders. A ninth section includes recommendations that should be considered by regional stakeholder coalitions and partnerships.

## RECOMMENDATIONS FOR HEALTH CARE PROVIDERS

**1** *Establish a Regional Health Information Coalition.* Such a coalition could provide leadership for using existing technologies effectively and developing new methods for collecting and sharing medical information. Capturing and sharing relevant data (while properly addressing privacy considerations) concerning factors that contribute to disparities could lead to more effective interventions. At the same time, providers also should work as a group with information technology experts to develop and deploy regional technical assistance mechanisms for setting up and using electronic medical records (EMR) systems that can be used to support clinical decisions, enhance care management and facilitate telemedicine and interactive health communications systems.

**2** *Modify provider billing and collection policies and practices to better accommodate the provision of free or discounted care to uninsured or underinsured patients.* The fear of accumulating unmanageable debt is a major deterrent to many minorities who might otherwise seek treatment at an earlier, less expensive stage. Hospitals should review policies for providing free or discounted care to people based on income and ensure that these are made public.

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*“To break down barriers in communication between health care providers and patients of different cultures, all health care workers need to become sensitive to the traditions, values, and attitudes of all ethnic groups. To this end, cultural competency training should become mandatory for all health care providers.”*

Charles S. Modlin, MD, Glickman Urological Institute, The Cleveland Clinic

**3*****Establish a “Health Empowerment Zone” in Cleveland.***

Such a zone was established by the Center for Minority Health (CMH) in Pittsburgh, where lifestyle and behavior modification education can be concentrated. One CMH initiative focuses on preventing diabetes and hypertension among African Americans in Pittsburgh’s East End. In addition, CMH’s “Take a Health Professional to the People Day” linked over 100 professionals from health sciences schools with local African-American barbershops and beauty parlors, dispensing free health advice and enlisting barbers and beauticians as allies in providing information about healthy lifestyles.

**4*****Increase the number of health care interpreters and develop systems for efficiently deploying interpreters where and when they are needed.***

Providers should work collaboratively with regional educational institutions and community organizations to share knowledge and expertise for developing and delivering the training needed to eliminate or reduce communication issues that inhibit effective health care delivery.

**5*****Produce and disseminate “state-of-the-art,” culturally sensitive and, where appropriate, “low-literacy” health care materials.***

Providers should work with community organizations to pool their expertise for providing culturally sensitive health care materials, perhaps modeled after those created by the Cleveland Clinic Foundation’s Minority Men’s Health Center. At the same time, providers and community organizations should collaborate to provide “low-literacy” educational materials and disseminate this information where it is most needed.

**RECOMMENDATIONS FOR RESEARCHERS****6*****Create a system to share information and resources to develop and test targeted interventions specific to our region.***

Consider forming a health disparities professionals group designed to share ideas and collaborate on possible funding opportunities. The Diversity Professionals Group, recently formed by the Commission on Economic Inclusion of the Greater Cleveland Partnership, may offer guidance.

**7*****Establish a common database identifying current and prospective research projects seeking to address local health disparities.***

The *Prescriptions for Change* initiative made clear that there is considerable research and activity taking place around this issue, but that many of the key players are not aware of the work of their colleagues. The same kinds of research collaborations that are becoming more common in connection with cancer and heart research should become models in this area as well.

**8*****Make efforts to increase representation of minorities and economically disadvantaged populations in all facets of research.***

New findings by researchers at the National Institutes of Health show that minorities participate in health research at the same rate as non-Hispanic whites when they are made aware of the study and meet the medical requirements. According to Ezekiel Emanuel, M.D., Ph.D., chair of the Department of Clinical Bioethics, and an author of the report, “The big take-home message here is that the main barrier is not the attitudes of African-Americans and other minorities. The main barrier is access, knowledge that these studies exist, eligibility criteria that ensure minorities can participate, and overcoming logistical barriers that exist, such as the location of the study or the need for child care.”<sup>89</sup>

- 9** *Increase diversity of research staff.* Acknowledge current research that suggests minorities may respond better to outreach efforts from research staff with whom they share some ethnic or cultural affinity.

## **RECOMMENDATIONS FOR INSURANCE PROVIDERS**

- 10** *Participate in the Regional Health Information Coalition.* (See “Recommendations to Health Care Providers.”)
- 11** *Develop agreement among the region’s major health insurance providers to collect relevant indicators of disparity and pilot promising interventions.*

## **RECOMMENDATIONS FOR LOCAL PUBLIC OFFICIALS**

- 12** *Support advocacy efforts on behalf of appropriate changes in Medicaid policy.* One key needed change is to authorize payment by Ohio Medicaid for interpreter services to limited English proficiency patients on Medicaid.
- 13** *Support programs that address infant mortality through tested pre- and post-natal interventions.* Consider expansion of programs such as Moms First, a nationally recognized model that provides access to pre- and post-natal care and addresses perinatal depression within the City of Cleveland. The program reaches a relatively large number of African-Americans who live in high-risk neighborhoods. Local elected officials should also collaborate with leaders in Franklin County to learn from that county’s successful model for reducing infant mortality.

- 14** *Establish goals, implement policies and ensure adequate funding to improve childhood lead screening rates in the City of Cleveland.* Elected officials should also help accelerate the Greater Cleveland Lead Advisory Council’s effort to eliminate lead poisoning in Greater Cleveland by the year 2010.

- 15** *Address current policies that promote the sale or distribution of unhealthy snacks and “junk food” in local elementary and secondary schools.*

- 16** *Consider replication of reforms being implemented by Arkansas Governor Mike Huckabee, current chair of the National Governors Association, designed to address his state’s obesity challenges and the economic impact it is having on his state.*

## **RECOMMENDATIONS FOR GRANT MAKERS AND FUNDERS**

- 17** *Establish a Regional Council to serve as a permanent vehicle for pursuing funds to address community health disparities.* Develop the infrastructure and expertise necessary to pursue National Institutes of Health (NIH) funding opportunities.
- 18** *Support tested local programs that promote activities designed to address obesity.* Consider continued support and replication of initiatives such as the City of Cleveland’s Steps to a Healthier Cleveland project (currently funded by the Centers for Disease Control and Prevention). Develop ideas from sources such as a recent book by Tom Farley and Deborah Cohen, entitled *Prescriptions for a Healthy Nation*, for local application.

## RECOMMENDATIONS FOR SECONDARY SCHOOLS, COLLEGES AND UNIVERSITIES

**19** *Access the resources available to students, researchers and institutions focused on eliminating health disparities.* Consider: (1) establishing a mechanism to facilitate student application to the National Institutes of Health's (NIH) Clinical Research Loan Repayment Program; (2) sharing information and knowledge needed to apply for the NIH Minority Health International Research Training Grant; and (3) providing support for institutions applying for NIH endowment.

**20** *Work collaboratively to identify existing, or develop new, curricula addressing health disparities for clinical practitioners.*

**21** *Develop programs to increase the availability of trained interpreters and train providers regarding the effective use of such interpreters.* (See Recommendations for Health Care Providers.)

**22** *Develop a regional initiative to increase the number of minority health care professionals.* Consider collaboration with programs such as The Physician Diversity Project of Community Catalyst, a national organization working to improve community participation in the health care system. (See: <http://www.communitycatalyst.org>)

## RECOMMENDATIONS FOR COMMUNITY ORGANIZATIONS

**23** *Promote the development and dissemination of effective anti-obesity media and counter-programming aimed at appropriately-aged students.* Consider the development and replication of a broad-based media campaign aimed at obesity, perhaps modeled after the "Truth" campaign that has contributed to the reduction in teen smoking.

**24** *Coordinate with existing major health disparity initiatives to leverage impact.* Support and coordinate with programs such as the Health and Caring for All Vision Council (HCVC)'s *Reducing Racial and Ethnic Disparities in Health and Access to Health Care* initiative.

**25** *Support efforts to eliminate lead poisoning in Greater Cleveland.* Support and collaborate with programs such as the Greater Cleveland Lead Advisory Council, Lutheran Metropolitan Ministry's lead poisoning education outreach and advocacy program, and the statewide *Help End Lead Poisoning* initiative.

**26** *Collaborate on the development of strategies and programs to provide culturally appropriate outreach and case management to vulnerable populations.<sup>90</sup>*

## RECOMMENDATIONS FOR NORTHEAST OHIO BUSINESS LEADERS

**27** *Support efforts to encourage major health insurers to collect relevant data through health plans.* Consider replication of current health data-collection initiatives to allow for the development of effective interventions to address health disparities.

**28** *Encourage key industry clusters to increase the number and quality of employer-sponsored wellness programs.*

**29** *Cooperate with efforts designed to educate stakeholders about the economic cost of failing to eliminate health disparities.*

**30** *Encourage broader development of employer-provided wellness programs.*

## RECOMMENDATIONS FOR COALITIONS AND PARTNERSHIPS OF THE ABOVE GROUPS

**31** *Establish a coalition of health care stakeholders to speak with “one voice” on public policies relevant to the elimination of health disparities.*

**32** *Support existing programs aimed at expanding the existence of “medical homes” for at-risk populations.* Collaborate with institutions such as The MetroHealth System and other stakeholders to promote the “medical home” concept and encourage the expansion of Federally Qualified Health Centers to increase the number of “medical homes” for area residents.

**33** *Convene local stakeholders to develop strategies to improve access to health coverage and health care by indigent and medication-dependent individuals.<sup>91</sup>*

**34** *Advocate with business organizations, public officials and other policy makers to integrate key health care priorities, such as the elimination of health disparities, into federal and state development initiatives.* Stakeholders should consider establishing coalitions and resources to effectively lobby for public policies that explicitly seek to address the causes of health disparities.

**35** *Develop culturally sensitive HIV/AIDS education and outreach programs.* Consider replication of efforts such as AID Atlanta, a nonprofit organization that has developed a model program for HIV awareness and testing, counseling, social services and public benefits. AID Atlanta operates several other HIV/AIDS programs, including a culturally appropriate project that focuses on providing information to the gay community and a program known as “Sista Sol” which was developed to reduce behaviors that place African-Americans at risk for HIV/STD infection and reinforce healthy behaviors. (See: [http://www.aidatlanta.org/education/education\\_programs.shtml](http://www.aidatlanta.org/education/education_programs.shtml).)

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- <sup>86</sup>The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 is federal legislation that addresses the unmet health needs of persons living with HIV disease by funding primary health care and support services. The CARE Act was named after Ryan White, an Indiana teenager whose struggle with HIV/AIDS and against AIDS-related discrimination helped educate the nation. The Act can be found at 42 USCS §§300ff *et seq.*
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- <sup>89</sup>"New Findings on the Willingness of Minorities to Participate in Health Research." *NIH News*. December 6, 2005. Available at: <http://www.nih.gov/news/pr/dec2005/cc-06.htm>. Accessed February 13, 2006.
- <sup>90</sup>For example, studies have documented the effectiveness of training "*promotoras de salud*," or health promoters, who are people from the target community who are trusted in the community. These individuals provide education and case management for people with chronic health conditions, pregnant women and others who are at risk for medical problems. Another example is project REACH (Racial and Ethnic Approaches to Community Health), a model that was developed in Detroit to produce and disseminate minority-specific intervention materials which are marketed by trained community residents to help inform area residents of lifestyle factors for risk of diabetes (REACH can be adapted for other disabilities). Another intervention is the model of *Abrete Sesamo*, a project of the Latino Empowerment and Outreach Network (LEON) in Columbus, Ohio, which trained lay health advisors who are organizing workshops among newly arrived Latino residents, teaching them how to use the health care system appropriately, why and how to establish a "medical home," how to pay for health care, and other skills needed to be effective patients. The project is also building relationships that link vulnerable populations with assistance in using the health care system.
- <sup>91</sup>DMA is a state-funded program for medication dependent, indigent people. One-third of current enrollees reside in Cuyahoga County. The recent state budget reduced funding dramatically and an advisory council developed recommendations for restructuring and preserving the program on a limited budget. No representatives participated from Cuyahoga County, which could benefit from a coordinated approach to serving this population. Because of funding cuts, enrollment is frozen and many eligible residents from Northeast Ohio will go without state-funded assistance.

# APPENDIX SECTION A: LECTURE SERIES PRESENTERS

OCTOBER 27, 2004

## “Unequal Health Outcomes: National Challenges and Progress Toward Reducing Health Disparities”

**Presenter:** John Ruffin, Ph.D., director, National Center for Minority Health and Health Disparities, National Institutes of Health.

DECEMBER 10, 2004

## Afternoon Lecture: “The Color Line: Why Race Matters in the Elimination of Health Disparities”

**Presenter (afternoon and evening):** Stephen B. Thomas, Ph.D., director, Center for Minority Health, University of Pittsburgh.

### **Panelists for the afternoon program:**

George Weiner, Ph.D., Community Solutions and Joseph Sudano, M.D., MetroHealth.

## Evening Lecture: “Light on the Shadow of the Tuskegee Syphilis Study (1932-1972): Implications for the Elimination of Racial and Ethnic Health Disparities.”

*Panelists from the December 2004 program (l to r): Joseph Sudano, M.D., MetroHealth; George Weiner, Ph.D., Center for Community Solutions; and Stephen B. Thomas, Ph.D., Center for Minority Health, University of Pittsburgh.*

*Rachel E. Spector, Ph.D., R.N., and CULTURECARE consultant, spoke on new approaches to multicultural health care.*



JANUARY 26, 2005

## “Identifying Barriers: Access and Quality Issues that Contribute to Health Disparities.”

**Presenter:** H. Jack Geiger, M.D., medical professor Emeritus, Sophie Davis School, City College of New York.

**Panelists:** Ashwini Sehgal, M.D., (moderator), director, Center for Reducing Health Disparities, Case Western Reserve University, MetroHealth Medical Center; Sonja Harris-Haywood, M.D., assistant professor, Case Family Medicine Research Division, and John F. Sideras, president and CEO, MetroHealth System.



*“Identifying Barriers” panelists (l to r): H. Jack Geiger, M.D., presenter, City College of New York, Sonja Harris-Haywood, M.D., CWRU Family Medicine Research Division, and John F. Sideras, The MetroHealth System.*



*“Economic Costs of Health Disparities” panelists (l to r): Mark Schweitzer, Ph.D., Federal Reserve Bank of Cleveland, moderator; Ronald L. Copeland, M.D., Ohio Permanente Medical Group; Susan Kennedy-Kalafatis, Ph.D., North Central Medical Unit, Aetna, Inc.; and presenter Kenneth E. Thorpe, Ph.D., Rollins School of Public Health, Emory University.*

APRIL 13, 2005

**“The Impact of the Rising Complexity of Health Care and Self Care on Challenged Consumers.”**

**Presenter:** Linda Gottfredson, Ph.D., professor of education and co-director of the Delaware-Johns Hopkins Project for the Study of Intelligence and Society.

**Panelists:** Gail Bromley, Ph.D., executive director, The Free Medical Clinic of Greater Cleveland and Sharon E. Milligan, PhD., associate professor, social work Case Western Reserve University, and co-director, Center on Urban Poverty and Social Change.

MAY 25, 2005

**“The Economic Cost of Health Disparities.”**

**Presenter:** Kenneth E. Thorpe, Ph.D., professor and chair, Department of Health, Policy and Management, Rollins School of Public Health, Emory University.

**Panelists:** Mark E. Schweitzer, Ph.D., assistant vice president and economist, Federal Reserve Bank of Cleveland (moderator); Ronald L. Copeland, M.D., executive medical director, Kaiser Permanente of Ohio; and Susan Kennedy-Kalafatis, Ph.D., special projects team lead, North Central Medical Economics Unit, Aetna Inc.

JUNE 22, 2005

**“Responding to Cultural Differences: New Approaches for Multicultural Health Care.”**

**Presenter:** Rachel E. Spector, Ph.D., CULTURAL-CARE consultant and former associate professor, Department of Community Health Nursing, Boston College School of Nursing.

**Panelists:** Deborah J. Nebel, associate director, UH-CAN Ohio (moderator); Bette Bonder, Ph.D., professor, Departments of Health Sciences and Psychology and associate dean, Cleveland State University; and Jennifer Saenz, R.N., B.S.N., project director, *Creando Posibilidades*, El Barrio.

AUGUST 10, 2005

**“Remedies for Change: Developing Effective Strategies to Eliminate Health Disparities.”**

**Presenter:** Georges C. Benjamin, M.D., executive director, American Public Health Association.

*Dr. Benjamin’s remarks included recommendations on how local stakeholders can begin developing a strategic plan to become recognized as a healthy community.*



## APPENDIX SECTION B: BIOGRAPHICAL SKETCHES OF KEY CONTRIBUTORS

THE following individuals provided extensive advice and guidance throughout the *Prescriptions for Change* initiative. Many produced papers that were incorporated into the regional health disparities discussion.

### **Melissa Aulisio**

**Moreira, MNO**, is the associate director for The Center for Reducing Health Disparities, a joint program of MetroHealth Medical Center and Case Western Reserve University. The Center's mission is to reduce health disparities through research, education and community partnerships. Her professional interests include evaluation, public health, health disparities and community development. Examples of current projects include a partnership with The AIDS Taskforce of Greater Cleveland to improve access to care for HIV positive/ AIDS Latinos in Greater Cleveland. In addition, the Center for Reducing Health Disparities has formed a partnership with the Cuyahoga Metropolitan Housing Authority to reduce obesity in the CMHA youth population. Ms. Moreira belongs to the Cleveland Women's Health Care Commission and the Westside Women's Health Consortium. She received her Master's degree in Nonprofit Management from Case Western Reserve University and her Bachelor's degree in English Literature, *summa cum laude*, from The Ohio State University.

**Nathan A. Berger, M.D.**, is the Hanna-Payne Professor of Experimental Medicine and director of the Center for Science, Health and Society. He is professor of medicine, biochemistry and oncology at Case Western Reserve University, School of Medicine. Dr. Berger is an active researcher and oversees collaborative initiatives between Case Western Reserve University and the City of Cleveland to improve the health of city residents through community outreach, health education and health policy programs. He leads the CWRU School of Medicine Mini-Med School, an adult learning series aimed at educating the public to lead healthier

lifestyles, become more informed healthcare consumers and better healthcare advocates. Dr. Berger coordinates the Scientific Enrichment and Opportunity Program at the CWRU School of Medicine, which provides Cleveland high school students with unique opportunities to engage in biomedical research. The program also provides mentoring that motivates students to complete high school, attend college and pursue careers in the biomedical sciences and health professions. He received his A.B. from Temple University in 1962 and his M.D. from Hahnemann Medical College in 1966.

**Gail Bromley, Ph.D.**, is the executive director of The Free Medical Clinic of Greater Cleveland where she has continued her ongoing commitment to serving the needs of the disenfranchised. The Free Medical Clinic serves more than 13,000 patients each year. Over 600 volunteers support the Free Medical Clinic, including doctors, nurses, lab technicians, dentists, psychiatrists, therapists, and social workers. Dr. Bromley has extensive experience in administration, research, strategic planning and program development. In her leadership positions, she has worked with members of the community to identify disparities in health care and has implemented programs to improve access. Dr. Bromley believes that health care is a right, not a privilege. Dr. Bromley is a graduate of Boston University, majoring in Psychology and Sociology. She holds Bachelor's and Master's degrees from Frances Payne Bolton School of Nursing, Case Western Reserve University and a Ph.D. from Mandel School of Applied Social Science where she was awarded a Mandel Leadership Fellowship.

**Matt Carroll, J.D.**, is the interim director of the City of Cleveland Department of Public Health. The Department is responsible for disease reporting and surveillance, health promotion, health clinic services, food safety, environmental inspections and hazard control, and air quality. Mr. Carroll began his professional career as an attorney with Baker & Hostetler. He began his government and non-profit service by joining Cleveland's Department of Law, and continued in management positions with ParkWorks, a non-profit green space development organization, and the Cuyahoga County Department of Human Services. At Cuyahoga County, Mr. Carroll was a senior manager for Cuyahoga Health & Nutrition, the agency primarily responsible for administering social service benefits, including food stamps, Medicaid, and day care. Mr. Carroll has volunteered for several Cleveland nonprofit organizations, including serving as president of the boards of the Hunger Network of Greater Cleveland and Merrick House. He received his undergraduate degree in Political Science from Brown University and his law degree from Georgetown University Law Center.

**Esa M. Davis, M.D., M.P.H.**, is an assistant professor in the Department of Family Medicine, Division of Research, at the School of Medicine at Case Western Reserve University. Dr. Davis's research is in the role of stress, insulin resistance and childbearing on the later life development of obesity and diabetes in women. She is particularly interested in understanding mechanisms for the racial and socioeconomic disparity in obesity occurring among women. She maintains a clinical practice at the University Hospitals of Cleveland Family Medicine Health Center. Dr. Davis is also involved in medical student and resident education. She is board-certified as a Diplomat from the American Board of Family Physicians. Dr. Davis belongs to several professional organizations, including the American Academy of Family Physicians, the National Medical Association and the North American Association for the Study of Obesity. She attended UMDNJ-New Jersey Medical School in Newark, and completed her research training as a Robert Wood Johnson Clinical Scholar at Johns Hopkins University School of Medicine in Baltimore. She received her Master's of Public Health degree from the Johns Hopkins University Bloomberg School of Public Health.

**Paula Gomez Farrell, Ph.D.**, is a vice president of NorTech, a technology-based economic development organization that focuses on continuous improvement of Northeast Ohio's technology environment and economy. Dr. Gomez Farrell previously served as a program director for the Greater Cleveland Partnership where she worked on programs and projects related to diversity and economic inclusion. Her current work with NorTech involves staffing the Urban Technology and Inclusion Initiative, which focuses on ensuring that regional tech-based economic development strategies address the needs of all populations in Northeast Ohio. Her areas of focus include developing strategies for using health information technology to reduce health disparities and supporting the expansion of programs that encourage underrepresented students to choose careers in science, technology, engineering, and math. Dr. Gomez Farrell's professional career has included a unique combination of experience in information technology, human service, and social justice. Dr. Gomez Farrell received her Ph.D. in Urban Studies and Public Affairs from Cleveland State University.

**Carla M. Harwell, M.D.**, is the medical director of the Otis Moss, Jr.-University Hospitals Medical Center, and assistant professor of Medicine at Case Western Reserve University School of Medicine. The Otis Moss Jr.-University Hospitals Medical Center, located in an urban area of Cleveland, the Fairfax community, offers primary care services to many residents in both Cleveland and the Greater Cleveland community. Since completing her residency training, Dr. Harwell has served as medical director there with a special interest in reducing the health care disparities that exist in the African-American community. Many of Dr. Harwell's patients are underinsured, and she works to reduce health care inequalities by empowering her patients to take control and become active participants in their own health care. Most recently, the Ohio Commission on Minority Health honored Dr. Harwell for her dedication to decreasing health disparities among African-Americans in the State of Ohio and beyond. She holds a Bachelor of Sciences degree in biology, a Bachelor of Arts degree in psychology, and a medical degree, all from the University of Cincinnati.

**Insoo Hyun, Ph.D.**, is an assistant professor of bioethics in the Department of Bioethics, School of Medicine, Case Western Reserve University, in Cleveland, Ohio. Most of his early training in philosophy focused on ethical theory and epistemology. Dr. Hyun later came to develop a predominant interest in biomedical ethics. His research projects include ethical issues surrounding patient autonomy and cultural diversity, equality and priority among claimants of medical resources, international dynamics of human research cloning, and theories of patient well-being. Dr. Hyun's primary research goal is to provide new ways of framing bioethical problems by reexamining the theoretical orientations that have become commonplace among many bioethicists. He was recently awarded a Fulbright research award to begin qualitative research on the ethical, legal, and cultural dimensions of human cloning research in South Korea. Dr. Hyun received his B.A. and M.A. in philosophy from Stanford University and his Ph.D. in from Brown University.

**Cathy J. Levine, J.D.**, is the executive director of the Universal Health Care Action Network of Ohio (UHCAN Ohio) a statewide, grassroots organization that promotes access to quality, affordable health care for everyone. She co-chairs the Ohio Family Coverage Coalition, which works to build upon public health care programs for low-income people. As UHCAN Ohio's policy director, she has monitored Ohio's Medicaid program, preservation of community health assets, and health care legislation from the consumer's perspective. Her other areas of focus include state coverage initiatives, hospital billing and collections, immigrant health access and affordable prescription drugs. Ms. Levine leads UHCAN Ohio's Columbus grassroots activities, connecting people living and working in medically under-served communities with health care policymaking. Ms. Levine is active in BREAD (Building Responsibility, Equality and Dignity), an interdenominational congregation-based organization working on social justice issues in Columbus. Ms. Levine practiced law in Massachusetts, Pennsylvania, Wisconsin and Ohio, primarily representing low-income and working people. She received her B.A. from New York University, her Master's degree from Goddard-Cambridge Graduate Program, and her J.D. from New England School of Law.

**Shana F. Marbury, J.D.**, is the manager of inclusion initiatives and associate general counsel for the Greater Cleveland Partnership. Her current work focuses on two GCP programs, the Commission on Economic Inclusion, an organization of more than 85 Northeast Ohio employers committed to increasing the meaningful involvement of minority businesses and individuals in the economic engines of Greater Cleveland, and the Roundtable Community Council, a program that advocates for economic inclusion and social equity as key factors in the development and implementation of business and economic development strategies. Ms. Marbury also assists with legal affairs at the GCP. Ms. Marbury received her J.D. from Tulane University Law School and completed her undergraduate work at Tufts University, where she double-majored in sociology and political science.

**Charles S. Modlin, Jr., M.D., FACS**, is the only African-American kidney transplant surgeon who is also a urologist in the United States. He is the founder and director of the Minority Men's Health Center at the Glickman Urological Institute of the Cleveland Clinic Foundation. In 1996, Dr. Modlin joined the staff of The Cleveland Clinic Foundation's Urological Institute, with a joint staff appointment within the Cleveland Clinic Transplant Center. He has authored scientific publications and presented scientific research at national meetings. Dr. Modlin has developed outstanding initiatives and made numerous contributions towards eliminating minority health care disparities. He is a leading force in Cleveland and leads the initiatives at the Cleveland Clinic toward elimination of health disparities. Dr. Modlin graduated from Northwestern University with a degree in chemistry and received his medical school education at Northwestern University Medical School in Chicago. He completed a six-year surgery-urology residency at New York University and a three-year fellowship in basic science transplant immunology, renal transplantation and clinical renovascular surgery at the Cleveland Clinic.

**Earl Pike** is the executive director of the AIDS Taskforce of Greater Cleveland (ATGC), Ohio's oldest and largest AIDS service, education, and advocacy organization. He began working in the AIDS field in 1985 when he established Minnesota's first statewide AIDS hotline, before becoming coordinator of education for special populations at the Minnesota AIDS Project. He served as the statewide AIDS Coordinator for the Minnesota Department of Human Services. Mr. Pike is the author of *We are All Living with AIDS* (Deaconess Press, 1993), on AIDS policy for workplaces and social service agencies. He has written many articles, monographs, educational video scripts, and training manuals. Mr. Pike helped found numerous AIDS initiatives, including an education program for incarcerated inmates, a program for the deaf and hard of hearing and a national AIDS prevention program for Native Americans. Before working in the area of AIDS, Mr. Pike was the director of a crisis intervention program in Minneapolis. He received his B.A. in organizational communications from the University of Minnesota and his M.A. in creative writing from Cleveland State University.

**Deborah Z. Read, J.D.**, is a partner and one of eight members of the firm-wide executive committee of Thompson Hine LLP. Thompson Hine lawyers serve as counselors, advisors and advocates to a full spectrum of clients ranging from major public and private corporations to financial institutions, governments, nonprofit organizations, venture capitalists and individual entrepreneurs. Ms. Read practices tax and health care law and functions as outside General Counsel to several large exempt organizations. She focuses her practice on tax and corporate planning for nonprofit organizations, foundations and health care organizations. Her health care practice focuses on advising hospitals, physician groups and health care providers on contractual relationships, corporate planning, acquisitions, and legal structures for affiliations, ventures and other business arrangements. Ms. Read is admitted to practice in the District of Columbia and Ohio. She received her J.D. from Boston University School of Law and her A.B. from Ohio University. She is a member of the American Bar Association, Tax Law Section; the American Health Lawyers Association; the District of Columbia Bar Association; and has served as a panel chair for the Cleveland Tax Institute.

**Sandra R. Schwartz** is the immediate past executive director of The National Conference for Community and Justice (NCCJ) Northern Ohio Region, a position she held for the past twenty years. Founded in 1927 as The National Conference of Christians and Jews, NCCJ is a human relations organization dedicated to fighting bias, bigotry and racism in America. NCCJ promotes understanding and respect among all races, religions and cultures through advocacy, conflict resolution and education. A recent focus of NCCJ's programmatic initiatives has been racial and ethnic disparities in health care which is aligned with the organization's mission of "fighting bias, bigotry and racism." NCCJ was the convener of a 2005 symposium to address this issue. Ms. Schwartz has a B.A. from The Ohio State University and a M.A. in Communication from Cleveland State University with a concentration in Health Care Communication.

**Ashwini Sehgal, M.D.**, is the Duncan Neuhauser Associate Professor of Community Health Improvement and director of the Center for Reducing Health Disparities at Case Western Reserve University in Cleveland, Ohio. He is also associate professor of medicine, biomedical ethics, and epidemiology and biostatistics at Case Western Reserve University. In addition, he is a practicing nephrologist at MetroHealth Medical Center. He was recently named the co-medical director of the Cleveland Department of Public Health. Dr. Sehgal's research has focused on quality improvement and health disparities. He has been the Principal Investigator of three community-based studies funded by the National Institutes of Health to identify and overcome barriers to effective care of renal patients. Dr. Sehgal received his Bachelor's degree in mathematics, *summa cum laude*, from the University of Rochester and his M.D. degree from Harvard Medical School. He then completed an internship and residency in internal medicine at Massachusetts General Hospital and a nephrology fellowship while participating in the Robert Wood Johnson Clinical Scholars Program at the University of California, San Francisco.

**E. Harry Walker, M.D.**, is the director of the MetroHealth Center for Community Health (CCH) where he administers nine medical outpatient clinics. Dr. Walker is also a staff physician for internal medicine at the MetroHealth Clement Center for Family Health in Cleveland. He is the former medical director of the Health Care Center for the Homeless in downtown Cleveland where he collaborated with social workers, medical students and nurses to administer and organized a health care system for homeless individuals. Dr. Walker is the former medical director of the MetroHealth Downtown Health Clinic and served as medical director of the MetroHealth Correction Center. He has been an assistant professor of medicine at Case Western Reserve University since 1985. Dr. Walker serves on the MetroHealth Center's Medical Executive Committee, MetroHealth Management Council, the Medical Operations Group, the Advanced Nurse Practitioners Steering Committee, and the Managed Care Education Committee. He is a recipient of the Henry D. Ziegler, M.D., Award for Community Health and has been honored by Cleveland Health Care for the Homeless. He received his Bachelor of Science in Chemistry from Williams College and an M.D. from the University of Cincinnati Medical School.

**George Weiner, Ph.D.**, is executive-in-residence at the Maxine Goodman Levin College of Urban Affairs at Cleveland State University and acting director of the University's Center for Health Equity. He also holds the William and Elizabeth Treuhaft Chair in Health Planning and Research at The Center for Community Solutions and an adjunct faculty position in epidemiology and biostatistics at the Case Western Reserve School of Medicine. At Cleveland State, Dr. Weiner is principal investigator for a three-year grant from the Center on Minority Health and Health Disparities at the National Institutes of Health. He previously served as vice president for policy analysis and research at the Center for Health Affairs and as the vice president of planning and institutional Research for The MetroHealth System. He has held faculty positions at the Maxwell School of Public Affairs at Syracuse University and the Nance College of Business Administration at Cleveland State. He received his undergraduate (mathematics) and graduate degrees (urban and regional planning) from Cornell University.

**Danny R. Williams, J.D., MNO**, is the senior vice president and general counsel of the Greater Cleveland Partnership (GCP), a recently formed business organization dedicated to economic development and job growth in Northeast Ohio. In this capacity, Mr. Williams also serves as the executive director of the Roundtable Community Council, a program of the GCP. Mr. Williams is responsible for GCP's education, workforce development and inclusion initiatives, and serves as the organization's in-house legal counsel. He previously served as the president and chief executive officer of the Greater Cleveland Roundtable, a Cleveland-based nonprofit organization focused on issues of social and economic equity. Before joining the Roundtable, he was general counsel and Cuyahoga metro executive for the Ohio Division of the American Cancer Society. Mr. Williams has also served as Cuyahoga County administrator, and as Cleveland Law Director in the administration of former Mayor Michael R. White, serving as the city's chief legal officer and chief prosecutor. Mr. Williams received his Master's of Nonprofit Organizations degree from Case Western Reserve University. He earned his law degree from the University of Michigan Law School and his Bachelor's degree in psychology from Princeton University.

**Carlumandarlo E. B. Zaramo, M.Sc., CLsp (MB), FGUI**, is a research scholar, genetics fellow and minority health educator at the Cleveland Clinic Foundation Minority Men's Health Center. Over the last eight years he has been conducting a summer educational collaborative professorship in Pathology and Microbiology for the Health Career and Opportunity Program at Cleveland State University. He has prepared exceptional education health literacy and culture "incompetence" initiatives towards the eradication of minority health care disparities. Prof. Zaramo has developed strategies to increase adequate preventive health methodologies throughout the nation's minority community. A native Clevelander, he completed his undergraduate training in biological sciences at Case Western Reserve University and a three-year Graduate Fellowship in biomedical engineering and clinical research.



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# NOTES

# NOTES

# NOTES

**SPECIAL  
THANKS**

**SAINT  
LUKE'S**  
FOUNDATION  
of cleveland, ohio

The vision of the Saint Luke's Foundation of Cleveland, Ohio is to achieve measurable, sustained improvements in health and well-being by targeting the root causes of problems.



THE MT. SINAI  
HEALTH CARE  
FOUNDATION

The Mt. Sinai Health Care Foundation seeks to assist Greater Cleveland's organizations and leaders to improve the health and well-being of the Jewish and general communities now and for generations to come.

