

“An Assault on Our Community”:
Racial Discrimination in the Closure and Demolition of the
Good Samaritan Hospital by Premier Health Partners in Dayton, Ohio

SUBMISSION FOR THE 107th SESSION OF THE
UN COMMITTEE TO END RACIAL DISCRIMINATION, AUGUST 2022

UNITED STATES OF AMERICA

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The Clergy Community Coalition (CCC), an association of pastors, churches, citizens, and community organizations in Northwest Dayton, one of the highest African American populated communities in Dayton, Ohio, U.S. came together to keep the Good Samaritan Hospital open, to preserve and improve health services to the minority community surrounding the hospital, and to prevent any demolition of the facilities.

The text in Paragraphs 1-27 is based on the documents submitted to the United States government’s Office of Civil Rights within the U.S. Department of Health and Human Services by attorneys with Advocates for Basic Legal Equality (ABLE), representing CCC. Joel R. Pruce and Shelley Inglis of the University of Dayton Human Rights Center, and Leslie Picca served as contributing authors. This report does not necessarily represent the views of the University of Dayton.

EXECUTIVE SUMMARY

“...the only option [was] to move him to a full-fledged hospital, to Miami Valley, which was 30 minutes away. When they got him there, they said there was nothing they could do. It’s horrible. It’s a horrible act. It’s an assault on our community. Since when does a person’s economic status determine the value of their life?” (an excerpt from an interview transcript with a community member from northwest Dayton whose brother died in transit to a distant hospital)

This report provides a review of the discriminatory conduct depriving African Americans access to health care facilities by a private actor in Dayton, Ohio, United States (U.S.). It outlines how the closure of a sole hospital in the majority (over 78%) African American community constitutes violations of state obligations under CERD and makes recommendations for action. This situation takes place in the context of a history of redlining, which was a long-standing discriminatory practice in housing and financial services, that resulted in segregation, underinvestment and divestment in Dayton’s west side. The community suffers as a food desert with aging infrastructure, failing public schools, foreclosed and abandoned houses, and high levels of poverty and crime. For instance, based on Montgomery County 2015 data the poverty rate among Black people is nearly 3x that for White people and median income for White people is nearly twice what it is for Black people.¹

Critical health disparities among racial groups, including in areas like infant and maternal mortality, are vast in Dayton. Public Health - Dayton and Montgomery County (PHDMC), the agency responsible for monitoring and addressing health across the city and county, emphasizes that “a clear racial disparity continues to exist with Black infants dying at a rate much higher than White infants.”² In 2016, the Black infant mortality rate was 12.6 infant deaths for every 1,000 live births or two and a half times higher than the White infant mortality rate of 5 infant deaths for every 1,000 live births.³ Specifically, the highest rate of infant mortality across Montgomery County where Dayton is located is among Black infants in the zip codes surrounding the hospital site.⁴

Against this backdrop, in January 2018, Premier Health Partners (PHP), shortly after acquiring Good Samaritan Hospital, announced the closure and demolition of the hospital. PHP is “the largest private, nonprofit, comprehensive health care system in Southwest Ohio” that operates five hospitals and a network of outpatient and urgent care centers.⁵ In fiscal year 2020, it reported over \$1.9 billion in total revenue.⁶ The local community’s immediate concern was that the closing would have a discriminatory and disparate adverse impact on African Americans, and particularly women. The Clergy Community Coalition (CCC), an association of pastors, churches, citizens, and community organizations in Dayton’s African American community, came together to advocate and fight to keep the hospital open, to preserve and improve health services to the minority community surrounding the hospital, and to prevent any demolition of facilities.

The July 2018 closure of Good Samaritan Hospital by Premier Health Partners in the majority Black community of West Dayton constitutes a violation of CERD. Evidence of wide gaps in health outcomes along racial lines were well recognized by PHP, PHDMC, and a range of local authorities. The segregation, and poverty facing this particular community is a result of well documented historical racial discrimination by private actors protected by public policies, such as redlining, restrictive covenants, and predatory lending. Government at all levels is responsible for the impact of actions of private actors, such as those by Premier Health. Moreover, the State is obligated to put in place proactive and supportive measures to remedy persistent inequalities. Local, state, and

¹ Urban League of Greater Southwestern Ohio. “[The State of Black Dayton: Opportunities Lost.](https://hansandcassady.org/State%20of%20Black%20Dayton%20book%20Web%20PDF.pdf)” 2017. URL: <https://hansandcassady.org/State%20of%20Black%20Dayton%20book%20Web%20PDF.pdf>.

² Ashley L. Seybold. Epidemiology Department, Public Health - Dayton & Montgomery County. “Perinatal Periods of Risk Analysis: A method for analyzing and investigating fetal and infant deaths to address local causes and existing disparities, Montgomery County, Ohio 2012-2015” (Jan. 2018). URL: <https://www.phdmc.org/epidemiology/health-profiles/775-montgomery-county-perinatal-periods-of-risk-analysis-2012-2015/file>.

³ Ibid.

⁴ Ibid at 3-4.

⁵ “About Us.” URL: <https://www.premierhealth.com/about-premier/about-us>.

⁶ “Fitch Affirms Premier Health Partners’ (OH) at ‘A.’ URL: <https://www.fitchratings.com/research/us-public-finance/fitch-affirms-premier-health-partners-oh-at-a-outlook-remains-negative-20-09-2021>.

federal government actors failed to prevent the closure of a main source of health care access for a marginalized community and has since not taken sufficient remedial action to ensure access to public health care for one of Dayton's poorest and majority Black community.

In March 2022, the CCC received notice that the federal government concluded its investigation stating they had found inadequate evidence to support the claim that Premier Health's actions constituted racial discrimination, setting up this alternative report to the Committee on the Elimination of Racial Discrimination.

OVERVIEW AND BACKGROUND

1. In 1996, Premier Health Partners was hired by the Sisters of Charity of Cincinnati, the owners of Good Samaritan Hospital (GSH), to be the operators of the hospital. In December 2017, Premier Health Partners purchased GSH from Catholic Health Initiatives (a multinational, charitable hospital network of 13 Congregation of Sisters, which now included the Sisters of Charity of Cincinnati) for 22 % operating revenue in the restructured joint venture. In January 2018, one month after the purchase of the hospital, Premier Health Partners announced the closure and demolition of GSH and stated a *deed restriction* would be placed on the property so no future healthcare facility could be built on the site. Premier Health Partners is "the largest private, nonprofit, comprehensive health care system in Southwest Ohio" that operates five hospitals and a network of outpatient and urgent care centers.⁷ In fiscal year 2020, Premier Health reported over \$1.9 billion in total revenue.⁸
2. GSH, located in the over 78% African American neighborhood of northwest Dayton, Ohio, has long been the major provider of healthcare in this area. The community's immediate concern was that the closing would have a discriminatory and disparate adverse impact on African Americans, and particularly women. The Clergy Community Coalition (CCC), an association of pastors, churches, citizens, and community organizations in Dayton's African American community came together to keep the hospital open, to preserve and improve health services to the minority community surrounding the hospital, and to prevent any demolition of facilities.
3. Premier Health Partners has expanded and continues to expand its buildings and services in affluent, majority White suburban areas at the same time it announced this plan to close its only hospital in an African American neighborhood without any previous indication to the Dayton community that it was even considering doing so. This took the community by surprise and generated a great deal of outrage. The stated reasons for the closure included excess capacity in beds and other services within Premier's system, changes in health care delivery, and the cost of repairing the facility.⁹ "We knew the community was over-bedded. The cost of redundancy was just not sustainable. All this redundancy has to be paid for and that overhead gets translated into what a patient pays for care in the community," said Barbara Johnson in 2019, who was Premier's chief human resources officer at the time.¹⁰ However, as a result of the closing, many other services besides excess beds were being eliminated. The new 50 bed Dayton Heart Hospital had been added to the GSH campus in 2010 and a new Emergency Center was expanded in 2016. "Premier Health officials said it would cost \$90

⁷ "About Us." URL: <https://www.premierhealth.com/about-premier/about-us>.

⁸ "Fitch Affirms Premier Health Partners' (OH) at 'A'; Outlook Remains Negative." URL: <https://www.fitchratings.com/research/us-public-finance/fitch-affirms-premier-health-partners-oh-at-a-outlook-remains-negative-20-09-2021>.

⁹ "Premier Health Announces Closure of Good Samaritan Hospital." URL: [https://www.premierhealth.com/your-health/articles/premier-pulse/premier-health-announces-closure-of-good-samaritan-hospital-\(closed-in-2018\)](https://www.premierhealth.com/your-health/articles/premier-pulse/premier-health-announces-closure-of-good-samaritan-hospital-(closed-in-2018)).

¹⁰ Kaitlin Schroeder. "A Year Later, Hospital System Stands behind Good Sam Closing." *Dayton Daily News*. URL: <https://www.daytondailynews.com/business/year-later-hospital-system-stands-behind-good-sam-closing/ACh5OtrDjUFznj2MQETS2I/>

million or more to keep the campus up to code over the next decade. Premier will also save about \$7 million to \$8 million annually in operating costs by shifting services to other hospitals.”¹¹

4. Premier Health Partners’ actions join in today’s trend of relocating hospitals from the city to the suburbs due to the desire to attract better paying privately insured patients and reduce the numbers of those on Medicare and particularly Medicaid (forms of U.S. government insurance for the elderly and indigent), who bring in less money. As a result, hospital systems have been building and ramping up new facilities in the suburbs and then closing ones in the city, often in areas where racial minorities and others who are disproportionately poor live.
5. In May 2018, the CCC filed a federal complaint with the US Department of Health and Human Services Civil Rights Division, hoping for intervention to prevent the closing and later for remedy.¹² Furthermore, in November of 2018, the CCC filed a Supplemental to the original complaint that included evidence of the impact of the closure on key health indicators like infant and maternal health; for instance, after years of a downward trend, 2020 saw the Black infant mortality rate rise from 10.5% in 2018 to 14.1% in 2020.¹³ CCC also filed a supplemental complaint about Premier’s expansion of services into the all White suburbs, which was merged into the original complaint for the purposes of HHS’s investigation.¹⁴
6. Meanwhile Premier Health continued to actively open new care centers in White-majority areas around the region—in particular its Lifestages Center for Women service, which was the first department to be closed at Good Samaritan prior to demolition. Across Spring and Summer 2018, three new Lifestages centers were opened in Centerville, Springboro, Beavercreek which have White populations of 86%, 94%, and 86% respectively, with no expansion in Black communities anywhere in the region. Since 2019, Premier has spent at least \$25 million to construct four health centers in majority White areas (two large centers and two smaller facilities in townships whose populations are 91%, 86%, 87%, and 98% White, respectively) and to this day has built no medical facility in a majority Black community.
7. In March 2022, the CCC received notice that the federal government had concluded its investigation and found inadequate evidence to support the claim that Premier Health’s actions constituted racial discrimination under U.S. law.

CONTEXT

8. Healthcare disparities are a major human rights issue in the U.S. today. For example, the life expectancy at birth for Black people in Dayton, Ohio is lower than in many developing countries.¹⁵ Black Daytonians’ top five causes of death are diseases that chronic discrimination can cause or

¹¹ Kaitlin Schroeder. “Empty Beds, High Costs led to Good Sam Closing.” *Dayton Daily News*. URL: <https://www.daytondailynews.com/news/special-report-empty-beds-high-costs-led-good-sam-closing/bhODmxuzFjJcUiAirJQcM/>

¹² In the Federal Complaint, had HHS found in favor of CCC and Premier failed to comply with a resolution, Premier Health would have lost its tax-exempt status and reimbursements for federal funding through Medicaid and Medicare.

¹³ “2020-2022 Community Improvement Plan.” URL: <https://phdmc.org/report/community-health-improvement-plan>.

¹⁴ In pursuing justice through routes provided by the U.S. federal governments, community groups like CCC can at a disadvantage when challenging well-resourced and well-connected organizations like Premier Health Partners. In this particular case, PHP’s legal representation in Washington, D.C. was Leon Rodriquez, the former Director of Health and Human Services Civil Rights Division.

¹⁵ “The State of Black Dayton: Opportunities Lost.”

worsen.¹⁶ Racially based inequalities in other social, economic, and civil systems contribute to ill health and make it difficult for Black Americans to be healthy.¹⁷ Dayton, Ohio is the fifteenth most segregated city in the U.S. where the extreme Black social isolation meets the criteria for “hypersegregation.”¹⁸ Good Samaritan Hospital was located in the northwest corridor of Montgomery County. This postal code is the second most populous in the area and over 78% of residents are African American.¹⁹ The closing of hospitals in predominantly minority neighborhoods is another example of how past racial discriminatory policies and practices negatively impact already segregated neighborhoods.²⁰

9. The segregation present in Dayton today is a direct result of discriminatory policies that prevented Black people from full participation in the housing market by devaluing the price of real estate in historically Black areas, while also preventing access to mortgages for Black people to move into areas with sustainable housing values. These policies, collectively known as *redlining*, drew maps that maintained racial segregation and continue to have specific impact on issues connected to where one lives, including access to education, food, and health care. Divestment from an area known to be the product of entrenched segregation by private actors such as grocery store corporations or hospital health care providers will undoubtedly have discriminatory effects.
10. Social vulnerability maps today, including demographic, economic, and health data strongly correlates with redlining maps used from the 1930s to 1970s.²¹ Median housing values across Dayton differ by more than \$100,000 across formerly redlined areas (which are still disproportionately populated with African Americans) compared with formerly greenlined areas (which are still disproportionately populated in affluent White suburbs); the disparity across the region for median home values is as large as \$250,000 difference. The housing values translate to educational school district ratings and substantial academic gaps; children in the Dayton suburb of Oakwood are 2.3 grades ahead of their peers, while children in the City of Dayton are 2.0 grades behind.²² The life expectancy across Dayton is more than a 25-year differential between the wealthy White suburbs (Centerville, 86.2 years; Oakwood, 82.1 years) compared with the Black majority impoverished areas (McCook Field, 61.1 years; Trotwood, 67.1 years).²³

¹⁶ “The State of Black Dayton: Opportunities Lost.”

¹⁷ Despite the passage of the Civil Rights Act over fifty years ago, minority healthcare remains separate and unequal. Segregation still survives and thrives in the Dayton region. The disparate medical treatment of minority patients is, to a large extent, the product of geography. Amitabh Chandra, Michael Frakes, and Anup Malani. “Challenges to Reducing Discrimination and Health Inequity Through Existing Civil Rights Laws.” *Health Affairs* 36(6) (June 1, 2017). URL: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1091>.

¹⁸ Michael Suater, Evan Comen, and Samuel Stebbins. “16 Most Segregated Cities in America” *Yahoo News*. (July 21, 2017). URL: <https://www.yahoo.com/news/16-most-segregated-cities-america-192040383.html>.; Michael Hotchkiss, “Hypersegregated Cities Face Tough Road to Change.” (May 18, 2015). URL:

<https://www.princeton.edu/news/2015/05/18/hypersegregated-cities-face-tough-road-change>

¹⁹ “45406 Population.” URL: [https://www.ohio-demographics.com/45406-demographics#:~:text=Race%20%26%20Ethnicity,Two%20or%20More%20\(4.8%25\)](https://www.ohio-demographics.com/45406-demographics#:~:text=Race%20%26%20Ethnicity,Two%20or%20More%20(4.8%25)).

²⁰ See for example the Miami Valley Regional Planning Commission Miami Valley “Equity Regional Profile,” available at <https://www.mvrpc.org/sites/default/files/equityregionalprofile.pdf>. The Profile discusses how past racially motivated policies have led to regional inequality in racial and economic segregation.

²¹ The Digital Scholarship Lab and the National Community Reinvestment Coalition, “Not Even Past: Social Vulnerability and the Legacy of Redlining,” *American Panorama*, ed. Robert K. Nelson and Edward L. Ayers, <https://dsl.richmond.edu/socialvulnerability>.

²² Motoko Rich, Amanda Cox, and Matthew Bloch. “Money, Race, and Success: How Your School District Compares.” *The New York Times*. (April 29, 2016). URL: <https://www.nytimes.com/interactive/2016/04/29/upshot/money-race-and-success-how-your-school-district-compares.html>.

²³ Data from Centers for Disease Control and Prevention.

11. In the time since the closure of the hospital, the United States has been ravaged by the COVID-19 pandemic. While data is not yet available about the direct impact of the closure of this hospital on harm to the Black community from COVID, the Black community in Dayton was disproportionately impacted by higher rates of transmission, hospitalization, and death. It thus bears emphasizing that the Northwest community faced the lack of availability of a primary care facility during an unprecedented public health crisis.

IMPACT

12. Good Samaritan Hospital served the majority Black neighborhood which surrounds it for 86 years. It earned a strong reputation in that neighborhood and drew the lion's share of its patients from that area. Premier Health operates four other hospitals (and various medical centers) across a total service area that is 12.5% African American and chose to close the hospital which primarily serves an area which is 78% African American. The disproportionate impact on African Americans is clear, it is stark, and the harm to this community is and will be severe. The closing results in diminished quality of service, excessive travel distances and times, loss of emergency services, pre-post and birthing services, loss of wellness and health maintenance programs in the area, economic hardship through loss of jobs and consumer traffic, and will decrease access to health care for African-Americans.
13. The CCC collected approximately 100 testimonies from people impacted by the closure. Interviewees consistently report a sense of trust and familiarity with Good Samaritan, as well as being treated with disrespect and discrimination at other area hospitals. In addition to practical impacts identified below, intangible variables like "trust" are not readily replaceable and their absence create real barriers for historically marginalized communities to accessing care. The specific impact is clearly identified in three categories: infant and maternal health and mortality; emergency care; and chronic care.

Infant and maternal health and mortality

14. Infant mortality is an important index of the overall health of a society and how well the society cares for its women and children. It is defined as the death of an infant before the child's first birthday. The infant mortality rate is not only seen as a measure of the risk of infant death but is used more broadly as an indicator of community health status, poverty and socioeconomic status levels in a community and the availability and quality of health services and medical technology.²⁴
15. Ohio had the 9th worst infant mortality rate in the United States in 2017 with a rate of 7 infant deaths for every 1,000 live births.²⁵ Montgomery County, Ohio has the fifth highest number of infant deaths in the state of Ohio.²⁶ Furthermore, the infant mortality rate for Montgomery County has not improved over the last 25 years.²⁷

²⁴ Seybold at 5.

²⁵ Ibid at 7.

²⁶ "Infant Mortality Rate Too High in Montgomery County, Health Officials Say." (February 2, 2018). URL: <https://www.daytondailynews.com/news/local/infant-mortality-rate-too-high-montgomery-county-health-officials-say/M8OzWjKRGf8ZawiMaqVf6H>.

²⁷ Dawn L. Ebron. Epidemiology Department, Public Health - Dayton & Montgomery County. "Perinatal Periods of Risk Analysis: A method for analyzing and investigating fetal and infant deaths to address local causes and existing disparities, Montgomery County, Ohio 2008-2011" (Nov. 17. 2015). URL: <https://www.phdmc.org/epidemiology/health-profiles/775-montgomery-county-perinatal-periods-of-risk-analysis-2012-2015/file>.

16. Public Health - Dayton and Montgomery County, the agency responsible for monitoring and addressing health across the city and county, emphasizes that “a clear racial disparity continues to exist with Black infants dying at a rate much higher than White infants.”²⁸ In 2016, the Black infant mortality rate was 12.6 infant deaths for every 1,000 live births or two and a half times higher than the White infant mortality rate of 5 infant deaths for every 1,000 live births.²⁹ The highest rates of infant mortality for all races in Montgomery County are located in the zip codes surrounding Good Samaritan Hospital. Moreover, the highest rate of infant mortality is among Black infants in the zip codes surrounding Good Samaritan Hospital.³⁰
17. The four areas of risk for infant mortality are maternal health/prematurity, maternal care, newborn care, and infant health. GSH was one of only two hospitals in Premier’s Health network and the only hospital on the west side of Dayton that provided labor and delivery services in Montgomery County. This care is critical to addressing infant mortality. In 2017, the last full year of operation, approximately 900 babies were delivered at GS H.³¹ Additionally, it provides critical outpatient care to women through their Life Stages Centers for Women.³² These centers provide pregnant women with “necessary prenatal care in a location near their home.”³³ Even though G SH was integral in reducing infant mortality by providing care to mothers and babies, their obstetrics and gynecology services were the first major service line to close in April of 2018, just three months after PHP announced the hospital’s closing. “The hospital closing means that pregnant women will no longer get care at Good Samaritan Hospital either on an inpatient or outpatient basis.”³⁴
18. Expectant mothers must now travel farther for care. As Premier Health indicates, “minutes matter” and so the amount of time it takes a mother to get care for herself or her infant affects their health. The closest hospital within the Premier Health Network is the Miami Valley Hospital, which requires either a car or a bus transfer to get there for those who live on the west side of Dayton. It can take up to thirty minutes by car and an hour by bus. Transportation challenges and inequities have a negative effect on health and is a leading cause of infant mortality.³⁵ Transportation challenges disproportionately affect Black persons as 22% of Black households in Ohio report having no vehicle, a figure 3.5 times higher than for White households.³⁶ Moreover, a 2017 analysis of Ohio Bureau of Motor Vehicles data found that low-income zip codes had much higher rates of driver’s license suspensions than higher-income zip codes.³⁷ “Not having a car is a challenge in urban, suburban and rural communities. Although public transportation may be available in an urban or suburban area, bus trips can often involve transfers to two or more bus routes which can result in a two-hour bus ride to travel what would have taken 20 minutes by car. Needing to get to multiple destinations, such as child care, work or a doctor’s appointment adds logistical challenges

²⁸ Seybold.

²⁹ Ibid.

³⁰ Seybold at 3-4.

³¹ Ohio Department of Health. Annual Hospital Registration and Planning Report Statistical Information, January 1, 2016 - December 31, 2016.

³² Affidavit of Dr. Matthew Noordsij-Jones.

³³ Ibid.

³⁴ Ibid.

³⁵ Health Policy Institute of Ohio. “A New Approach to Reduce Infant Mortality and Achieve Equity.” Ohio Legislative Service Commission. (December 1, 2017), p.51. URL: https://www.lsc.ohio.gov/documents/reference/current/SDOIM_FinalCombined.pdf.

³⁶ Ibid at 53.

³⁷ Sara Dorn. “License Suspensions Disproportionately Imposed on Poor Ohioans, Trapping Them in Debt.” *Cleveland.com*. (March 31, 2017). URL: https://www.cleveland.com/metro/2017/03/license_suspensions_disproport_1.html.

with getting around by bus.”³⁸

19. Before deciding to close Good Samaritan Hospital, Premier Health Partners listed birth outcomes in “Good Samaritan’s Community Health Improvement Strategies for 2017-2019.”³⁹ Birth outcomes is listed as one of the top three priorities for Premier with the focus on the zip codes surrounding Good Samaritan Hospital. Premier Health Partners thus knew that the closure would harm the surrounding community’s maternal and infant health rather than improving it.

Emergency Care

20. Good Samaritan Hospital operated a large and busy emergency room. In 2015, 64,884 people were treated there. In 2016, 78,621 were treated and in 2017, 71,621 were treated and of those, 9,866 were admitted to the hospital after treatment.⁴⁰ The emergency room had 50 beds. In 2017 Dayton fire and emergency medical services alone brought 4,400 patients to the Good Samaritan Emergency Room.⁴¹ Other EMS services also serve that emergency room. These 71,000 patients will need to be treated elsewhere and travel significantly farther to be treated. Furthermore, the hospital emergency rooms the patient will have to travel to are already over-crowded.
21. Among the patients going to the GSH Emergency Room (ER) are those with heart attacks, strokes, serious injuries and drug overdoses. In each of those situations every minute counts. With heart emergencies, “time is tissue, the faster a patient gets to a hospital for treatment the more quickly a patient is treated in a hospital, the better the outcome.”⁴² Moreover, the rates of these conditions are higher for the Black population than White population in the area serviced by the Hospital. The heart disease death rate per 100,000 is 178.7 for Whites and is 235.8 for Blacks. The stroke death rate for Whites is 41.1 but 55.5 for Blacks, and the homicide death rate is 3.2 for Whites but 27 for Blacks.⁴³ In the same year as the closing of the hospital, Public Health - Dayton and Montgomery County reported that there are, “staggering health disparities within predominantly Black communities in Montgomery County Ohio, with Black residents shouldering a higher disease and premature mortality burden than their White counterparts.”⁴⁴
22. With the closure of GSH, the closest emergency room is at Grandview Hospital, which is part of the Kettering Network and 2.5 miles away. It is half the size of Good Samaritan’s ER, according to Rebecca Lewis, the CEO of Grandview. It has 25 beds, treated 37,600 people in 2017, and is “pretty much at capacity.”⁴⁵ While Grandview has increased the size of its ER from 25 to 50 beds, the result will still be 25 fewer beds than had existed at the two hospitals. Grandview also has a limited number of inpatient beds. More ER patients will result in more patients who, in order to receive continuing inpatient treatment, will need to be transferred to a different hospital. Because Grandview is part of the Kettering Network, insurance carried by previous patients of Good

³⁸ Health Policy Institute of Ohio at 52.

³⁹ Good Samaritan Hospital Community Health Improvement Strategies for 2017-2019.

⁴⁰ Ohio Department of Health. Annual Hospital Registration and Planning Report - Statistical Information. January 1, 2016 - December 31, 2016.

⁴¹ “Good Samaritan Hospital Closing: Ambulance Rides Will Cost More.” *Dayton Daily News* (Feb., 1 2018). URL: <https://www.daytondailynews.com/news/good-samaritan-hospital-closing-ambulance-rides-will-cost-more/f6PpqT5JdmsnBRD5rAB4XI/>.

⁴² Ibid.

⁴³ JSI Research & Training Institute, Inc. “Community Needs Assessment and Recommendations to Address Social Determinants of Health in Selected Zip Codes in Dayton and Montgomery County.” (Feb. 27, 2018), p.36. URL: <https://www.phdmc.org/epidemiology/special-reports/850-social-determinants-of-health-jsi-report/file>.

⁴⁴ Ibid.

⁴⁵ Telephone interview with Rebecca Lewis, CEO of Grandview Medical Center, Apr. 30, 2018.

Samaritan Hospital, which is part of the Premier Health Network, may not be compatible. This leads to patients receiving care from out-of-network providers which can potentially create an avalanche of debt and possible medical bankruptcy. Equally, since Grandview does not have a maternity ward, all babies and new mothers will need to be transferred for that care. According to Dr. Matthew Noordsij Jones, “Any transfer to another hospital, no matter how carefully done, adds risk to the patient.”⁴⁶

Chronic Care

23. The closing of the GSH will also have a significant impact on the ability of people to get care for chronic conditions. As highlighted above, many chronic conditions are more prevalent in the Black community, again amplifying the effect of the closing on that particular community. Patients saw pulmonary, cardiac and other specialists at Good Samaritan Hospital. They also went there for diagnostic, laboratory, imaging and rehabilitation. The effect of the closing of the hospital and the attendant doctors’ offices, clinics, and laboratories will be compounded by the fact that the neighborhood already has a shortage of medical offices.⁴⁷ When the Five Rivers Health Centers conducted focus groups for residents of the Good Samaritan neighborhood in March of 2018 residents identified “the shortage of doctors in our area” and “transportation” as the biggest challenges to getting health care services.⁴⁸ Before deciding to close Good Samaritan Hospital, PHP also listed chronic care in their “Community Health Improvement Strategies for 2017-2019.” It acknowledged the prevalence of chronic conditions in the area around the hospital and listed chronic care improvement as one of its three top priorities.⁴⁹ This demonstrates that PHP knew the impact of its closure of the hospital on chronic care would be significant.

STATE ACTION

24. When the decision to close the hospital was announced in January 2018, local public officials expressed shock and dismay. Former Dayton Mayor Nan Whaley described being deceived by PHP, saying that the City “even had asked in the fourth quarter [of the previous year] were they [Premier] making this consideration” but was told “no,” only to be notified four hours before the news became public.⁵⁰ However, unlike mayors in other Ohio cities that experienced hospital closures, Mayor Whaley did not attempt to create an emergency ordinance, a court injunction on the property, or to legally delay or negotiate that another healthcare provider could purchase the facility. For example, after the announcement of the closure of Affinity Medical Center in February 2018 (one month after GSH) by Quorum Health Network, Stark County Pleas Judge Chryssa Hartnett issued a temporary restraining order by the physicians of Affinity and city officials. Eventually the City of Massillon purchased Affinity Medical Center for \$1. In Cleveland, Ohio, Mayor Frank Jackson sued Cleveland Clinic when they announced the closure and demolition of Huron Hospital in 2011, though he was not successful. Recently in Chicago, the city and community leaders successfully stopped the closure of Mercy Hospital.⁵¹ When the CCC filed the HHS Federal complaint, Mayor Whaley asked PHP to delay the demolition until after the government’s investigation concluded.

⁴⁶ Affidavit of Dr. Matthew Noordsij-Jones.

⁴⁷ An environmental scan of the Montgomery County Safety Net, prepared for the Montgomery County Affordable Care Act Task Force by the Health Policy Institute of Ohio (Oct. 2013), p. 30-31.

⁴⁸ Five Rivers Health Centers Focus Groups, March 2018, Summary of Results.

⁴⁹ Good Samaritan Hospital Community Health Improvement Strategies for 2017-2019.

⁵⁰ Kim Allen. “Mayor Whaley: City Caught Off Guard by Good Samaritan.” *WDTN.com*. URL: <https://www.wdtn.com/news/mayor-whaley-city-caught-off-guard-by-good-samaritan-closure/>

⁵¹ Jamie Nesbitt Golden. “Mercy Hospital Sale Finalized Saving the Bronzeville Hospital from Closing.” *Block Club Chicago*. (April 5, 2021). URL: <https://blockclubchicago.org/2021/04/05/mercy-hospital-sale-finalized-saving-the-bronzeville-hospital-from-closing/>.

25. Elected officials for the County and Ohio state also appeared to have few tools to prevent or respond. Montgomery County Commissioner Dan Foley asked whether there were ways for Premier to repurpose the site, rather than destroy the buildings.⁵² County Commissioner Debbie Lieberman acknowledged the harm the closure would cause but conceded to understand the business rationale. Representative Mike Turner, a member of Congress whose district includes northwest Dayton, followed suit: “I look forward U.S. Senator Sherrod Brown, in a visit to Dayton, responded to community pleas by admitting, “I don’t know what to do.” to working with them on their plans for the future at this site and their other hospital locations.”⁵³ Amid regular community protests, demonstrations, letters and public outcries, GSH closed its doors on July 23, 2018, six months earlier than they had announced. As a response, Representatives Jim Butler and Fred Strahorn sponsored a bill in the Ohio legislature (H.B. 780) that would require any network seeking to demolish a hospital to pursue all reasonable paths to its continued operation as a hospital. The bill gained no significant traction among lawmakers, however.
26. In the aftermath of the murder of George Floyd in 2020, the city and county within which the hospital was located declared racism to be a “public health crisis,” joining many local and federal agencies. Despite this, the concrete steps toward addressing racial disparities in health access and outcomes remain inadequate. As recently as October 2021, the CCC put forward a grant proposal to the city to obtain funds from the American Rescue Plan Act (ARPA) which was funded by the federal government’s COVID relief package. The CCC’s grant request was to support an impact and needs assessment of healthcare in the tract area hardest hit by the loss of GSH. The CCC argued that a needs assessment was never performed by Premier Health Partners prior to the announcement, closure and demolition of GSH. The funds from ARPA, were earmarked for healthcare to the City of Dayton as a federal grant. The CCC’s grant entitled “We Need a Hospital Impact Study and Hospital Plan for the Creation of a New Hospital at 2222 Philadelphia Ave, Dayton, Ohio,” was rejected by the decision makers of the City of Dayton.
27. Premier’s latest plan for the former hospital site is a public-private partnership between Phoenix Next, Premier Health Partners, the YMCA, Wright State University, CareSource, Easter Seals, and Goodwill. This site proposal was recently ratified by the City of Dayton Planning Committee and supported by the City of Dayton. However, the plans for an urgent care, physical therapy, lab services, medical imaging, and physician office space do not measure up to the scale of need left by the closure of a fully functional hospital facility with an ER and comprehensive maternity and infant services, along with 24-hour services. Moreover, the \$15 million promised to this initiative by Premier Health Partners is insufficient to address the damage caused.⁵⁴ The City of Dayton has also pledged matching funds in a later phase of the redevelopment project.⁵⁵ As of July 2022, four years since the closing and over two years into a global pandemic, there remains no effective access to a comprehensive health care facility to replace what was lost to the community on the northwest side of Dayton.

⁵² Kaitlin Schroeder. “Why Can’t Good Sam Buildings be Saved?” *Dayton.com*. (July 30, 2018). URL: <https://www.dayton.com/business/why-can-good-sam-buildings-saved-hospital-leaders-weigh/iH8dsXwU1Gk1ryuqXexgl/>.

⁵³ John Bush. “Local Leaders React to Dayton Hospital Closure.” *Dayton Business Journal*. (January 17, 2018). URL: <https://www.bizjournals.com/dayton/news/2018/01/17/local-leaders-react-to-dayton-hospital-closure.html>.

⁵⁴ The current plan includes an urgent care, medical imaging and physicians offices, a community wellness center, and a range of social service organizations. For plans as of June 2022, see <https://daytonphoenixproject.org/wp-content/uploads/2022/06/NW-Health-and-wellness-boards-062022.pdf>.

⁵⁵ Aliah Williamson. “Premier Health, City of Dayton Plan \$30M Redevelopment Project fo Former Good Samaritan Hospital Site. *WDTN.com*. (July 21, 2021). URL: <https://www.wdtn.com/news/premier-health-city-of-dayton-plan-30-million-redevelopment-project-for-former-good-samaritan-hospital-site>

OBLIGATIONS UNDER INTERNATIONAL HUMAN RIGHTS LAW

28. The United States of America ratified CERD on October 21, 1994. Article 5 of the Convention stipulates its authority over issues addressed in this report: “(e) Economic, social and cultural rights, in particular: (iv) The right to public health, medical care, social security and social services.”
29. Pursuant to the provisions of CERD contained in Articles 2 and 5 (e) (iv), the closure of the Good Samaritan Hospital results in racial discrimination through the lack of effective access to affordable and adequate health care services for the African American community in northwest Dayton, and well below what is offered to more affluent White neighborhoods. Government actors were aware of historic, present, and persistent disparities based on race already impacting the community, but took insufficient action to satisfy their obligations to protect residents from the further discriminatory impact of this event. Specifically, they have not used “all appropriate means” to eliminate racial discrimination in the health sector and have fallen short of the additional requirement to remedy racial disparity, including through the implementation of “special measures.”
30. In its 2014 Concluding Observations, the Committee refers explicitly to subcategories of access to health care contained in this report in Paragraph 15: “It also reiterates its previous concern at the persistence of racial disparities in the field of sexual and reproductive health, particularly with regard to the high maternal and infant mortality rates among African American communities.”
31. Leading up to the 2022 CERD round, the List of Themes issued by the Committee contains particular mention of discriminatory practices in the health care sector in Paragraph 18: “Measures to ensure that all individuals, including those belonging to racial and ethnic minorities, Indigenous Peoples and migrants, have effective access to affordable and adequate health-care services. Further measures to address the persistence of high maternal and infant mortality rates among racial and ethnic minorities and to ensure access to health and reproductive health services without discrimination.”
32. The closure and demolition of a hospital in an area already widely acknowledged to be suffering from the impacts of racial segregation would clearly have a multiplying negative effect on the enjoyment of the right to effective access to health care on an equal footing by the majority Black community of Dayton. Evidence of wide gaps in health outcomes along racial lines were well recognized by Premier Health Partners, Public Health - Dayton and Montgomery County, and other state and local authorities. The segregation and poverty facing this particular community is a result of well documented historical and ongoing racial discrimination by private actors protected by public policies, such as redlining, restrictive covenants, and predatory lending. Government at all levels is responsible for the discriminatory impact of actions of private actors. The State is obligated to put in place proactive and supportive measures to remedy persistent inequalities and should have sought to prevent the closure of a main source of health care access for a marginalized community or to provide a suitable remedy to meet the health needs of this community already suffering from inequitable health outcomes.

Segregation and the Legacies of “Redlining”

33. As indicated above, the historic legacies of redlining policies in the housing and banking sectors create the context within which the hospital closure results in racial discrimination. Redlining is a contemporary form of segregation that was not ended *de jure* until 1968, while persisting in practice to this day. For example, in 2016, Black applicants for a home mortgage were over twice as likely to be denied as White applicants in Dayton, Ohio controlling for a range of financial and personal

variables.⁵⁶ The Committee has recognized the role that historic discrimination around housing plays in contributing to unequal conditions with human rights implications in the present.

34. The Committee has interpreted the extent of state obligation under Article 3 in General Recommendation 19 as encompassing segregation that arises from “residential patterns [...] influenced by group differences in income, which are sometimes combined with differences of race, colour, descent and national or ethnic origin.” This description is intended to broaden segregation that emerges as “an unintended by-product of the actions of private persons” as well as “created by governmental policies.” Redlining was, in fact, an intentional by-product of actions of private persons working in concert and through governmental policies. Further, the document “affirms that a condition of racial segregation can also arise without any initiative or direct involvement by the public authorities,” thereby explicitly identifying the role of private actors in bringing about and perpetuating segregation.
35. Moreover, in its 2014 Concluding Observations, the Committee writes on “Discrimination and segregation in housing,” linking it as a structural barrier for individuals from racialized minority groups to accessing a broader range of rights: “While acknowledging the positive steps taken by the State party to address discrimination in access to housing and to reverse historical patterns of segregation, the Committee remains concerned at: (a) the persistence of discrimination in access to housing on the basis of race, colour, ethnicity or national origin; (b) the high degree of racial segregation and concentrated poverty in neighbourhoods characterized by sub-standard conditions and services, including poor housing conditions, limited employment opportunities, *inadequate access to health-care facilities*, underresourced schools and high exposure to crime and violence; and (c) discriminatory mortgage-lending practices and the foreclosure crisis which disproportionately affected, and continues to affect, racial and ethnic minorities (arts. 3 and 5 (e))” (emphasis added).

Role of public and private actors

36. Upon ratification, the U.S. government included a reservation that explains its view of its obligation in the area of access to health care: “To the extent, however, that the Convention calls for a broader regulation of private conduct, the United States does not accept any obligation under this Convention to enact legislation or take other measures under paragraph (1) of Article 2, subparagraphs (1)(c) and (d) of Article 2, Article 3 and Article 5 with respect to private conduct except as mandated by the Constitution and laws of the United States.”
37. The health care system in the United States, even when controlling for the 2010 passage of the Affordable Care Act that expanded the government’s role in increasing access to health care, remains primarily reliant on private provision. In 2020, 67% of health insurance coverage was private and 55% was employer-based.⁵⁷ Nationwide, African Americans are more likely than White people to be uninsured with comparative rates of 11.4% and 7.8% in 2019.⁵⁸

⁵⁶ Katie Wedell. “Modern Redlining: Racial Disparities in Lending Persist in Dayton.” *Dayton Daily News*. (February 24, 2018). URL: <https://www.daytondailynews.com/modern-redlining-racial-disparities-lending-persist-dayton/>.

⁵⁷ Katherine Keisler-Starkey and Lisa N. Bunch. “Health Insurance Coverage in the United States: 2020.” US Census Bureau. (September 14, 2021). URL: <https://www.census.gov/library/publications/2021/demo/p60-274.html>.

⁵⁸ Samantha Artiga, Latoya Hill, Kendal Orgera, and Anthony Damico. “Health Coverage by Race and Ethnicity, 2010-2019.” Kaiser Family Foundation. (July 16, 2021). URL: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>

38. In a mixed system relying mostly on private provision of health care access, for the U.S. to carve out an exception for private actors undercuts the object and purpose of the Convention in relation to the right to effective access to affordable and quality health care and its obligation to protect against racial discrimination. In this case, the private actor is a non-profit health provider receiving federal tax breaks. In its 2014 Concluding Observations, the Committee commented on this deficit, urging the U.S. to: “Consider withdrawing or narrowing its reservation to article 2 of the Convention and broaden the protection afforded by law against all discriminatory acts perpetrated by private individuals, groups or organizations” (C.5.b.).
39. Prior to 2014, the Committee had expansively defined state obligation as inclusive of the responsibility to protect individuals from actions taken by private actors in regards to racial discrimination. In General Recommendation 20, Paragraph 5 stipulates that, “To the extent that private institutions influence the exercise of rights or the availability of opportunities, the State party must ensure that the result has neither the purpose nor the effect of creating or perpetuating racial discrimination.” Furthermore, in General Recommendation 32, the Committee broadly interprets the word “protection” in Article 1, Paragraph 4 of the Convention to be understood as “[signifying] protection from violations of human rights emanating from any source, including discriminatory activities of private persons, in order to ensure the equal enjoyment of human rights and fundamental freedoms. The term ‘protection’ also indicates that special measures may have preventive (of human rights violations) as well as corrective functions” (IV.a.23). In this regard, the closure by the private actor of the only hospital in this Black community constitutes a failure on the part of the government to protect the human rights of its residents under CERD.

“Special Measures”

40. An additional legal obligation in this situation stems from the Committee’s understanding of language in Article 1 Paragraph 4 and Article 2 Paragraph 2 of the Convention that establishes the imperative as well as the limits of the use of “special measures” taken by State Parties. The Convention text sets out the need to remedy persistent inequality by using “special measures” “when the circumstances so warrant, take, in the social, economic, cultural and other fields, special and concrete measures to ensure the adequate development and protection of certain racial groups or individuals belonging to them, for the purpose of guaranteeing them the full and equal enjoyment of human rights and fundamental freedoms” (Art. 2, Para. 2) without creating separate categories of rights holders disadvantaged by said measures.
41. General Recommendation 32 contains extensive discussion of these issues beginning with the notion of equality itself: “The principle of equality underpinned by the Convention combines formal equality before the law with equal protection of the law, with substantive or de facto equality in the enjoyment and exercise of human rights as the aim to be achieved by the faithful implementation of its principles.” With respect to the latter, “special measures” captures the lengths states can and should go in order to ensure full enjoyment for all. This broadens the conventional understanding of racial equality in the United States by focusing attention on outcomes and consequences.
42. Coupled with “special measures” is the concept of “adequate advancement,” which General Recommendation 32 also defines expansively as “[implying] goal-directed programmes which have the objective of alleviating and remedying disparities in the enjoyment of human rights and fundamental freedoms affecting particular groups and individuals, protecting them from discrimination. Such disparities include but are not confined to persistent or structural disparities and de facto inequalities resulting from the circumstances of history that continue to deny to vulnerable groups and individuals the advantages essential for the full development of the human personality. It is not necessary to prove ‘historic’ discrimination in order to validate a programme of special

measures; the emphasis should be placed on correcting present disparities and on preventing further imbalances from arising.”

43. Moreover, in its 2014 Concluding Observations, “The Committee reiterates its previous recommendation (para. 15) to adopt and strengthen the use of special measures, which is an obligation arising from article 2, paragraph 2, of the Convention, when circumstances warrant their use as a tool to eliminate the persistent disparities in the enjoyment of human rights and fundamental freedoms, based on race or ethnic origin.” Taken together, in this situation, the State should have taken specific and robust policy and programming action to redress racial disparities in effective access to health care and health outcomes in the Black community in west Dayton in order to alleviate the sources of racial inequality and all consequences emerging therefrom.

Recommendations

44. Consistent with the imperative of Article 6 of the Convention on the obligation to “assure to everyone within their jurisdiction effective protection and remedies,” this section contains recommendations. Furthermore, General Recommendation 26 interprets Article 6 to include “the right to seek just and adequate reparation or satisfaction for any damage suffered as a result of such discrimination...and other competent authorities should consider awarding financial compensation for damage, material or moral, suffered by a victim, whenever appropriate.”
45. Government authorities should conduct a comprehensive impact and needs assessment in the geographic area surrounding the former site of the hospital, to determine how the closure has affected health outcomes and the economic condition for impacted communities and to inform the future plan for a hospital in that or an equally accessible location. Plans for a new health care facility should be undertaken through extensive consultation with the community, and community groups, such as the CCC, should approve plans as meeting the community requirements.
46. The healthcare services lost through the closure must be restored to meet the needs of the community and that are also sufficient to address the structural health inequalities that have existed for far too long. Each of these services must be provided at a scale appropriate to meet the needs of the community and redress inequality. This scale should be determined by a measurement against other comparable healthcare sites, populations, and demographics.
47. A new healthcare facility built at this or another site should uniquely take as its mission to target and combat chronic and prevalent diseases and illnesses which plague racial and ethnic minorities and low-income communities, many of which are disproportionately higher in many ways due to overt and/or systemic racism and neglect. Areas of specialty to address these concerns would include, but are not limited to: mental health, maternal health, infant mortality, oncology, cardiology, pulmonary, neurology, nephrology, high blood pressure, diabetes, and stroke care. Measures should include the intentional hiring of African American and other minority doctors and health care specialists commensurate with the makeup of the community to tailor services and treatment to the specific needs of this community.
48. Programs and services in this facility would not only treat illnesses and trauma, but also provide wellness services and programs designed at proactively treating and educating citizens how to reduce and/or avoid these chronic and lethal illnesses. Minimum requirements of the facilities must include, but are not limited to:
 - Emergency/trauma department
 - Mental health programs and services
 - Intensive Care Unit (ICU)

- Urgent Care
- Diagnostic Laboratory
- Imaging Center
- Outpatient Obstetrics clinic (LifeStages or similar)
- Birthing Center – prenatal and neonatal care
- Primary Care offices/clinics
- Outpatient specialty offices in oncology, cardiology, pulmonology, neurology, and nephrology
- Physical therapy
- Prevention/wellness programs
- Hospital beds as needed to support the above services, as well as to sustain patients through all stages of their health care needs until they are deemed able to return home, be moved to another healthcare facility or rehabilitation center.
- All insurances are to be accepted by this facility, including but not limited to: CareSource, Medicaid, Medicare, self-payers, and those who do not carry insurance.

49. The full scope and scale of the impact of the closure on this community are measurable and financial compensation is essential for “effective protection and remedies” and “adequate reparation or satisfaction for any damage suffered as a result of such discrimination,” as the Convention stipulates in Article 6. Governmental authorities must begin a process to assess the damage of the closure for the purpose of arriving at economic restitution. Premier Health Partners must be a central actor as a responsible party and the CCC could serve as key partner and community liaison. These steps are crucial for offering redress for the impact of this particular decision while beginning to correct historic abuses that set the stage for the racial discrimination the community of northwest Dayton experiences today.

50. Local government should commit to upholding international human rights norms and establish mechanisms for their implementation in Dayton, Ohio. Putting a human rights process in place can assist in the prevention of further harm and the protection of the economic, social, cultural, civil and political rights of all Dayton residents to the extent possible within local authority, including redress for and protection from racially discriminatory impacts.