January 2005

Dear Community Partner,

The Educational Collaborative for the Elimination of Health Disparities in Mecklenburg County is pleased to share with you conference proceedings from our November 2004 **Health Summit**.

As promised, the report captures the detail and synergy of the general sessions and participant workshops. Attendees requested that the action plan be distributed quickly so it could be used for 2005 policy and program planning and development. We promised to deliver the information in a timely manner and we have kept that commitment.

This report documents the history of our efforts to confront and address health disparities gaps in Mecklenburg County. We have included:

- County health statistics
- What we have learned about our local health disparities problem
- Priorities identified by conference participants; and
- What we plan to do to address identified problems.

This is serious and important work that we have begun. Your participation is key to the success of this unique partnership between government, higher education and community-based organizations. You are invited to work with us as we continue to address Our Health – Our Priority – Our Policy.

Joining you in service,

Vernease Herron Miller, M.H.A., JD
Program Chair

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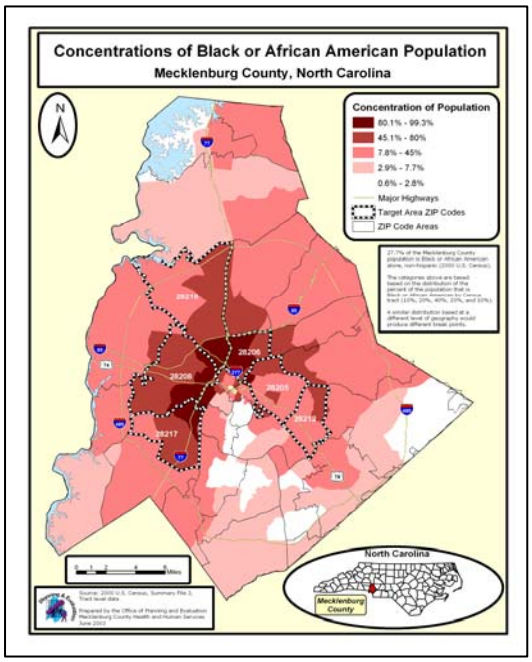
STATUS OF OUR HEALTH

HEALTH OUTCOME DATA AND DEMOGRAPHIC INFORMATION

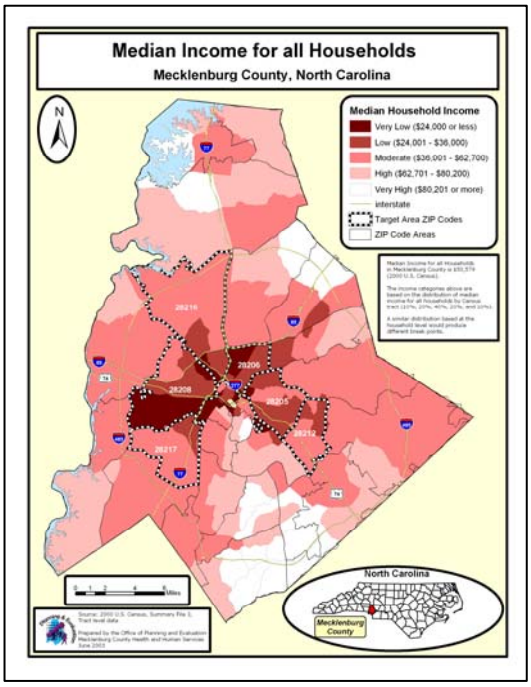
from the US Census to Explore Health Disparities and Socioeconomic Status in Mecklenburg County

While health disparities are readily demonstrated through data, the causes and means for prevention are not well understood. Research suggests issues of social inequality are involved and must be addressed before differences in health outcomes among racial and ethnic groups can be eliminated. Among topics being studied are differences in access to health care, the effects of racism and segregation, and socioeconomic status (SES).



Map 1

The Centers for Disease Control and Prevention notes SES is "central to eliminating health disparities because it is closely tied to health and longevity. At all income levels, people with higher SES have better health than those at the level below them." SES status includes income, education, occupation, and neighborhood and community characteristics.



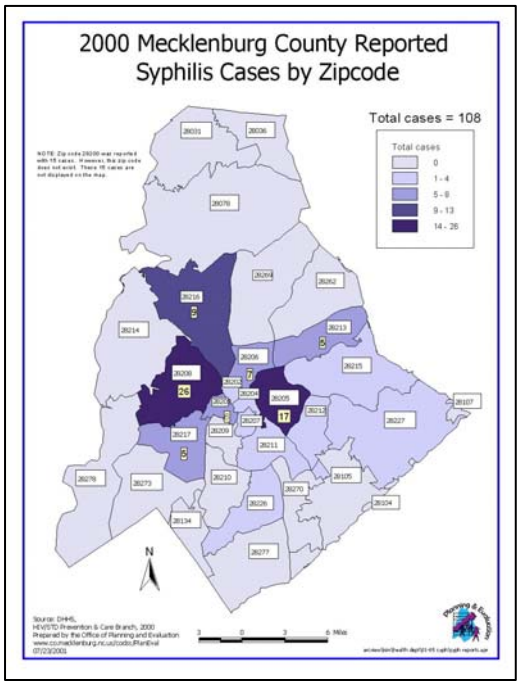
Map 2

Researchers have found that African American and Hispanic families, more frequently than white families, live in areas of concentrated poverty resulting in racial as well as economic segregation. Low-income neighborhoods may offer inadequate healthcare services, lower quality educational opportunities, fewer job opportunities, and higher crime rates when compared to more mixed-income or high-income communities, all factors which may contribute to continued poverty and the development of poor health comes.

A review of 2000 US Census data suggests such a pattern of racial and economic segregation in Mecklenburg County. African Americans representing 28% and Hispanics making up over 6% of the population are the two largest racial/ethnic minority groups in the County. While African Americans and Hispanics live throughout the community, mapping census tract data shows these two groups heavily concentrated in a crescent-shaped area stretching from southwest to east around the northern end of the city of Charlotte. African Americans more commonly reside on the west side (See Map 1) and Hispanics are more frequently found to the east. Mapping median household income for the county shows a concentration of lowest incomes in a similar crescent pattern. (See Map 2). Other indicators associated with low economic status such as receipt of Medicaid or food stamps also map in this same pattern.

Mapping health data shows this crescent shaped area of black/Hispanic and low-income resident concentration also experiences many poor health outcomes including high rates of sexually transmitted diseases and deaths from diabetes and HIV disease. (See Map 3.)

Six zipcodes (28217, 28208, 28216, 28206, 28205 28212) representing over 186,000 people (or almost ¼ of the county population) make up a large portion of the crescent area referred to above. An examination of demographic data from the 2000 US Census for these six zip codes shows, when compared to Mecklenburg County as a whole, a higher proportion of African American and Hispanic residents, a lower median household income, a lower percentage of college graduates, a lower percent of private transportation, and a higher proportion of families with limited English proficiency. (See Table 1.)



Map 3

TABLE 1. DEMOGRAPHICS

2000 Census	**Six Zipcodes**	**Mecklenburg County**
Race/Ethnicity		
% African American	53.1	27.5
% Hispanic	10.1	6.5
Age		
% Under 18 Years	25.8	24.9
% 65 Years and Over	9.0	8.5
Median Household Income	$26,553 - $40,740	$50,579
Education (pop >=25 yrs) % 4 yr degree or more	17.9	37.1
English % pop. none or not spoken very well in the home	10.5	6.7
Transportation % occupied Units w/ no vehicle available	14.1	6.9

When looking at health outcomes for this same area, hospitalization and mortality rates for heart disease, stroke, diabetes, and asthma are higher than those for the county. (See Table 2.)

Combining census information with health outcome data can provide a picture of SES related to health disparity in a community and suggest populations most in need of assistance. Further research is required to understand which SES factors or combinations of factors have the greatest impact on health and what type of interventions can result in improved health outcomes.

TABLE 2. HEALTH OUTCOMES

2001 Rates* (cases/100,000 population)	**Six Zipcodes**	**Mecklenburg County**
Diabetes		
Mortality	27.0	19.6
Hospitalization	21.7	13.6
Heart Disease		
Mortality	172.3	145.4
Hospitalization	114.5	101.3
Stroke		
Mortality	62.7	49.2
Hospitalization	33.0	26.6
Asthma		
Mortality	1.7	1.2
Hospitalization	7.5	5.4

* 2001 Cases per 2000 US Census Population

SOURCES

Chronic Disease Notes & Reports, CENTERS FOR DISEASE CONTROL AND PREVENTION. Volume 15 • Number 2 • Spring/Summer 2002
US Census 2000
NC DHHS, State Center for Health Statistics/Vital Records
Prepared by Mecklenburg County Health Department Epidemiology Program with maps from Mecklenburg County DSS

MECKLENBURG COUNTY RACIAL AND ETHNIC DIFFERENCES IN HEALTH

Despite significant improvement in the overall health of the nation, minority populations continue to experience a disproportionate burden of disability and death compared to the US population as a whole. Healthy People 2010 and Healthy Carolinians target the elimination of health disparities. Differences in mortality rates for leading causes of death among the white population and other populations of color in Mecklenburg County, NC are highlighted in this brief report.

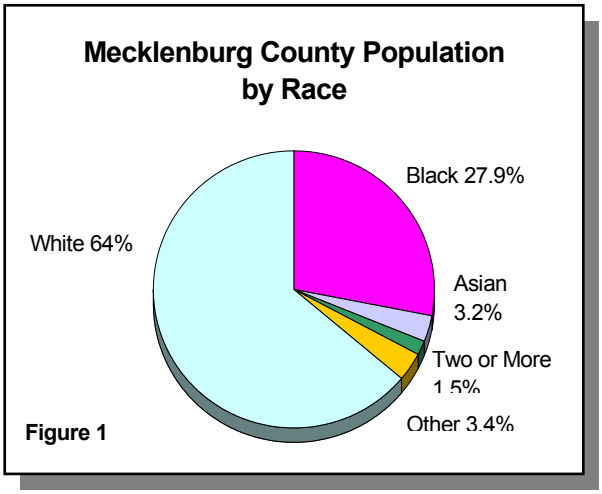


Figure 1

MECKLENBURG COUNTY RACIAL/ETHNIC POPULATION

The 2003 certified population estimate for Mecklenburg County, prepared by the State Demographer, reports 750,221 residents, 67% of whom are white and 33% of other races. No numbers for other races/ethnicity are provided. Per the 2000 US Census, people of other races are described as 77% African American and 23% other including Native Americans (American Indians, Eskimos & Aleuts); Hawaiian & Pacific Islanders; Asians; persons of two or more races; and persons who elect none of the other choices. Of the total population, African Americans represent 27.9%, Asians 3.2%, Two or More Races 1.5%, Native Americans and Hawaiians less than 1%, and Other (or none of the previously listed) over 3%. (Figure 1). The Hispanic/Latino community increased by 570% between 1990 and 2000 and continues to grow. People of Hispanic/Latino ethnicity may be from any race and per the 2000 census represent at least 6.5% of the total population. In 2003, almost 16% (2038) of 12,773 Mecklenburg births are to mothers of Hispanic/Latino ethnicity.

HEALTH OUTCOME DIFFERENCES

When comparing Mecklenburg to North Carolina and the United States, most health indicators for the total county appear favorable. Rates for many causes of death have been decreasing during the past decade in both white and other race populations. The overall mortality rate has been falling for both groups since 1994. However, this decrease in rates has not always been accompanied by an elimination of differences between white and other race rates.

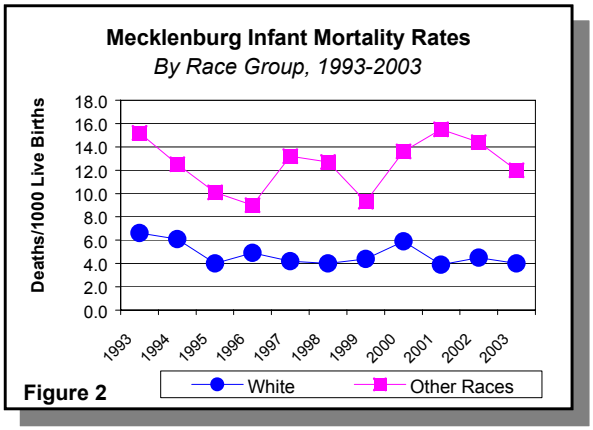


Figure 2

The overall death rate is higher for people of other races than whites in every age group. In 2002, the age-adjusted rate for All Causes of Death is 1.3 times greater for other races than whites. Despite a general downward trend since 1990 for both whites and minorities, the 2003 Infant Mortality rate is 3 times greater for other races than whites. (Figure 2).

LEADING CAUSES OF DEATH

Leading causes of death for Mecklenburg County white and other race populations in 2003 are presented in Table 1. Coronary health disease, cancer, and stroke are leading causes of death for both whites and other races, including African Americans, Asians, and Native Americans. However, minorities may die at higher rates and younger ages. Unlike other groups, Hispanics/Latinos in Mecklenburg County die at the highest rates from motor vehicle injury and homicide. This difference may be explained because rates for heart disease, cancer, and stroke increase with age, and the Hispanic/Latino population in Mecklenburg County is younger than the population as a whole.

Age-adjusted 2002 mortality rates show rates for other races exceed white rates:

- *1.3 times for heart disease*
- *1.2 times for all cancer*
- *1.3 times for breast cancer,*
- *1.3 times for colon cancer*
- *2.4 times for prostate cancer, and*
- *1.5 times for stroke.*

Other races also have higher rates of death from motor vehicle injury, HIV disease, diabetes, and homicide:

- *1.2 times for motor vehicle injury*
- *12.2 times for HIV disease*
- *3.0 times for diabetes, and*
- *3.9 times for homicide.*

Whites die at higher rates from chronic lower respiratory disease, Alzheimer's Disease, pneumonia & influenza, and suicide:

- *1.5 times for chronic lower respiratory disease*
- *1.4 times for Alzheimer's Disease*
- *1.2 times for pneumonia & influenza, and*
- *1.7 times for suicide.*

2003 LEADING CAUSES OF DEATH

White	Other Races
Cancer	Heart Disease
Heart Disease	Cancer
Stroke	Stroke
Alzheimer's Disease	HIV Disease
Chronic Lower Respiratory Disease	Diabetes
Unintentional Injury	Unintentional Injury

Table 1

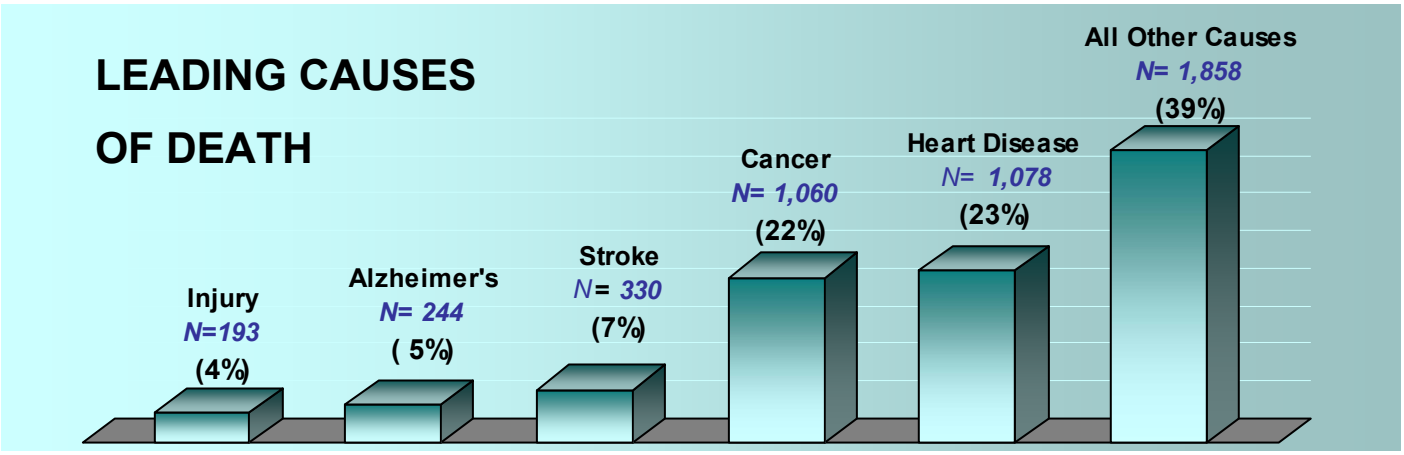
HEALTH RISK BEHAVIORS

The high other race mortality rate seen with HIV Disease stems from the disproportionate number of HIV disease cases experienced by the African American community. Of 437 cases of HIV Disease reported in 2003, 308 (70%) were black. African Americans also have higher rates of gonorrhea and syphilis.

Health behaviors contributing to the prevention of heart disease, some forms of cancer, stroke, and diabetes include not using tobacco products, maintaining a healthy weight, eating a diet rich in fruits and vegetables, and engaging in regular, moderate physical activity. Data from the 2001-2002 Mecklenburg Behavioral Risk Factor Surveillance Survey show a higher percent of whites than African Americans reporting smoking (1.2 times) and a greater percent of African Americans than whites reporting obesity (1.4 times), not eating five or more servings of fruits and vegetables a day (1.1 times), and not getting moderate physical activity (1.2 times).

DATA SOURCES/INFORMATION

Data are from NC DHHS State Center for Health Statistics and State Data Center. For more detailed information on health statistics, please contact the Mecklenburg County Health Department Epidemiology Program at (704) 336-2900.



4,763 deaths occurred in Mecklenburg during 2003

Ranked Cause of Death Mecklenburg and North Carolina 2003, United States, 2002

	Meck	NC	USA
Heart Disease	1	1	1
Cancer	2	2	2
Stroke	3	3	3
Alzheimer's Disease	4	7	8
Unintentional Injury	5	5	5
Chronic Bronchitis and Emphysema	6	4	4
Diabetes	7	6	6
Pneumonia and Flu	8	8	7
Kidney Disease	9	9	9
HIV Disease	10	*	*

* not in Top Ten for NC or USA

Mecklenburg ranks comparably with NC and the USA with the following exceptions: Mecklenburg ranks higher for Alzheimer's and lower for Chronic Respiratory Disease; for HIV disease Mecklenburg ranks higher than NC and the USA.

Leading Causes of Death by Age Group 2003 Mecklenburg County

Infants
* Congenital Defects
* Prematurity and Immaturity

Ages 1 -14
* Cancer
* Unintentional Injury
* Congenital Defects

Ages 15 - 24
* Unintentional Injury
* Homicide
* Suicide

Ages 25 - 44
* Unintentional Injury
* HIV Disease
* Heart Disease

Ages 45 - 64
* Cancer
* Heart Disease
* Stroke

Ages 65+
* Heart Disease
* Cancer
* Stroke

Homicide and motor vehicle crashes are the leading killers of adolescents and young adults, age 15 -24, in Mecklenburg.

Leading Causes of Death by Gender 2003 Mecklenburg County

Males
1) Heart Disease
2) Cancer
3) Stroke
4) Unintentional Injury
5) Chronic Respiratory Disease
6) Homicide

Females
1) Heart Disease
2) Cancer
3) Stroke
4) Alzheimer's Disease
5) Chronic Respiratory Disease
6) Unintentional Injury

Women tend to live longer than men. In 2003, more men died from stroke than unintentional injury. Women die from Alzheimer's at higher rates than men.

Leading Causes of Death by Race 2003 Mecklenburg County

White
1) Cancer
2) Heart Disease
3) Stroke
4) Alzheimer's Disease
5) Chronic Respiratory Disease
6) Unintentional Injury

Other Races
1) Heart Disease
2) Cancer
3) Stroke
4) HIV Disease
5) Diabetes
6) Unintentional Injury

While the three leading causes of death are similar among all racial groups, people of other races often die at higher rates and younger ages than whites.

SEXUALLY TRANSMITTED INFECTIONS

2001/ 2003 Statistics for Mecklenburg County Residents

HIV disease refers to all people infected with the human immunodeficiency virus, regardless of an AIDS defining condition. AIDS cases are a subset of HIV disease.

Syphilis is a sexually transmitted infection caused by a bacterium called *Treponema pallidum.* The course of the disease is divided into four stages – primary, secondary, latent, and tertiary (late). Early syphilis includes primary, secondary and latent stages of the disease.

Chlamydia is a curable sexually transmitted infection, which is caused by a bacterium called *Chlamydia trachomatis*. It can cause serious problems in men and women as well as in newborn babies of infected mothers.

Gonorrhea is a curable sexually transmitted infection caused by a bacterium called *Neisseria gonorrhoeae*. These bacteria can infect the genital tract, the mouth, and the rectum.

The following table includes demographic information for sexually transmitted infections in Mecklenburg County.

	HIV DISEASE				EARLY SYPHILIS				CHLAMYDIA				GONORRHEA			
	2001 (N=257)		2003 (N=437)		2001 (N= 99)		2003 (N=42)		2001 (N= 1999)		2003 (N=3171)		2001 (N=2096)		2003 (N=2279)	
Characteristics	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
Race																
White	42	16%	107	24%	7	7%	5	12%	248	12%	444	14%	162	8%	200	9%
Black	208	81%	308	70%	88	89%	31	74%	1541	77%	2374	75%	1871	89%	2030	89%
Native Am.	2	1%	1	0%	0	0%	0	0%	7	0%	2	0%	5	0%	0	0%
Asian	2	1%	4	1%	0	0%	0	0%	30	2%	37	1%	11	1%	8	0%
Hispanic	3	1%	17	4%	4	4%	6	14%	171	9%	313	10%	45	2%	41	2%
Other	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Missing	0	0%	0	0%	0	0%	0	0%	2	0%	1	0%	2	0%	0	0%
Age																
0 - 12	0	0%	0	0%	0	0%	0	0%	6	0%	10	0%	6	0%	5	0%
13-19	9	4%	19	4%	11	11%	3	7%	767	38%	1341	42%	591	28%	701	31%
20-29	51	20%	91	21%	28	28%	14	33%	989	49%	1471	46%	973	46%	1018	45%
30-39	105	41%	130	30%	40	40%	10	24%	193	10%	279	9%	357	17%	348	15%
40-49	65	25%	136	31%	13	13%	11	26%	32	2%	51	2%	136	6%	171	8%
50+	27	11%	61	14%	7	7%	4	10%	11	1%	19	1%	31	1%	36	2%
Missing	0	0%	0	0%	0	0%	0	0%	1	0%	0	0%	2	0%	0	0%
Gender																
Male	161	63%	290	66%	58	59%	30	71%	467	23%	575	18%	1231	59%	1212	53%
Female	96	37%	147	34%	41	41%	12	29%	1532	77%	2596	82%	865	41%	1067	47%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%

Source: NC DHHS, HIV/STD Prevention and Care
Prepared by Mecklenburg County Health Department/Epidemiology, 03/02

BEHAVIOR RISK FACTOR SURVEILLANCE SYSTEM

2001-2003 Health Outcomes for Mecklenburg County

The Behavioral Risk Factor Surveillance System (BRFSS) is a random telephone survey of state residents aged 18 and older in households with telephones. BRFSS was initially developed in the early 1980s by the Centers for Disease Control and Prevention (CDC) in collaboration with state health departments and is currently conducted in all 50 states, the District of Columbia, and three United States territories.

Through BRFSS, information is collected in a routine, standardized manner on a variety of health behaviors and preventive health practices related to the leading causes of death and disability such as cardiovascular disease, cancer, diabetes, and injuries.

Behavioral Risk Factor Surveillance System (BRFSS)
Mecklenburg County 2001-2003

	Total	White	African American	Disparity Ratio*
Health Care Access				
No Health Insurance-All Residents over 18 years	13.2%	8.1%	12.6%	1.6
No Health Insurance-All Residents between 18-65 years	14.8%	9.4%	13.0%	1.4
No Health Insurance-All Residents between 18-65 years and are employed for wages	12.1%	6.6%	6.8%	1.0
Behavioral Health Risks				
Smoking	19.7%	20.3%	19.0%	0.9
Overweight/Obesity	54.8%	49.1%	69.8%	1.4
Does not meet recommended physical activity	63.7%	58.8%	69.5%	1.2
Does not consume 5 or more servings of fruits & vegetables a c	75.4%	73.1%	78.2%	1.1
Chronic Conditions				
Diabetes	5.2%	4.6%	7.1%	1.5
High Blood Pressure	22.4%	21.5%	27.2%	1.3

Overweight/Obesity- Body Mass Index (BMI) greater than 25.0. (BMI is computed as weight in kilograms divided by height in meters squared:(kg/ m2).

Moderate Physical Activity - Respondents who report doing moderate physical activity for 30 or more minutes per day, five or more days per week or respondents who report doing vigorous physical activity for 20 or more minutes per day, three or more days per week.

The ***Total Percentage*** represents all races, not just White and African American.

Disparity Ratio: The disparity ratio compares African American measures to White measures. A ratio of 1.0 suggests no disparity.

ABOUT HEALTH DISPARITIES

OVERVIEW

The Educational Collaborative for the Elimination of Health Disparities held a community and family focused **Health Summit** – subtitled, *Many Hearts, One Mission* – to help community attendees gain a sense of knowledge and empowerment over diseases that disproportionately affect them – obesity, heart disease, diabetes, high blood pressure, high cholesterol and HIV/AIDS prevention.

Several hundred participants convened during the weekend on the campus of Johnson C. Smith University in Charlotte, NC to discuss health disparities that affect them, their families and communities. Key community leaders, college students, youth, legislators, policy makers, medical professionals, lay health advisors, business leaders, academics, and members of the faith community gathered for the purpose of articulating priorities, defining tasks and discussing the necessity of continued activities and full engagement in developing solutions to the challenges of health disparities.

SUMMIT OBJECTIVE

Racial and ethnic minority populations experience disparities in health outcomes and access to care despite the extraordinary progress made in improving health behaviors, health practices and improved technologies.

Reducing the prevalence of diseases and morbidity among uninsured and underserved populations, particularly among African-Americans and Latinos in the Charlotte-Mecklenburg County is a high priority for the Mecklenburg County Health Department. Increasing health care utilization for underserved populations and creating coordinated linkages and outreach efforts to the community are pivotal tasks in this undertaking.

A coordinated effort to address health care disparities in Charlotte-Mecklenburg began in January 2000 when the Director of the Mecklenburg County Health Department created the position of Community Health Administrator. The new Administrator, Cheryl Emanuel, took the lead in conducting a series of “Community Think-Tank Dialogues.” These dialogues brought together representatives from health groups, minority organizations, universities, community and faith-based organizations and the private sector.

On June 4, 2004, a leadership symposium initiated by the Mecklenburg County Health Department in cooperation with Johnson C. Smith University and Pfeiffer University was held to

address health disparity issues in Charlotte-Mecklenburg and the surrounding communities. From that symposium, we created the Educational Collaborative for the Elimination of Health Disparities in Mecklenburg County. At the time of the summit, active participants in this collaborative included:

- Mecklenburg County Health Department
- Johnson C. Smith University
- Pfeiffer University School of Adult Studies and Masters in Health Administration Program
- The University of North Carolina-Charlotte
- The Latin American Coalition
- The Metrolina Native American Association
- Charlotte REACH 2010 Coalition
- Pfizer, Inc.
- Project HealthShare, Inc.
- CMC Inter-Faith Care Links
- PeopleSouth Consulting
- Mecklenburg County Department of Social Services
- CHS Community Health Institute
- Fighting Back
- Lincoln Heights Community Association
- CN Jenkins Memorial Presbyterian Church
- Teen Health Connection
- NCDHHS/HIV/STD Prevention and Care Branch
- Volunteers in Medicine Institute
- Sickle Cell Regional Network

Unlike most initiatives, the *Educational Collaborative for the Elimination of Health Disparities in Mecklenburg County* is unique because it seeks to build a constituency base, so that all voices within Charlotte –Mecklenburg are heard. This "Collaborative" represents a comprehensive cohesive group that gives structure and voice to segments of the population, which have been viewed as a part of the problem, but not consulted when addressing the solution. The strength of this effort is the unprecedented commitment by the core partners, and the unselfish attitudes of the groups working for the greater good of all constituents in the establishment of an even broader base in Mecklenburg County.

Working from a platform, *Many Hearts, One Mission*, the Collaborative hosted the **Health Summit** to raise awareness, prioritize solutions, and forward an agenda for policy development that will lead to a reduction in health disparities.

The **Health Summit** was designed to help attendees gain a sense of empowerment to prevent diseases that disproportionately effect target communities –obesity, heart disease, diabetes, high blood pressure, high cholesterol, HIV/AIDS prevention. Participants were able to:

1. Evaluate information about health challenges
2. Discover ways to work with the health providers
3. Examine processes that address policy/infrastructure
4. Learn behavior strategies to improve self-care
5. Identify priorities for action planning.

PROCEEDINGS

Friday, October 8, 2004 President's Reception and Opening Plenary Session

Dr. Diane Bowles, Vice President for Grants and Contracts, Johnson C. Smith University, welcomed and introduced the presenters and keynote speaker. Dr. Bowles emphasized that the purpose of the Summit was to galvanize the attention, and creative energy of the whole community to create a healthier Mecklenburg County. Dr. J.T. Garrett opened the session with meditative message that touched each spirit. The assemblage was lead in a prayer chant from the Cherokee nation followed by a solo by Ms. Teresa Moore, Soprano.

Dr. Bowles returned to the podium to read a proclamation from the City of Charlotte and Mecklenburg County signed by the Honorable Mayor Patrick McCrorey and the Honorable Mr. Tom Cox, Chairman of the County Board of Commissioners. Dr. Bowles also acknowledged the corporate sponsors whose names were detailed on the back of the program.

Dr. Nathaniel Pollock, Jr., Executive Vice President, Johnson C. Smith University, brought welcoming remarks on behalf of Dr. Dorothy Cowser Yancy, President, Johnson C. Smith University. Dr. Pollock noted that the energy in the room was exciting. He noted that while Johnson C. Smith University is a storehouse of knowledge, everyone was encouraged to take away some knowledge with him or her that evening. He also welcomed Dr. Cristina Beato, keynote speaker and Dr. Charles Ambrose, President, Pfeiffer University, Charlotte, NC. Dr. Pollock concluded his welcome remarks by sharing with the assemblage the commitment of Johnson C. Smith University, not only to the scholarship of research, but to the application of that research to solving real problems in their community.

Mr. Dennis Joyner introduced Dr. Kweku Laast, Executive Director of the Priority Populations Health Institute in Raleigh, NC. Dr. Laast emphasized the importance of the conference as he shared his commitment to the concept of public-private partnership. Using allegory to emphasize the importance of public-private partnerships, Dr. Laast asked the audience, "What does a robber reply when asked why do you rob banks?" Collectively the audience responded, "Because that is where the money is." So then, Dr. Laast asked, "How can you impact public health by ignoring the private sector? Business is a major stakeholder. Public-private partnerships are a critical tool in driving solutions. It is clear that no one entity can address the health disparity challenges alone. Cooperation is unavoidable if success is the goal. For example, Dr. Laast shared that employers and health insurance companies, are on the front line of the health care struggle and make good partners in the challenge of addressing health disparities. They are interested in the need to reduce disparities and reduce their premium costs.

Everyone wins from public-private partnerships, Dr. Laast emphasized when three things occur:

1. Motives are right
2. Shared goals are clearly defined and authentic.
3. The partners share decision-making and management responsibilities.

Dr. Laast ended his presentation by encouraging everyone to take advantage of the networking opportunities that they would experience during the Summit.

Dr. Charles M. Ambrose, President, Pfeiffer University gave a response to Dr. Laast's challenge. He asked the audience to tap into the collective energy and rally to Dr. Laast's call for action, by focusing on the power and symbols that the organizers of the Summit chose. The audience response, he said, should be a pledge for heightened resolve to reduce health disparities. It is supposed to be community building from a platform of educational opportunities (where learning and teaching takes place for the next generations' involvement in the solution). The experience of community organizations coming together and working toward shared goals is very encouraging. Dr. Ambrose noted a recent enlightenment – the opposite of mission is maintenance. We can no longer maintain our current position. So, Many Hearts and One Mission is the opposite of maintenance. Dr. Ambrose emphasized that the mission of the community and the organizers of the Summit will work together to accomplish the public health goals. This Summit is one step, but the pledge of continued commitment is real. Earnest intentionality is not just words, but rather real service based action.

Dr. E. Winters Mabry, Interim Health Director, Mecklenburg County, introduced the keynote speaker, Dr. Cristina Beato. Her biographical sketch reveals a remarkable physician who has made major contributions to patients and families in her community. Dr. Beato and her family emigrated from Cuba and made their home in New Mexico. Dr. Beato attended medical school at the University of New Mexico. Her work in that area, and the organizations she worked with benefited from her knowledge. In her current position, she brings field experience. As Acting Assistant Secretary of Health, she serves as the principle adviser overseeing medical and scientific matters in public health. President Bush has nominated Dr. Beato as Assistant Secretary for Health, pending Senate approval. The audience gave her a warm welcome.

Dr. Christina Beato began by thanking the audience, Dr. Mabry, Cheryl Emanuel, Dr. Yancy, and all those involved in the planning of the Summit. She also brought greetings from President Bush and Secretary Thompson.

One of the reasons, Dr. Beato stated that she believes she does well in this position, is that when you're doing something you believe in, it is not a job. It is one of the reasons she loves medicine. She considers it a gift everyday to live in this country, and that it is a gift to be able to give back and serve its entire people.

As a physician, she realizes that not all people have the same outcomes in health, and not all of the people have the same access to health. The barriers are many. There are issues of disparity in culture and language. There are issues of disparities in gender and age. She continued that there are disparities all around us, but it is difficult when you have cohorts of the same age and gender, the differences seem to be racial and ethnic. You wonder why is that the greatest country on earth can't do better to improve the health status of its people. The challenge is big. Some common themes are lack of awareness, access, and compassion by those who are treating others. Stereotyping is also an issue. All of these factors are unacceptable.

What shall we do? How do we approach public health policy and address an issue that has been here for decades and seems to be getting worse? We have data that can track and prove that things aren't improving, as we would like them to. With all the resources we are given, and all the good will that exists, why are we falling behind in areas that are killing our people?

You have begun with a great theme. You started with "families", the core of everything. When we look at habits and talk about prevention it is incredible to note that the biggest issue we have

now is obesity. This year obesity will surpass the other causes of preventable death in this country. Why did it happen? Perhaps it has to do with "too much of a good life."

You see the human body? I believe that God made an incredibly wondrous thing with the human body. The millions of years that we've been around, we have been programmed to be very efficient. Your system is designed to use the calories we put in efficiently, but if we don't expend the calories, they stay with us and we start getting bigger and bigger. Look at our children. Data shows that we may not have used all our resources wisely. About 15% of our children are overweight or obese. About 7% of them are diagnosed with Type 2 Diabetes. There are many reasons, including eating poorly and portions that are too large in size. Many moms tell me they don't have time to cook, but there are ways. The pressure cooker is my best friend! My children, who are 14 and 16 years of age, know that they can go to the freezer and put dinner I have prepared in the microwave. I want to help men and women know – you can do this.

We are talking about families. I surprised to know that in our African American families, over 54% between the ages of 25 and 34 have never been married. Kids that come from families that don't have two parents in the home have more chances to live in poverty, not go to school, to be exposed to abuse. Families are important. Dr. Beato stated that the elimination of domestic violence is a personal passion. She encouraged everyone to support the efforts to Stop Domestic Violence. Continuing, Dr. Beato shared that children are her passion. Her motivation is her children, and the families of children. She pays attention to information that empowers her to be a better mother. It is also important to empower men in marriages. Good healthy homes are the best environment for children. Men today die younger than women and are unhealthier than women. They die more of heart disease, cancer, and diabetes. Married men tend to live longer. Married men have less depression, and commit less suicide. We want to be married, in healthy, loving relationships. We don't accept men who abuse their wives. So when we talk about healthy families, it has to begin in the home.

Community and churches can further support families. Dr. Beato noted that it was admirable that the universities are brining community leaders together with government for a common solution, the health of your community. If you don't have health, you have nothing.

What is happening in our communities with adolescents, particularly adolescents of color? Sometimes, in spite of good guidance, kids get in trouble. They may start smoking or abusing alcohol or become sexually active. Sometime in that premature sexually activity, they might become pregnant and the cycle then starts with a lot of pain for that youth who now has to accept adult responsibilities for raising a child. Also, sexually transmitted diseases occur, which have severe consequences in women. The most threatening of them all is HIV/AIDS. Make no

mistake about it; there are about a million individuals in this country with HIV/AIDS. About a third of them don't know they are infected. Communities of color are affected the most by HIV/AIDS. Why are our rates are so disproportionately high? This is a problem that affects African American women and it is affecting the babies that they bring into the world. More than 90% of infants that are affected by HIV/AIDS are born to women of color. Last year, over 350 infants in this country were born HIV positive. I could continue to recite the problems, but I also want to share some solutions.

The CDC, for the first time, is actually keeping track in 48 states, I believe, of HIV/AIDS. The money must follow the disease. We know now that the face of HIV/AIDS has changed. It is now the face of women and children and older Americans. But the money is not following this information – it is still following HIV/AIDS as a "gay man's disease." So it is important to have numbers that show where the incidents of HIV/AIDS occur and we are doing that. The picture is scary. But we must work with our communities to resolve this issue. No program from the Federal government works without community involvement. HIV/AIDS is currently ranked as the fifth killer of African Americans, ages 15 – 34. Since the year 2001, over $7.1 billion has been directed to assist those with HIV in our country. There are over 530,000 people in our nation who have HIV. Almost 3/4s of them are in communities of color.

Prevention is still going to be the key. Once you have HIV, quality of life diminishes. When youth are so affected, public health policy must be proactive. The Bush Administration sends this message of prevention, which came from the country of Uganda. It is the ABC approach. I believe we can learn from other countries in the world, and then tailor it to our communities. Every community must develop solutions that work for it. There must be a common goal to improve something. The ABC strategy is very simple:

a) Abstinence for youth and young adults. Our children are becoming sexually active prematurely.
b) Be faithful and monogamous. People should be honest. If it is hard to be faithful and committed, then one should use condoms.
c) Use a condom every time you have sexual intercourse.

Diabetes also disproportionately affects communities of color, specifically African American communities, both in incidence and outcomes. For some reason, the treatment of the disease is not the same in African American communities as it is in other communities. I have heard many theories, but we have things that we know work.

There is a Diabetes Collaborative. Approximately 380 clinics are involved. There were no disparities in outcomes when participants in the collaborative used the guidelines. The disparities

disappear. Dr. Beato noted that these successful standards should be national news. Unfortunately it seems that prevention is not news. She shared that a NIH study shows that if overweight people lose 5 to 10% of their body weight, and walk daily, the incidence of becoming diabetic drops 60%, everything else being equal. That should be front-page news!

Policy changes are occurring. The department (DHHS) was able to get Medicare to pay for the flu vaccine for the elderly. Most of the 36,000 people that die on average every flu season are elderly. They die because they have heart disease, diabetes, and immune disease. The flu vaccine is inexpensive. The majority of Medicare dollars for individuals are spent during the last 30 days of life. Medicare spent over $860 billion last year. The total bill for healthcare in this country was $1.7 trillion. If we put prevention on the front end, we may be able to save lives. So we have been pushing for the flu vaccine for the elderly.

The Medicare Modernization Act created important policy changes. We were operating Medicare as in the 1960s. Medicare did not pay for any prevention. It would not pay for the medicines that prevent the elderly from having ulcer disease or cardiovascular bypass surgery. That has changed. If we don't start inserting prevention as a part of Federal policy, then prevention is not going to be a word that most people really appreciate.

Cancer in our nation is being addressed. We have more people than ever before living with cancers that were once considered terminal. The death burden has decreased, but the incidence of cancer has not. There are disparities in African American women with cancers like cervical, colon cancer. It isn't because of genetics. What is different is that preventive screenings are not happening in that population. The mammograms, PAPs and lipid checks are not happening like they are in other communities. The CDC has a wonderful program, the Breast and Cervical Early Treatment Program for women who are not insured or are underinsured, but do you know how many women still do not seek care. We need to reach out. We asked for $10 million to serve more women and we were able to serve 3.5 million women.

Dr. Beato urged men over the age of 50 to get regular prostrate screenings. Two percent of breast cancers happen in men. Colon cancer, detected early can be treated. Leukemia in children is no longer terminal. Over 85% of children diagnoses with leukemia will live. But we must get people thinking about prevention and provide access to quality healthcare.

Finally, heart disease and stroke is still the number one killer. These diseases are prevalent in the "stroke belt," certain eastern states. North Carolina is one of them. The diseases are strongly related to hypertension, smoking, and obesity. I am proud that NIH and NHLBI launched the Heart Beat campaign for women. This campaign and others like it encourage women to know

their measurements with the Red Dress campaign. A large number of women have shared that they did not know that heart disease was also the number one killer of women. From a public policy perspective, how can your population not know that heart disease is the number one killer of men and women? These facts have been known for years.

In summary, Dr. Beato stated that she began by emphasizing the importance of strong family. If you don't have the benefit of a two-parent married family, there are many gifts and talents in every family. Let there no violence in the home. Let's start with that. And let's start with common sense things like nutrition, and teaching our children about screening exams. We should not take better care of our cars than our bodies. Let's work together to eliminate disparities between men and women, young and old and all racial groups. I would like to thank you again for inviting me and I encourage you with your partnerships. Education is indeed the great equalizer. "God Bless You and God Bless Our Country."

The audience thanked Dr. Beato with a round of applause. Dr. Bowles returned to the podium and expressed the planning committee's appreciation for Dr. Beato's presence. Dr. Bowles stated that we know the challenge is enormous and we are assembled out of necessary. The capacity to heal our people is in our own hand and now the work begins.

Dr. Bowles introduced Dr. Vernease Miller, who provided an overview for the next day's activities. She also thanked Dr. Pollard on behalf of Dr. Yancey, and Dr. Beato and her chief of staff, Josephine Robinson, for coming.

Dr. Miller thanked the dignitaries that were present and especially noted the presence of Miss Johnson C. Smith University, Shandra Crawford.

Dr. Miller acknowledged that we have heard the statistics and the problem stated. She encouraged everyone to return on Saturday. She assured the attendees that this would not be a top down process, but rather on that elicits the input of the people who are affected. She then introduced the workshop facilitators and gave a brief overview of what they would cover.

Finally Dr. Miller thanked a very special person. She shared the thought that this type of collaborative does not happen by accident. It begins in the heart with intention. We are fortunate in the Charlotte-Mecklenburg to have a Community Health Administrator who has the community's health foremost in mind. Cheryl Emanuel is one of a kind – an excellent professional and dedicated public servant.

The audience stood as Ms. Emanuel joined Dr. Miller. On behalf of the planning committee, Dr. Miller presented an Achievement Award to Ms. Emanuel for outstanding community service. Ms. Emanuel received a round of applause from the audience and gave brief remarks. She noted that everyone in the audience can make a difference. Before a problem can be addressed, it must be deemed worthy of confronting. Then you have to have people who believe in you and know how to use the gifts God has given you. She admitted to having the gift of being able to work with those others can't for the greater good of all. Ms. Emanuel then acknowledged key members of the Collaborative planning team.

Chaplain Harry Burns was asked to deliver the Benediction. Chaplain Burns asked spiritual leaders from the many cultures to join him on stage to pray for the same purpose. Each person called came and prayed for peace and the success of the conference.

Saturday, October 9, 2004 – Morning Plenary Session, Dr. Ruth Greene presiding

Dr. Ruth Greene, professor, Psychology Department, Johnson C. Smith University opened the session at 8:30 a.m. She reviewed the objectives of day, and invited attendees to treat Johnson C. Smith University as their community home.

Dr. Ruth Greene reminded the participants that they would receive a certificate of attendance if they stayed the entire day. She also encouraged the attendees to complete the Evaluation form. Dr. Greene described the action planning sessions that would occur at the end of the day and then introduced Melvin Pinn, MD, MPH, Senior Medical Director, Virginia Premier Health Plan, and a graduate of Johnson C. Smith University.

Dr. Pinn used a slide presentation. He noted that we have fragments of a healthcare system in our country and that while universal healthcare is important, it does not necessarily translate into equal care. That complexity, and the fragmented way healthcare is delivered in the country was the basis behind Dr. Pinn's challenge to the assemblage: Today, we decide what we can do.

Dr. Pinn introduced his topic, Links in the Chain - Empowerment Strategies for Community Action by compelling everyone to decide what he/she will do, individually, to make a difference in impacting the $1.7 trillion that is spent on healthcare in this country. His role, as keynote speaker, would be to outline the workshop topics and provide a framework for more detailed discussions later in the afternoon workshop session. Dr. Pinn shared that he would present information about the impact of heart disease, diabetes, and obesity and HIV/AIDS on individual health.

Dr. Pinn shared a quote by W.E.B. Dubois that suggests the necessity to address issues of disparities in minority population groups. 100 year later, African Americans are still dying of diseases at a great rate than the majority population. Dr. Pinn then asked all the American Indians in the audience to stand. He thanked them for attending, and shared that he did not know enough about Indian medicine, but that he did know that progress was being made in that area. Dr. Pinn stated that many health solutions are transferable across populations.

Dr. Pinn's highlighted the disproportionate weighting of minorities and disease. HIV/AIDS, diabetes and heart disease disproportionately affect African Americans. He led with this data, and these thoughts, because the institution of medicine, he believes, has been unduly charged with the solution for many healthcare issues. As of 2003, chronic conditions are the leading cause of illness, disability and death in the United States. He stated he was involved in the study of health plans while in the Charlotte-Mecklenburg community, and is been a proponent of universal health care. Countries that have universal healthcare systems spend less money and have less disease and death than we do currently. There is something good about universal healthcare. Communities and individuals could have one of the biggest impacts of bringing solutions to this crisis in healthcare. Mobilizing community action, Dr. Pinn suggested during the remainder of his keynote presentation, begins with trust.

So, Dr. Pinn asked next, "Do relationships matter?" He shared that he went to a conference on building trust and asked did you know that Dr. David Shore (slide's author) as subpoenaed by a Federal Judge to be an expert on trust. One of the most important comments that emerged from a survey conducted by Dr. Shore was this statement: "If you don't trust your doctor, you ain't gonna get well." In community, we need ways to build relationships; trust between doctor and patient. Another survey showed that while people were unlikely to trust a car salesman or politician, they trusted managed care the least. Building good relationships and trust begins with certain actions:

1. Understanding and appreciating cultural competencies.
2. Interpersonal treatment and trust.
3. Personal connections with your doctor.
4. Continuity of care is very important and difficult to obtain. It is now difficult to develop "cradle to grave" relationships.
5. Shared decision-making. Involve the community in the decisions that affect them. Listen to the needs that they identify.
6. Outcomes. We believe that we can measure things. If you have a good patient/physician relationship, the outcomes will be measurable.

The next slide was a cartoon, of an overweight male with a barcode on his back. The caption read that "I think healthcare has become too impersonal, doctor." The doctor replies, "just relax and lie back on the barcode scanner." It is humorous, but we're not far from it Dr. PInn suggested.

Spending on healthcare increased from $1.4 trillion to $1.7 trillion this year. Something is not right. Over twenty percent of the people in this country use some form of Medicaid. Almost 20% of the population receives Medicaid. Most of the expenses are spent in the last thirty days of life! I know that healthcare is in a crisis. Managed care is in a crisis.

But there is an opportunity. When all your money (for healthcare) is spent on the last thirty days of your life, there is an opportunity. In order to solve the crisis you have to first know you're in danger. So, know you are in danger because the AIDS rate is increasing. Know you are in danger because so many people have Diabetes. Know you're in danger because when you go to the shopping centers you see people in wheel chairs as a result of an amputation (diabetes). Know you're in danger because the infant mortality rate remains 2 times higher than the majority population.

But you have an opportunity to change all of these statistics. I challenge you, Dr. Pinn said, to recognize that there is a crisis and that there we are in danger. I further challenge you to make a commitment to change, this weekend.
The next slide showed the location of all the REACH 2010 projects across the United States. But in North Carolina, Dr. Pinn said, we have two REACH 2010 projects, one central coordinating unit is Carolinas Healthcare System and one is the Eastern Band of Cherokee Indians. I'm proud of the state of North Carolina.

Dr. Pinn returned to the issue of trust. The major thought I want to leave you with is: "If you don't trust your doctor, you ain't gonna get well." Who you really know, you trust. 70% of people surveyed said that they did not know who to trust. So I'm challenging you to make sure that you do things to gain the trust of the people you touch. They should trust you the way we trust Cheryl Emanuel. If Cheryl said it, it is true. We trust it.

Make sure when you are serving the community that they get to know you. One way of measuring the success of your trust-building efforts is the number of referrals. Factors that lead to referrals are interpersonal treatment, knowledge of the patient, patient trust and communication. Dr. Pinn personalized his last remarks further.

I'm a family doctor and we're having a tough time. There are serious health policy issues. At least 48 million people lack health insurance. At least 20% of population lack access to health care. But, he said, Mecklenburg County is experiencing success in the process of community action planning. You have identified the participants in the action planning process. You have identified the leaders and the future leaders (pointing to the children in the audience). You have identified the people at increased risk in the community. You have identified community solutions and perhaps resources. Still, the challenge is to change behavior. While we can build a Food Lion grocery store in the neighborhood and provide exercise at the local YMCA, we still have to help people understand how their behavior impacts their health. Changing the behaviors of people is your hardest challenge. I didn't do a study, but I'll tell you, I told a group of my patients that if they did not quit smoking they were going to die the next day. They quit. Remember that when you're trying to change behavior. This tactic could work with the obesity challenge as well – "what you eat can kill you." The consequence must be compelling enough to influence an individual's motivation to make immediate changes in their behavior.

In conclusion Dr. Pinn told the audience that they have done many things right. I hope, he said, that I have emphasized that you have done it. You have made improvements by providing access to a grocery store and exercise facilities. It is obvious that collaboration exists among many entities. So going forward, remember these four things:

1. Measure what you do.
2. Quality healthcare can be culturally challenging so we must be culturally competent.
3. Managed healthcare was touted as the solution, but we have not gotten there yet; and
4. "If you don't trust your doctor, you ain't gonna get well."

Introduction of Edgardo Valeriano, MD MPH, Diabetes Prevention and Control Program, Raleigh, North Carolina

Dr. Greene returned to the podium and introduced Mr. Ken Westerly, Vice President for Institutional Development at Johnson C. Smith University, who introduced Dr. Edgardo Valeriano.

Dr. Valeriano began by emphasizing that while there might be differences in people, we were gathered here now with Many Hearts and One Mission. He reminded the audience that change was already occurring and that they were part of the solution. We need to reflect in order to make changes. What do we need to change at the personal level, at the family level? What do we need to change at the community level and at the state and national level? There are many important issues as we define our health, and the health of our children. We understand that it's important that everyone comes to participate in this discussion and that no one is left out. Good health care is a human right. So we must not only take care of ourselves, but our communities.

Dr. Valeriano pointed out that we make choices everyday about exercise. We can choose to walk instead of driving, for example. When, as Dr. Beato pointed out, that 75% of the costs in the healthcare systems are applied in the last 30 days of patients' life, we should be more conscious of our daily life choices. Prevention is one of the most important elements of change. We have to decide how we will build a healthy community. A healthy community has greenways, bike paths and jogging trials. A healthy community incorporates healthy behaviors in daily living.

Children experience higher rates of obesity. About twenty years ago, we didn't have to do much to help children exercise. Further, 80% of the people with Diabetes, particularly type 2 Diabetes, are obese. 61% of the general population is obese. Something has happened, and we need to understand what that is. We are seeing more diagnosis of Type 2 Diabetes in children. So individually, we have to make decisions about what we will do to be healthy, so that we can help children to be healthy, and build healthy families and communities. Can we continue to pay for the high costs of healthcare? Why don't we invest in preventative health instead?

For example, prevention can include more workplace exercise sites. People are capable of making healthy choices, but only when the environment around them allows them to do so. When we think about healthcare disparities, we know minorities have more diabetes, heart disease, and morbidity. But behind that, there is something that we don't talk about. It is the level of income. Income affects access to healthcare. Education can also affect individual choices about healthy behaviors. There are gaps in income and education distribution even among minority groups. In comparing like populations and environments, we find a high prevalence of Type 2 Diabetes in low-income populations. This may be an area to focus some programs and action planning.

The next slide used showed leading causes of death in the Hispanic and Latino populations. Heart and Lung disease were the primary causes of death. Listed next were Stroke, Diabetes, Alzheimer, Non-intentional injuries, Pneumonia , Car accidents and Kidney disease. Many of the co-morbidities can be traced to Diabetes. In North Carolina, causal reasons for the prevalence of these diseases were (1) Lack of activity; (2) Not enough Fruits and Vegetables; and (3) Overweight and Obesity.

Obesity has almost doubled since 1990. Over 50% of the Hispanic population in North Carolina is overweight/obese. The next slide emphasized the importance of weight in relationship to Diabetes. The propensity for acquiring Diabetes increased with the addition of weight and obesity. The good news is that the loss of 5 – 7 pounds has a positive effect. Dr. Valeriano emphasized that early intervention for children reduces the prevalence of childhood diabetes.

Adding more fish and vegetables is a good behavioral change that also reduces propensities for Diabetes, Hypertensions, and High Cholesterol.

Dr. Valeriano discussed other statistics that showed the impact of Diabetes on the cost of health care. Data shows a 375% increase in hospitalization of people with Diabetes, occurring from 1992 to 2002 in North Carolina. We must begin to emphasize the need for healthy eating in the community. We must get access to better food in the community. An active community with active children should be encouraged to avoid the alarming consequences of diseases, particularly Type 2 Diabetes.

This ended the morning plenary session. Participants then left to participate in one of three action planning workshops:

Track A – Stop Before You Break my Heart focused on obesity, heart disease, diabetes, high blood pressure, high cholesterol, and wellness strategies.
Track B – Free Your Mind focused on lifestyle choices, HIV/AIDS prevention, and wellness strategies.
Track C - Success By Choice was the workshop designed to address the health and wellness issues confronting youth.

Saturday, October 9, 2004 – Luncheon Session

Conference attendees returned from the workshops, invigorated by their discussions. Dr. Diane Bowles asked Mr. Robert McCullough to offer inspirational thoughts and a prayer. At the conclusion of the meditation period, Dr. Bowles introduced Tina Hunt who introduced Dr. J. T. Garrett, Eastern Band of Cherokee Indians, and Health Director of Carteret County. The audience greeted Dr. Garrett with warm applause.

Dr. Garrett began his presentation with an Indian prayer chant. He acknowledged the youth in the room and said he looked forward to speaking with them later.

Dr. Garrett discussed the prevalence of Diabetes among the American Indian community. Among American Indians, Diabetes is three times greater than among other races. Genetics affects people in differing ways. Because of our genetics, we have propensities for certain diseases. It is important therefore that populations that experience health disparities begin to better understand and communicate within the framework of genetic propensities. He encouraged the young people to be aware of their family history and to understand genetic propensity.

As a reminder, he shared some of the Healthy People – 2010 goals. There are two overriding goals and we want to be sure that our public policy efforts are aligned. A primary goal of Healthy People 2010 is to "increase the quality and years of healthy life". The second goal of the program is to "eliminate health disparities". Dr. Garrett said it is everyone's obligation to be vigilant in holding the national policy makers accountable to ensure achievement of these goals. The speakers we have invited to this summit is one way of staying in front of the issues.

Cardiovascular disease is a leading cause of death in minority populations. Racial and ethnic minorities are disproportionately represented in the disease and morbidity categories. Dr. Garrett reminded the audience that he sees these disparities daily as a Health Director. Mental health is a tremendous problem, especially among our elders and youth. It does not get the recognition it deserves. We have conditions, Dr. Garrett said, that other parts of the population rarely have to think about. We have people still fighting the conditions of malaria from earlier years. Tuberculosis is prevalent as well.

But here is the good news. It does not have to be this way. We can do something about this.

I talked to the Elder and I said what am I going to say. I talk to people all the time. The Elder said, wait a minute, where are you? I said, I am here. He said, okay, you are here. Yeah, I said, but I talk to young people all the time, about the choices they have to make, and the pressures they have to endure. The Elder said, wait a minute, where are you? I said, well, I am here. I'm going on and on and the elder interrupted and said, where are you? I said, I am here. The Elder said, that is all that matters. I said, what I am supposed to do? The Elder said, you are here and that is all that matters.

Looking at the audience, Dr. Garrett said, **you are here, and that is all that matter**s. Each one of you is here, because you care. It is in your heart. Its in your spirit. You think it. Whatever you think is going to be. So the Elder said, **focus your thinking on what you want to do**. Reciting a chant in Cherokee, he said, **a little bit of this, and a little bit of that, and you will be on track**.

Dr. Garrett then picked up his rattle, and while creating a rhythmic sound he asked the young people to help him with the spirit of the chant. He asked the young people to say, **"a little bit of this, and a little bit of that, and you will be on track"**. He asked the adults to understand, that we can't do anything about tomorrow without **a little bit of this, and a little bit of that, and you will be on track**.

Now, he asked, what are we going to do about the problems of cardiovascular disease, diabetes, and getting funding that we need to do something about these things?

Youth: **A little bit of this, and a little bit of that, and you will be on track**.

Now here we have a Summit to bring to the public eye, the issues of disease and its disproportionate impact on our populations. What are we going to do about that?

Youth: **A little bit of this, and a little bit of that, and you will be on track**

The attendees applauded with approval. Dr. Garrett thanked his youth participants for their assistance.

Dr. Garrett ended with another chant and asked that the Collaborative leadership remember that one step at a time will lead to progress.

THE RESPONSE

COMMUNITY ACTION PLANNING SESSIONS

The primary purpose of the **Health Summit** was to engage the citizens of the community, particularly those from high morbidity areas in the process of communicating their priorities for health initiatives and related public policy.
Through the integration of authentic deliberation and the application of a process known as storyboarding, everyone had a chance to provide input, and to see the story of their choices and priorities unfold. Each person received the community action planning process summary, Why We Are Here, post-it-notes and voting stickers to facilitate the prioritization process.

Citizens were engaged in the process from the start. Three tracks were offered, and individuals were able to elect the track of their choices.

Track A – Stop Before You Break my Heart focused on obesity, heart disease, diabetes, high blood pressure, high cholesterol, and wellness strategies.

Track B – Free Your Mind focused on lifestyle choices, HIV/AIDS prevention, and wellness strategies.

Track C - Success By Choice was the workshop designed to address the health and wellness issues confronting youth.

In addition to the presentations of the day, conference participants were provided with published statistical data, such as *Healthy Mecklenburg, A Profile of Health Indicators and Prevention Priorities for Our Community,* produced by the Mecklenburg Healthy Carolinians program, and *Mecklenburg County Racial and Ethnic Differences in Heath* statistics.

Citizens were asked to center their discussion on the following topics:

1. *Access to Healthcare*
2. *Economic Resources*
3. *Quality of Services Sensitive to My Needs, Culture, Language*
4. *Education, Knowledge, Programs*
5. *Transportation*
6. *Neighborhood Resources, Parks, Sidewalks, Lights, Safety*
7. *Good Habits, Good Choices, Wellness Behaviors*

The process led to the development of three to four priorities per track. The following pages are the verbatim reports from each track.

TRACK A: STOP BEFORE YOU BREAK MY HEART

Priority #1	*Tasks To Be Done*	*Who/Dialogue*
Universal Healthcare – Regardless of income	• Identify currently available healthcare programs that are income sensitive. Communicate criteria to community regarding eligibility, how to access.	• Delivery system, agencies, providers-public and private
	• Make universal healthcare a political agenda item with National, Regional and Local Policymakers • Augment current data collection methodologies to allow individuals to self-select and specify their ethnicity and culture in order to develop accurate statistical linkages with genetic/family history and disease propensities • Collect data to analyze potential viability and timeline for "Pay for Prevention" coverage • Examine collection of data and information available regarding existing universal healthcare programs; including sliding scale and criteria/threshold based programs like Medicaid, Medicare • Begin "Good Faith" process for Pay for Prevention" process with Nutritional Guidelines that Physicians can share with patients	• Right Messenger, i.e., Clout, Viability • Work with allies to develop mutually effective policies • Specifically, work with Speaker of the House and legislature to link funding to agencies and programs that address implications of disease-relationship (disparities) to ethnicity and culture, such as propensities for Diabetes in African American and American Indian populations • Specifically recruit assistance of NC Commission of Indian Affairs

Priority #2	*Task to be Done*	*Who/Dialogue*
Higher Level of Sensitivity to Patients' cultures, ethnicity and the implications of genetics/family history for care at onset of relationship with Physicians, Care providers	• Legacy of mistrust between patient and physician. Trust has eroded between Physicians' offices and patients; patients' experiences with front line people reinforce concerns about sensitivity regarding patients' cultures. Believe an orientation program for new employees and/or front line people at provider sites, with built-in feedback/evaluation processes from patients, should be implemented using available tools.	• Physicians Reach Out
	• Patient satisfaction surveys conducted. Feedback documented and communicated to patient community/provider community to encourage improvement.	• Create Provider Rating System Communicate annual "Report Card"
	• Establish guidelines for practitioners. Begin by working with JACHO and other evaluators to develop guidelines for physician/provider offices that can used as "turn key" training resources.	• Policy Makers, Healthcare System Leadership
	• Work with Medical Associations and others to develop patient - culture -sensitivity curriculum for educational institutions.	

	• Guidelines to include cultural nuances
	  ○ Older African Americans very private- even with doctors
	  ○ People, especially older, learn to tolerate pain/discomfort due distinction between what is "normal" pain for age vs. their experience "fuzzy"
	  ○ Create literature that presents "barometers" which explain "what to expect" as natural part of aging.
	• More consumer education/checklists that empower patients to ask right questions/trust/share
		• Public/private partnership, i.e., agencies like County Health and professional medical associations, educational institutions, Educational Collaborative

	• Communicate, broadcast healthcare agency information websites to consumers ○ Make listings of resources available at physicians/provider offices in pamphlets, brochures	• MedLink, Mecklenburg County Health Department; Medical Societies collaborate to create list of resources

Priority #3	*Task to be Done*	*Who/Dialogue*
What Programs are out there? *(obesity, diabetes, high cholesterol)* **How do we access them?**	▪ Prioritize Child Healthcare Programs ▪ Include Behavior Change, Mental Health Support Programs ▪ More health screenings – ○ Access/leverage faith based organizations □ Sites may exist in high morbidity areas □ Outreach for population with service needs □ Accountabilities established and executed from beginning to end by all parties □ Support efforts at delivery level to encourage participation □ Joint marketing efforts □ Evaluate participation in screenings	• Policy Makers • Provider Community and Faith-based Community leadership • Reach 2010 Lay Health Advisors • Trained community advocates/outreach workers • Providers must contact right party for that particular faith-based organization. • Faith-based organizations will determine processes that facilitate on-site responsibilities, accountabilities, coordination and cooperation.

Priority #1	*Tasks To Be Done*	*Who/Dialogue*

Policy change to promote abstinence plus education within schools.
 	
Curriculum that focuses on impact of choices/ behaviors on your life and the lives of others.
 	
Establish grassroots processes that build collaborations for educational support in neighborhoods and schools.
 	
Engage all populations and cultures.
	• Get on the County Commission, City Council's Agenda
	  Education/Government officials
	  Hold elected officials (specifically Health Department) accountable for community health outcomes
	  Develop relationship with officials ---Adopt a Commissioner
	  Increase visibility of Faith-based Community with Government Officials
	▪ Educate Community re: Disease
	▪ Collect and confirm data – link funding with tangible relationships
	▪ Involve Business Leaders
	▪ Encourage specific actions/program development and funding
	▪ Open intergovernmental discussions with cities that have established promising practices. (San Francisco, NY, Chicago)
		• Health Summit – Education Collaborative
		• Health Departments should take the leadership role.
		• County Commissioners should support the community efforts to exercise self-determination over their own health status.

Priority #2	*Task to be Done*	*Who/Dialogue*

Neighborhood Health Care
 	
Bring care systems into neighborhood to facilitate access to care, ease transportation needs, address housing needs, support educators, and providers.
 	
Universal Healthcare
 	
Educators
	▪ Involve Summit participants in follow-up – activities/actions
	
	▪ Form a group of people to work specifically on housing access
	
	▪ Break down the barriers to housing in neighborhoods
	  Petition County Commissioners/ City of Charlotte for information about all housing that has not be rented/sold as a step to create better and more available housing
	  Redevelop available properties and make them available to special population groups, such as mothers with children who have HIV/AIDS.
	
	▪ Research information given to the population at large
	
	▪ Examine policy positions – review political websites during election years.
	
	▪ Establish HIV/AIDS education as a requirement for certification for K-12 educators
	
	▪ Empowering/ Re-empowering Parents
	
	▪ Community accepting problems as a whole
		Educational Collaborative Contact participants with proceedings and “next steps”.

Priority #3	*Task to be Done*	*Who/Dialogue*

Good Habits supported through targeted media campaigns.	▪ Develop a media/marketing committee
	▪ Letter writing campaign
	▪ Encourage messages that emphasize
	  Take charge of all of your actions
	  Don't blame someone else for your behavior
	  Media press release
	  Media focus groups
	  Grants for media
	  Lobbying against lewd TV commercials that promote sex
		▪ Education Collaborative and Summit participants

Priority #4	*Task to be Done*	*Who/Dialogue*

Higher levels of sensitivity to patients' cultures, ethnicity and needs that include culturally competent, non-judgmental service providers.	▪ Someone that "looks like me" that is promoting care delivery and involved in advocating services
	▪ Faith-based outreach that occurs without condemnation
	▪ Evaluation forms for patients during visit to health provider sites
	▪ Suggestion box in waiting rooms to improve health care at that site
	  Hold client/health care providers accountable for their actions in writing
	  Objective monitoring
		Educational Collaborative partners

Priority #1	*Tasks To Be Done*	*Who/Dialogue*
Improve neighborhood resources, specifically parks, side walks, lights and safety tools/resources.	▪ Youth-oriented personal protection programs with community police and security resources ▫ Enforcement of strict punishments ▪ Redeveloping impoverished areas ▪ Work On: ▫ Self-esteem ▫ Peer Pressure ▫ Communication/Social Skills	During weekly/monthly meetings During educational outings Church members Community Leaders Parents/Guardians Active club members and officials Children/youth
Access to Healthcare	▪ Affordable health insurance as part of employee benefits ▫ Educational Stability ▪ Reduction in health care cost ▪ Different care specialists that understand Cultural values, gender, ethics, knowledge, broad dimensions of health (physical, mental, emotional, social) ▪ Discuss universal health care	▪ During interview with employers ▪ Health professionals ▪ Youth forums
Good Habits, Good Choices, Wellness Behaviors	▪ Engaging in good habits ▪ Set goals—celebrate accomplishments ▪ Make healthy choices ▪ Spend time with positive influences	▪ Participants and other youth can engage in good habits during school, during club activities, with peers, teachers, mentors and leaders.

WHERE DO WE GO FROM HERE?

The *Educational Collaborative for the Elimination of Health Disparities in Mecklenburg County* is excited about the work accomplished at the Key Leader Symposium held in June 2004 and the **Health Summit** in October 2004. These were necessary planning steps toward the goal of developing effective community-based strategies for addressing the county's health disparities problem. Our plan is to aggressively move forward to implement priority action steps.

First, it has been suggested that the name we chose for the collaborative is too long. So we're working on a shorter version. When we have agreed upon a new name, we will use it to formalize our organizational structure. This is a necessary step as we seek to attract local, state and national funding.

Secondly, we are actively seeking funding that will enable the collaborative partners to develop and implement programs in keeping with suggestions received at the Summit. Our goal is to begin start-up operations by July 2005. This is an ambitious timeline that will require maximum cooperation from our local and state governmental partners.

The Collaborative has decided to initially focus its attention on eliminating health disparities in the areas of:

- Heart Disease
- Obesity/Diabetes
- Hypertension
- Cancer
- HIV/AIDS
- Infant Mortality
- Healthcare Workforce Development

Finally, we have begun to plan a second key leader symposium to discuss provider coordination strategies. The symposium will again be held in the spring. A second **Health Summit** is also being planned for October 2005.

If you or your organization would like to join the Educational Collaborative please feel free to contact any of our participating partners for information about upcoming meeting dates.

EDUCATIONAL COLLABORATIVE FOR THE ELIMINATION OF HEALTH DISPARITIES IN MECKLENBURG COUNTY

PARTICIPATING AGENCY DESCRIPTIONS

AMC International Group

AMCIG is a **global management consulting company** committed to partnering with its clients to deliver innovative solutions in performance excellence technologies. We provide performance excellence services and information in four broad categories: Strategic Planning; Leadership Development Systems; Executive Development and Coaching; and Performance Excellence Roadmap. We build results that last. For any questions please contact: Mr. Christopher Abiodun at 704.650.7688 or email: christopher@amcig.net

Charlotte Medical Pharmaceutical & Dental Society

A minority-based medical society consisting of 70 members. The members consist of healthcare providers including physicians, dentists, optometrists, and pharmacists of Mecklenburg County. Services provided include:

- Promote Preventive Health
- Scholarship Funds
- Community Health Education Seminars

For additional information please contact **Trent Augustus** by email: augustus@medscape.com

Charlotte REACH 2010 Program

Racial and Ethnic Approaches to Community Health (REACH) 2010 is a federal initiative launched by the Centers for Disease Control and Prevention to eliminate disparities in health among persons of color. The program encourages communities to mobilize and organize resources, and develop effective, sustainable programs to eliminate leading disparities in health.

The Charlotte REACH 2010 initiative consists of collaborative interventions that focus on the primary prevention of heart disease and diabetes among African Americans in the Northwest Area of Charlotte. The project intervention is based on community education and the promotion of healthy behaviors. The program utilizes representatives from neighborhoods in the Northwest Area to provide outreach and education to peers. The representatives, also known as Lay Health Advisors, are trained on health issues, risk reduction strategies, knowledge of local resources and communication skills to motivate residents to make healthy lifestyle choices. Community members are linked to health promotion programs to support changes in behavior and to increase activities that reduce risks for disease.

Coalition partners include: Mecklenburg County Health Department, Mecklenburg County Fighting Back Program, Healthy Families Healthy Communities Organization, community representatives, McCrorey Family YMCA, Carolinas Community Health Institute, CMC – Biddle Point Health Center, N.C. Division of Public Health – Chronic Disease & Injury Section, Presbyterian Health Care Parish Nurse Program, Substance Abuse Prevention Services, Inc.

For more information, visit the program website (**www.reach2010charlottenc.org**) or call LaTonya Chavis, Project Coordinator, at 704-548-5629.

Carolinas Healthcare System-Interfaith Carelinks

Carolinas Healthcare System-Interfaith Carelinks are comprised of professional staff, clergy, who have special training in interfaith pastoral care supervision- help organize, coordinate and consult with Care Teams. Care Team enhances a congregation's human resources through the training, supervision and continuing education of team members. This group is well equipped to respond to family crises, to understand the stresses of chronic illness and caregiving and, in consultation with the team staff, to identify and use resources that are beyond the team's boundaries. Service Provided: Companionship, Meals, Homemaking, Shopping, Emotional Support and loving kindness, Basic physical care, Spiritual Support, Respite for Exhausted primary caregivers, Training Workshops

Johnson C. Smith University

Founded in 1867 under the auspices of Presbyterian Church, USA, Johnson C. Smith University (JCSU) is an independent, private, coeducational institution of higher learning. Located in Charlotte, NC, this historically African-American university has a residential campus with a familial atmosphere in which students are stimulated and nurtured by dedicated, caring faculty and staff.

The mission of Johnson C. Smith University is to provide an outstanding education for a diverse group of talented and highly motivated students from various ethnic, socioeconomic and geographic backgrounds. JCSU offers liberal arts education in conjunction with concentrated study in specialized fields in preparation for advanced study and specific careers.

The University endeavors to produce graduates who are able to communicate effectively, think critically, learn independently as well as collaboratively, and demonstrate competence in their chosen areas. The University also embraces its responsibility to provide leadership, service and lifelong learning to the larger community.

Latin American Coalition

Latin American Coalition

Charlotte's oldest and largest Hispanic service agency, The Latin American Coalition was founded in 1990 to advise, orient, evaluate, and respond to the needs of the Latino community and to promote intercultural exchange activities and programs. In 2001, The Coalition became a member of the United Way of Central Carolinas.

Coalición Latinoamericana

La agencia de servicios hispana mas antigua y grande, La Coalición Latinoamericana fue fundada en 1990, con el propósito de asesorar, orientar, evaluar, para responder a las necesidades de la comunidad Latina promoviendo intercambios y programas culturales. En el 2001, la Coalición se convirtió en miembro de United Way of Central Carolinas.

Programs and Services

Information and Referral: We serve as liaisons between the services available in our community and the families and individuals that require them, providing basic orientation as needed.
Job Bank: Access to employment information in our community and workshops to enhance employment opportunities, including teaching how to fill out a work application, reading maps, writing a resume, how to survive an interview, and other important related facts. Emphasis is given on understanding abbreviations used in newspaper work ads, strategies on how to find a job and basic information on labor laws.
Latin American Festival: Annual celebration of the diverse culture, music, food, dance and folklore of all Latin American Countries.
Mentor Tutor Program: Enables English as a Second Language (ESL) students, to overcome learning and acculturation obstacles through intensive instruction in the English language, reading comprehension and homework assistance.
Tertulias: Reunions and celebrations that mainly highlight the culture, music, dances and food of a particular Latin American Country.
Pura Vida Program: Designed to foster family participation on areas of activities available in the area, including museum visits, parks and recreation trips.
Other Services: Labor related information, Notary Services, Translation, assistance with official documents, like filing W7, Tax, Title Transfers and other documents.

Programas y Servicios

Información y Referencia: Servimos como punto de enlace entre los servicios disponibles en nuestra comunidad y las familias e individuos que los requieren, proveyendo orientación básica de acuerdo a necesidad.
Banco de Trabajo: Acceso a la información de empleos disponibles en nuestra comunidad y talleres para mejorar las oportunidades de obtener empleos, incluyendo enseñanza del llenado de aplicaciones, lectura de mapas, redacción de currículo vital, como sobrevivir una entrevista y otros aspectos importantes relacionados. Se da énfasis en comprender las abreviaciones utilizadas en los periódicos,`estrategias para obtener un trabajo e información básica sobre leyes laborales.
Festival Latinoamericano: Celebración anual de la diversidad en cultura, música, comida baile y folklore de todos los países Latinoamericanos.
Programa Tutelar: Permite a los estudiantes de Ingles como Segundo Idioma (ESL), sobreponerse a los obstáculos de aprendizaje y aculturación, mediante instrucción intensa del idioma Ingles, comprensión de lectura y apoyo en las tareas escolares.
Tertulias: Reuniones y celebraciones que primordialmente ensalzan la cultura, música, baile y comida de un País Latinoamericano en particular.
Pura Vida: Diseñado para promover la participación familiar en los centros de actividades disponibles en el área, incluyendo visitas a museos, parques y viajes de recreación.
Otros Servicios: Información relacionada con Aspectos Laborales, Servicios Notariales, Traducciones, Asistencia en llenado de documentos oficiales, como el llenado de la forma W-7, Impuestos, Transferencia de Títulos, y otros documentos.

For more information about the Latin American Coalition please contact:
Angeles Ortega-Moore, Director (704) 531-3848 email: aortega@latinamericancoalition.org
Samuel Dickerman MD, MSPH Director, Health Community Programs (704) 531-3848
email: Sdickerman@latinamericancoalition.org

The Mecklenburg County Department of Social Services (DSS)

The Mecklenburg County Department of Social Services (DSS) is one of the region's largest providers of human services. The federal government mandates, and North Carolina supervises, the county-administered DSS programs and services that help citizens achieve self-sufficiency, protect children and senior adults, and strengthen families. DSS helps individuals and families who qualify in areas such as Work First cash assistance, food stamps, and health insurance for children, families and older adults through Medicaid and the N.C. Health Choice for Children program.

Other services include employment assistance, childcare, low-income energy assistance, transportation, prevention of abuse and neglect of children and the elderly, foster care and adoption services, and meals and nutrition counseling for seniors.

The Wellness Interfaith Network (W.I.N.) developed by the DSS Faith Initiative Office with three other Mecklenburg County departments (Area Mental Health Authority, Public Health, and Park and Recreation) creates collaborative initiatives with the faith-based community to help strengthen mind, body and soul. For more information visit the Web site at http://www.CharMeck.org/Departments/DSS/Home or call DSS Citizen Information Referral at 704-336-3150. The Wallace H. Kuralt Centre at 301 Billingsley Road, Charlotte, N.C. is the main DSS office.

The Mecklenburg County Health Department

Mecklenburg County Health Department's Role in Reducing and/or Eliminating Health Disparities:

- Examine current programs to assure cultural competence into its programs, practices and policies
- Focus on customer service with respect, dignity, and willingness to serve
- Increase collaboration among health department management and community partners to share responsibility in addressing and raising awareness of:
    - disparity issues
    - minority health needs
    - available resources
- Collect and analyze data to aid in improving the quality of life for residents of Mecklenburg County
- Promote educational awareness, training and technical assistance in response to disparities
- Advocate to make culturally competent healthcare accessible to those who need it
- Advocate for cultural diversity in staff and management

Community Health Administration develops visibility of health disparity issues through **identification**, **collaboration**, *and* **education**. The Community Health Administrator identifies opportunities for

partnerships and advocates for **targeting resources** for where they are most needed to serve the population and decrease health disparities.
The Community Health Administration **works in partnership** with local and state public health groups, medical professionals, universities, community-based groups, faith-based institutions, and the private sector as part of its efforts and commitment to reducing and/or eliminating health disparities.

Please contact the Community Health Administrator, Cheryl Emanuel at (704) 432-0216
www.meckhealth.org

Metrolina Comprehensive Health Center

A private, non-profit community health center dedicated to providing area families with quality managed, primary medical care. MCHC is a Section 330 Community Health Center providing primary care services to the medically underserved residents of Mecklenburg County. MCHC is designated as a federally Qualified Health Center, receiving cost-based reimbursement through Medicaid and Medicare. MCHC participates in Mecklenburg County's Medicaid Managed Care Program on a fee-for-service basis.
Contact **Carolyn C. Allison,** *Executive Director* at (704) 393-7720 or email allisocc@aol.com.

Number of Locations

C.W Williams Office
3333 Wilkinson Boulevard

Metrolina Midtown Medical Service
1918 Randolph Road, Suite 670

Metrolina Native American Association, Inc.

Metrolina Native American Association, Inc. is a nonprofit organization that was chartered in January 1976 by a group of American Indians living in Charlotte and the 10 surrounding counties. The purpose of the organization is to support the needs of Indian people in the areas of health and welfare. Additionally, the Association promotes the development of the Indian Community through cultural awareness and economic development; MNAA provides job training and placement and provides for the well being of Indian people. Our membership consists of Native Americans and their families who live within our ten county service area. Metrolina Indian News, the associations' monthly newsletter, keeps the community members informed of activities sponsored by MNAA.

Please contact the administrative office to be included on the mailing list and to receive a membership application: Metrolina Native American Association 8001 North Tryon Street Charlotte, NC 28261
Phone: (704) 926-1524 Fax: (704) 347-0888 email: mnaa2000@excite.com

North Carolina Office of Minority Health & Health Disparities

Promotes and advocates for the elimination of health disparities among all racial and ethnic minorities and other underserved populations in North Carolina.

Major Focus Areas

- ***Research and Data:*** Improve the quality of health information, data collection and analysis.
- ***Culture:*** Provide cultural diversity training to health and human services staff.
- ***Language Services:*** Advocate for Spanish-language services in local health departments.
- ***Policy Development:*** Support policies and legislation to improve the availability and delivery of health services to the racial/ethnic and undeserved population.
- ***Health Initiatives/Program/Services:*** Collaborate with others to ensure that programs and services are culturally and linguistically appropriate.
- ***Communication:*** Work with others to raise awareness of minority health needs, issues and resources.
- ***Work Force Diversity***:
- ***Student Internship:***
- ***Support:*** Provide support to the Minority Health Advisory Council (MHAC)

For more information, please contact the Office of Minority Health and Health Disparities at **(919) 431-1613**

PeopleSouth® Consulting

PeopleSouth® Consulting offers unique solutions to work life balance challenges through its ***Well Within ™*** program. By recognizing the implications of lifestyle choices on stamina, mental acuity and communication style, the ***Well Within ™*** program focuses on the alignment of individual behaviors with performance goals. Through two components, the ***Well Within ™*** program assembles the disciplines of behavior science, exercise and meditation into a flexible, interactive learning format. The *Work Life Balance* component addresses the affects of job stress on the mental acuity and stamina of employees. Our program guides participants through a self-assessment process that enables them to analyze the content of the work they do with the context of the life they choose. Additionally, the ***Well Within ™*** program offers a *lifestyle change program for overweight and obese body* types. We understand that overweight and obesity are blocks that may inhibit a person's ability to perform and contribute at optimal levels. Using a combination of workshops, and guided learning workbooks, participants are aided in re-framing self-image while learning new behaviors.

Please contact: Charlotte Grant-Cobb, PhD, Managing Partner –Professional Development Practice
P.O. Box 1510, Cornelius, NC 28031 8420 Medical Plaza Dr., Charlotte, NC 28262
Phone: (704) 650-4430 Fax: (704) 895-4344 email: charlottegrantcobb@peoplesouth.com
www.peoplesouth.com

Pfeiffer University – School of Adult Studies and Masters in Health Administration Programs

Pfeiffer University is recognized as a model church-related institution that prepares servant leaders for lifelong learning. The Charlotte campus houses the Graduate School and School of Adult Studies. The School of Adult Studies educates adult learners in business administration, criminal justice, healthcare management, liberal arts, management information systems, and organizational communication. We specialize in the application of theory with practice. Our programs provide a stimulating learning experience to a culturally diverse population.

The Master in Health Administration program is designed for clinicians and first line or middle managers who have worked in healthcare for at least three years. The practical course of study provides the requisite knowledge, and wisdom, necessary for successful leadership in the rapidly changing, and highly complex, healthcare environment of the 21st century. For more information contact: www.pfeiffer.edu.

Project HealthShare, Inc.

Project HealthShare, Inc. is a non-profit community health outreach program engaged in the development of a free medical clinic under the leadership of Donna Murray Lacey, MS, PA-C. Project HealthShare, Inc. has provided health education and screening to thousands throughout Charlotte-Mecklenburg since 1999. The mission of the organization is to empower individuals to actively participate in their own health and wellness and to improve access to primary care. To meet the goal of improving access to care for the uninsured PHS will open the Charlotte Volunteers in Medicine Clinic in late 2004. The clinic will serve those most in need in the Statesville Avenue Corridor of Charlotte.

Donna Murray Lacey, Executive Director of Project HealthShare, Inc/Charlotte Volunteers in Medicine Clinic is a certified Physician Assistant who worked for Carolinas HealthCare System in Charlotte for seven years. She is also a provider with Mid-Atlantic Emergency Medicine Associates at Presbyterian Hospital. For more information please call 704-996-9269 or see the website www.projecthealthshare.com.

Sickle Cell Regional Network

The Sickle Cell Regional Network (formerly Sickle Cell Disease Association – Southern Piedmont) is a nonprofit, community-based organization dedicated to addressing the comprehensive needs of sickle cell and thalassemia patients.

The agency provides free sickle cell testing (including sickle cell anemia, thalassemia, and other hemoglobin disorders); education, and genetic counseling. Additional services include case management, referrals, and follow-up. SCRN provides child service coordination for children up to 5

years old who have special needs. Sickle Cell Regional Network was founded in 1972 and currently serves Mecklenburg County.

For more information contact: **Sickle Cell Regional Network, 821 Baxter Street, Suite 312, Charlotte, NC 28202-2713 (704) 332-4184 or (800) 435-6004; Fax: 704/332-2246**

Teen Health Connection

Teen Health Connection is a non-profit agency that provides family-centered medical and mental health services to low-income adolescents ages 11 to 21. In addition, the agency provides community education and advocacy for teen health issues. For more information contact: Linda Gallehugh, Executive Director

Teen Health Connection 251 Eastway Drive Charlotte, NC 28213-7103; Phone: 704-446-0855; Fax: 704-446-0957 linda.gallehugh@carolinashealthcare.org www.teenhealthconnection.org

Special Thanks

*The Collaborative wishes to thank everyone who participated in the **Health Summit**. By doing so you became part of the community solution to our health disparities problem. Please continue to partner with us as we advocate for closing the health care gaps.*

The Educational Collaborative for the Elimination of Health Disparities in Mecklenburg County

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Charlotte REACH 2010

Charlotte LINKS

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