Health disparities in Chicago and the work to solve them with RUSH University Medical Center [Podcast]

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Health disparities in Chicago and the work to solve them with RUSH University Medical Center

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From RUSH University Medical Center, President and CEO Omar Lateef, DO, and David Ansell, MD, MPH, senior vice president of community health equity, join to discuss Chicago’s health disparities and how RUSH is partnering with the community to solve them. AMA Chief Experience Officer Todd Unger hosts.

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Speakers

- Omar Lateef, DO, president, RUSH University Medical Center
- David Ansell, MD, MPH, senior vice president of community health equity, RUSH University Medical Center

Transcript

Unger: Hello and welcome to the AMA Update video and podcast. Today, we're talking about how one academic health system is addressing health disparities, both within and beyond its hospital walls. Here with me today in our Chicago studio are two physician leaders from RUSH, Dr. Omar Lateef, president and CEO, and Dr. David Ansell, senior vice president for Community Health Equity for RUSH University Medical Center. I'm Todd Unger, AMA's chief experience officer. Welcome, Dr. Lateef, Dr. Ansell. How are you doing today?
Dr. Ansell: Good. Thank you for inviting us.

Unger: Well, it's the first time we've ever had three people in our studio, so we're breaking a record here. And thanks for joining us. It's great to have you today. Really excited to talk with you about your work in health equity and at RUSH. Dr. Lateef, let's start with you. You started as a fellow at RUSH the better part of 20 years ago, and now I've assumed your role about a year ago as president and CEO.

Just to kind of kick us off, I'm curious, in that period of time of your journey, at what point did you realize the traditional methods and kind of the container of the hospital and the health system was not going to be enough?

Dr. Lateef: I think that—so my career evolved in working in an intensive care unit under sort of the mentorship of Dr. Ansell, who was a prominent leader in showing that patients had different outcomes from the same disease. And you would see it first hand sometimes working in an ICU, and you'd see it first hand sometimes working in health care.

The challenge is, we all see it, and articles would come out over and over again. It's not new to talk about inequity in health care. I think one of the things that we talked about at RUSH was, at some point, we should stop presenting articles about how it exists and start figuring out how to change it. And I was fortunate enough to be part of a team that engaged in that movement.

And seeing it firsthand, of people saying, look, if you're an African American woman with breast cancer, you're going to have a worse outcome than a Caucasian woman, there were paper after paper being published about it, but very little work being done to solve it. Dr. Ansell and his team worked together with different hospitals and health care systems all across Chicago to sort of work for solutions.

And when you see it work, you realize that the solutions weren't necessarily building a bigger ICU, but building more access or figuring out what was at the root cause of people not knowing how to get access. Seeing it firsthand and then seeing that it's possible to make a change is a self-fulfilling motivational project that we were able to get on board in our institution.

Unger: Curious. I think one of the things that I've seen you talk about is this issue of the death gap in Chicago. It's really an underlying indicator of just that level of disparity. Talk a little bit about that.

Dr. Lateef: Yeah. Where you live or where you're born should not dictate how long you live. And I would probably make the argument that not just in every city in America, but every city in the world, has a death gap based on the social structure of that community. I'll say this sort of many times during the course of this conversation. In Chicago, many teams have showed that if you're born along the Gold Coast, you live 16 years longer than if you're born a couple subways, several subway stops west, just five subway stops west.
The fact that you can have the same diseases with different outcomes in the same city, in the most developed nation in the world, with unprecedented phenomenal technological health care, is something that nobody should be proud of. It's in fact something we should align our resources to solve.

Once you do the analytics around it, you realize that people aren't dying from things like acute violence, which is the knee-jerk reaction to say this is why people are dying in certain communities. People are dying from hypertension, uncontrolled diabetes, and we know how to treat those diseases. So we should be able to extend the treatment of what we know how to treat to the people that have those diseases.

It didn't take long for anyone in health care to realize it takes more than giving a diabetes medication to help someone's blood sugar. It takes access to healthy foods. It takes access to affordable foods. It actually takes people having resources to buy healthy food. So that's where you get into the social determinants of health, things like getting good jobs, things like getting good community opportunities to get better access to health care.

Once we realized all that, we put programs together strategically designed to tackle those specific challenges. And then you see results, and that's where you start to feel like this is something more than just talk. How do you transition into action? But I would feel disingenuous talking about it when the author of the death gap is sitting next to me. So David, what are your thoughts?

Dr. Ansell: Yeah. Well, I had worked before coming to RUSH as the inaugural chief medical officer to other prominent health systems, safety net health systems, in Chicago. Cook County Health was there for 17 years, and Omar and I have in common having worked at two of the great public hospitals in this country, Omar at Bellevue, and Sinai Health System, the largest private safety net system in Chicago.

Now I'm the inaugural chief medical officer at RUSH, and a little bit, I walked into RUSH. What just happened? What was this last 30 years about? My patients came with me who had been mine, some of them from my internship at County. So through my patients, I began to understand, just like Omar in the ICU, I began to understand why are the diseases in my patients so complicated and so difficult to treat.

And then there was something about the neighborhoods in which they lived in that was causing them to be harmed, and I didn't understand it because the biomedical model that I was trained on didn't make sense to me. So along the way, I'm at RUSH now. I'm saying, what just happened led me to write The Death Gap: How Inequality Kills, because it was through my experience, personal experience with my patients.
But then I'm a social epidemiologist as well. Why is it in West Garfield Park now today, literally seven train stops, L stops from where we're sitting right now, life expectancy is 66? And if that were a county in the United States, it would be the lowest life expectancy County—think Pine Ridge Reservation—whereas where we're sitting right across from Trump Tower, life expectancy here is around 85, and if we were a country, we'd be first in the world.

So something is going on, and it's a different problem than I was taught to solve in medical school, or even that I had to solve when I was chief medical officer. And so as we at RUSH—it's one thing to have those experiences individually within communities, or as doctors and nurses taking care of these patients. It's another thing for an organization to sort take this on as a problem that we needed to solve. And when I got to RUSH, the problem we needed to solve was, RUSH's goal was to be the best in health care.

And arguably, on metrics and measures of quality, we're always among the top in the country and in the world in quality. And yet, as Omar mentioned, people are literally dying outside of our doors of common problems. And that change, of changing our mission to improve the health of the populations we serve, led us on this new strategic direction, which by the way, we didn't have to do.

Most institutions have not done it. We did it way before COVID hit. COVID opened everyone's eyes to the world of how structural inequities kill people. But we embarked on it because we changed our mission, and that led us to really think about what would it take to solve for the death gap.

**Unger:** Now, in your book you have a very interesting framing about inequality. And I've heard—we talk about addiction as a disease, but I've never heard of what you say in there, which is that inequality is a disease, and we need to treat it and eradicate it as we would any major illness. Tell us a little bit about how you came to that framing and why you think that way.

**Dr. Ansell:** Well, here I am a doctor. I did everything in an academic career. I was head of a division of general medicine, of a department of medicine, an inaugural chief medical officer, working within the medical model, which is important. I don't want to minimize how important great health care is. But the fact of the matter is, you have to always look for the root cause of the disease or the root cause of the problem, because if you don't get to root causes, you can never really adequately solve it. And there's not one, but there tend to be seven or eight key root causes. And as I began to think about putting together the connections between my patients and their experiences, being at these three different health systems and understanding that there was structural inequality, the care I could deliver at RUSH was much different than the care that could be delivered at County or Sinai, but not because of the doctors or the patients, because of structural capabilities.

And it became clear to me that the root cause—I think about malaria, for example. Malaria, the female Anopheles mosquito transmits the malarial parasite, and no eradication of malaria can be addressed...
without having a plan for the mosquito. So I began to think what was the mosquito here was inequality itself, is the problem we have to try to solve for. And it's not to say we're not ever going to eradicate inequality, but if we can narrow the gap—and it's not just health gaps. They're wealth gaps.

And if we can begin to think about strategies, as a giant employer, as a big institution, as a moral leader, not around health—we might begin to find solutions to inequality. And what I said, exactly, inequality, we need to consider that inequality is like an epidemic, and we have to eradicate it like we would any virus. That's what I said in the book, and that became—if we wanted to solve that problem, how would you build a strategy?

**Unger:** Dr. Lateef, I want to talk a little bit more about this issue around root causes. You did a kind of a community assessment back in 2016 or so and launched a health equity strategy for RUSH. Talk to us a little bit about what you learned in that assessment, in that report, about the root causes, and then how that drove your framework for a strategy moving forward.

**Dr. Lateef:** Yeah, I think this is an important conversation. I don't think the root causes are a mystery. I think Dr. Ansell just spent some time talking about some of the root causes, which are really wealth inequity, and gaps between haves and have-nots, and access to resources. I think a couple sort of key facts that we went on our learning, and a couple sort of key points I'd like to make about next steps—what we learned is, there wasn't a tremendous amount of trust between traditional health care organizations and community leaders.

And one of the things that we realized very early in this process was that you can't go into a community and start talking about the changes you're going to make without the community understanding what changes you're going to make and why, and you had to do it together. And if you spoke, and then you didn't make the changes, you would very rapidly lose community trust and lose the ability to make a change.

So this comes by tabling egos and saying we're going to partner and learn what are the problems we're trying to solve, agree on a list of prioritizations, and then go forth and solve those. I think David made the point that many health care institutions today aren't doing this work, and I want to talk about why that is, because that's what communities are frustrated by as well.

It turns out that you can take any disease that exists today, just about any disease, and show that there's a different outcome based on racial lines and economic lines. And it turns out when you do that, you can publish that paper. And it turns out when you publish a paper, you can get invited to two different places, some very famous, and go present those papers.

That becomes very lucrative and self-fulfilling. However, if you try to solve that problem, which is, people have a different outcome with this disease and this disease, it entails investing significant amount of resources with a lower return than other things health care institutions can do with those resources.
resources.

So this is a scenario where actions speak louder than words. When we went on listening tours or communities, what we heard from communities are, everybody says the right thing. Where are the actions behind this? You can embark on a journey like this without putting together tangible plans and delivering on those plans.

Otherwise, you'll lose the support of the community. And I think that the challenge for health care moving forward is to stop talking about the inequity, stop publishing articles on the different outcomes in just about every disease, stop funding that research and accepting that research is well shown. It exists everywhere. Assume that it exists in every city, and stop trying to prove it over and over again. And we don't need another book on the death gap in every city in America. What we need is, how are there targeted systemic plans to reverse the death gap. And that's what the community will tell you when you go talk to them.

Unger: Really interesting. And I know to execute a strategy like that, it's a lot of money, as you were talking, and a big part of what you've been able to do. And I think in your article, you talked about as kind of an anchor strategy, but is to bring on the partnerships that you've talked about, one of those, obviously, with the AMA. Can you talk to us a little bit about how important partnerships are, in general, and the work with the AMA?

Dr. Ansell: I can talk about it. When we started this and said, well, what would we do—well, when we named the root causes in our community health needs assessment, and we did do listening tours, as Omar said, and we said, among the root causes were structural racism and economic deprivation, we didn't even say poverty, because we wanted to be clear about roots.

And people are working. They're just not making enough to live. We actually looked at our own employees along the same L tracks, and we realized if you lived in Garfield Park, and you're employed at RUSH, you were less likely to be saving in your retirement, and you're more likely to experience economic distress. So we understood we needed to solve this inside and outside.

When we began to think about going outside, we didn't feel like we had the credibility. We'd been there 180 years, but we didn't feel like we had the kind of credibility and the community that Omar talked about. And so we convened hospitals in communities. We did a Malcolm X College in 2017, and just asked a question, this is the problem. We showed the map of the death gap that I described. This is the problem. How do you think that we could work together to solve this?

And the community had a list of things they wanted, support for local businesses, jobs. Our children are feeling hopeless. We don't feel safe in our neighborhoods. Walking around, we want exercise, options. We want healthy food, things that anyone would want. We convened the hospitals in the community into something that now called West Side United.
We didn't make it a RUSH thing. We made it an all of us thing, and we named the West Side of Chicago neighborhood of 500,000 people, mostly because West Side had been ignored. 500,000 seemed like a lot of people to begin to wrap our heads around, 40% African-American, 40% Latinx and 20% white. Very diverse communities.

And we set our sights on what would we do. The institutions themselves that included not just RUSH, Cook County Health, Sinai, U of I, Lurie Children's Hospital and Ascension, would be the largest corporation in the state of Illinois, with about 70,000 employees among all of us, huge purchasing ability, and said, what if we aligned our business units towards building wealth and health on the West Side of Chicago, and then invited the AMA to join.

Unger: And so proud to be partners in this and the impact that we see there. Dr. Lateef, we're talking about two things a lot on the AMA Update recently. One is AI and the other one is value-based care. And I'm really interested to talk about that because you said to really scale something like what you're working on, it does require a larger shift to value-based care. Talk about that. Why is that?

Dr. Lateef: You know, I spent a huge part of my life as a critical care physician, and it's a spiritual and amazing opportunity to be able to take care of patients at the end of life. It's also painful at times to see data that shows how much money is spent on the last 10 days of life, the last one month of life, the last three months of life.

You'll hear that in the total spend in this country, it's as much as half of our total spend on a person's health care is in the last several months or several weeks, or even several days of their life. That doesn't seem logical. It doesn't seem logical that you could, instead of invest in ECMO, which is a phenomenal, phenomenal care technique to take care of critically ill people, that we could perhaps invest in exercise regimens or job programs, or food security programs, which the amount of investment would result in a significantly massive improvement.

We talk about phrases like value-based care, and this country goes through various iterations of risk-based care, and here's a fixed amount of money for a fixed amount of care. These models all work when they're done across a broad population. They fail when we segment out and say we're going to do value based care in this area and not in this area, this area, not in this area.

The whole model works because we have to take the net amount of resources we spend in this country and share those resources across the people that need it. Value-based care will work. It will have to work because we have to extend the amount of care and resources to all people once we agree that health care is a human right.

Getting to that point means different institutions that are siloed have to work together, because what happens now is different institutions have different programs, which segment out a population, which makes value-based care more complicated. The models that show that it improves the health of an
entire community are models that have to be shared by different people that right now are competing against one another rather than working together.

We saw during the pandemic what happens when people take down their walls and work as partners. You can take care of more people at a lower price. That's going to be the next challenge for our nation as we get into value-based care. It's not for RUSH to solve, or any one health care system to solve. It's for all of us in a community to say this is the number of people, these are the resources that we have. How do we best utilize these resources to offer the best amount of care for these communities?

As the AMA pushes research and the envelope around how do we get better care models, I think what has to be part of the larger conversation is, how do we break down the silos of competing health care systems to leverage scale, knowledge and technology across the board.

Unger: That's great. One final question for both of you. As you look to the future, how would you both like to see the health system and the profession evolve? And I think maybe it touches a little bit on what you talked about as we try to resolve these disparities once and for all in the long term. Dr. Ansell, why don't you start?

Dr. Ansell: Well, we've got to start with the realization that the problem we have to solve goes beyond the four walls of a health care institution. That's number one. Number two, it's long term. It can't be solved in a few years, so when you're committing—and because health care institutions are anchored in their towns and cities and rural areas, wherever they are, that they are anchor institutions, and as such have this sort of obligation and ability to influence that life of a community.

And probably, the third thing is that some of the measures, things we have to measure, are some of those structural determinants of health and social determinants and how we can ameliorate them. Right now, our health care system is a sick care system. Imagine a collision shop where you bring the car in and your dents get removed, but really, what you need to do is prevent the crashes. And that's what Omar's talking about, value-based care and scaling it.

We have to think about how do we prevent the crashes and more of our dollars going into that, and that's not just health. It's economic. It's wealth creation as well. So I think that that's it, but it requires long-term commitments and not just a 24-month budget look, and that's hard for health care institutions.

Dr. Lateef: The only point I would accentuate on that is, this is a monumental challenge for an entire community. It's not going to be solved by a health care institution. A health care institution is not going to solve racism as a public health crisis. It's not going to solve inequity. It's going to take the entire community working together, the entire ethos of all the different aspects of health care, to recognize this as a strategic priority.
That doesn’t exist today. And so simply put, there are organizations that have billions and billions of dollars that need to participate with the health care providers in this country to be part of the solution. And so many of those organizations are left out of the conversation right now.

We have to bring everybody together, have comprehensive conversations around it. The technology companies that are working in health care, how can they be part of this solve? Insurance providers, how are they part of this solve? Health care providers, how are they part of this solve? It can’t just be one, because the resources aren’t there for just a individual health care institution to change a death gap that exists in every city in America.

**Unger:** Dr. Lateef, Dr. Ansell, thank you so much for being here. This has been such an interesting conversation, and so impressive just from the laying of the foundation and the data, describing the problem, the shift to action and then seeing it, seeing it happen. It’s such a great example for the nation. Thank you so much. That’s it for today’s AMA Update. We’ll be back with another segment soon. In the meantime, if you to check out any of our podcasts, you can check them out at ama-assn.org/podcasts. Thanks for joining us. Please take care.

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