Reducing Health Disparities Post-Covid-19

With the worst of the pandemic seemingly over, what steps are local health departments and institutions taking to reduce inequities?

By Delia O'Hara

Chicago Medicine's COVID-19 Series

HEALTH DISPARITIES, and our awareness of them, are nothing new, but the disproportionate toll Covid-19 has taken on Black people in our city has raised the urgency among Chicago healthcare leaders to address the crisis. Even before the pandemic, Chicago reported the largest number of excess Black deaths in the country, according to a study in *JAMA Open Network*.

"Inequities are landing all the time, but when people are dying at such different rates from Covid-19, it's more noticeable, even among people who had not thought about this in depth before," says Allison Arwady, MD, commissioner of the Chicago Department of Public Health.

Of the first hundred deaths from Covid-19 in Chicago, 70 were Black people, even though they make up only 30% of the city's population. An early response to this news was the formation of the city's Racial Equity Rapid Response Team (RERRT), whose first job was to partner with grass-roots groups in hard-hit majority-Black communities on the South and West Sides to slow the spread of the virus and improve outcomes.

While that outsize difference in mortality leveled out over time, the Omicron strain, too, took a high toll on Black Chicagoans, only 56% of whom were vaccinated as of March 2022; unvaccinated people have been more than 20 times more likely to die from Omicron. All told, Black people account for about 42% of all Covid-19 deaths in the city.

Among Latinx Chicagoans, deaths overall from the disease nearly track their 29% representation in the city's population. In the early days of the pandemic, Latinx communities, too, saw high numbers of hospitalizations and deaths, but as of early March 2022, 68% of Latinx Chicagoans were fully vaccinated, as were 71% of whites and 78% of Asians, and that helped protect them when Omicron hit in December 2021.

Vaccination hesitancy is complex, but trust plays a role, says Wayne Detmer, MD, chief clinical officer of operations for Lawndale Christian Health Center, a faith-based medical home and Federally Qualified Health Center (FQHC) based on the West Side. He was heartened that the city partnered with community health centers like his in areas where people often don't have a relationship with a hospital, canvassed door-to-door to share information about the vaccines, and prioritized vaccinating people experiencing homelessness, majority-Black neighborhoods and other communities most impacted by COVID-19, through the Protect Chicago Plus initiative. "This made a significant difference for Chicago residents who are often overlooked," Dr. Detmer says.

Taking the time to listen, to understand, "to come alongside as partners," had a positive impact in those communities, he says.

Chicago's Life-expectancy Gap is Getting Worse

Even before the pandemic, nationally, the all-cause mortality rate among Black people was 24% higher than Whites'. Chicago has one of the largest life-expectancy gaps of any city, according to an analysis by the New York University School of Medicine's Department of Population Health. And it's getting worse; the City of Chicago published a "data brief" last year that showed that the difference here has grown from 8.3 to 9.2 years in the past decade. Five causes of death are largely to blame — chronic diseases like cardiovascular disease, cancer and diabetes; homicide; infant mortality; HIV-AIDS, influenza and other infections; and opioid abuse.

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Researchers have spent decades identifying upstream causes of poor health, including inadequate housing, food deserts, poor education, family instability, street violence that traps people in their homes and damages their prospects and mental health, if it doesn't injure or kill them outright, and targeted advertising for such products as junk food and cigarettes.

Meanwhile, the Affordable Care Act began requiring hospitals to complete community health needs assessments every three years, and those serve to highlight geographic areas where people are less healthy.

"We still are quite a segregated city and that means that geography can sometimes be shorthand for race and ethnicity," Dr. Arwady says. Majority-Black areas often have fewer resources, "whether you're talking about grocery stores or safe spaces or clinics."

Responses have actually been underway for years by hospitals and other healthcare institutions, in concert with the city, business community and nonprofit sector, to improve the health and circumstances of Black people and other disadvantaged groups.

In 2016, the city launched Healthy Chicago 2.0, which expanded the traditional public health focus on improving treatment and access to health care, to include housing, education, public safety,

LEFT TO RIGHT: Allison Arwady, MD, commissioner of the Chicago Department of Public Health; Wayne Detmer, MD, chief clinical officer of operations, Lawndale Christian Health Center, a faith-based medical home and FQHC based on the West Side; Brenda Battle, RN, BSN, MBA, senior vice-president for community health transformation at the University of Chicago Medical Center.

economic development, and the built environment. In 2020, that program was replaced with Healthy Chicago 2025, a five-year plan that specifically aims to close the life expectancy gap, with an end goal of "a more just, equitable city."

Building on the RERRT concept, the city also established six "health equity zones," first to direct vaccination efforts, and then to "confront factors that contribute to health and racial disparities," with initial federal Covid-19 funding of $9.6 million.

Hospitals are Collaborating with Community Groups

"When something like Covid hits communities that are already suffering from high rates of diabetes, heart disease, cancer, lung disease, you name it, areas that have high rates of poverty, the impact will be worse than in communities that are better resourced," says Brenda Battle, RN, BSN, MBA, senior vice-president for community health transformation, and chief diversity, equity and inclusion officer, at the University of Chicago (UChicago) Medical Center.

UChicago Medicine, based on the South Side, has deployed an Urban Health Initiative for years, collaborating with neighborhood healthcare providers and other community groups. Patient advocates follow up with people who have been hospitalized, and community health workers hired from the area help coordinate transportation, obtain social services and in general navigate a system that can be bewildering, Battle says. UChicago Medicine also uses the ECHO model to bring specialists' knowledge into a primary-care setting through teleconferences and case-based learning.

During the pandemic, UChicago Medicine convened 12 other South Side hospitals, health systems and FQHCs for the South Side Health Transformation Project to improve the health of Black South Siders. The group is poised to create a new community health organization with funds made available by the Illinois Hospital and Healthcare Transformation Act. Dozens of Chicago healthcare institutions are involved in similar new collaboratives that will address health disparities with state and federal funding.

In 2018, in response to years of community activism, UChicago Medicine reinstated its Level 1 Trauma program. A subsequent study showed that the program has reduced transport times and improved access to care, and hundreds of patients have taken part in the Violence Recovery Program there to address the aftermath of traumatic injury and violence.

By the Numbers

CHRONIC DISEASES like diabetes plus homicide, infant mortality, and opioid abuse, account for the growing gap in life expectancy between Black Chicagoans and non-Black Chicagoans. Here's what the latest numbers reveal:

- **9.2 years** — the gap in life expectancy between Black and non-Black Chicagoans, up from 8.3 years over the last decade.
- **70% higher** — diabetes-related deaths among Blacks compared with non-Blacks
- **9 times higher** — homicide among Blacks, compared with other Chicagoans
- **3 times higher** — the mortality rate for Black infants, compared with non-Black babies
- **3 times higher** — opioid deaths among Blacks, compared with other Chicagoans

Source: 2021 Data Brief / The State of Health for Blacks in Chicago

LEFT TO RIGHT: **David Ansell, MD, senior VP for community health equity at Rush University Medical Center; Trevonne Thompson, MD, associate dean of admissions at the University of Illinois College of Medicine; Clyde Yancy, MD, vice dean for diversity and inclusion at Northwestern University Feinberg School of Medicine.**

"I don't think you can overstate the effects of violence on well-being," LCHC's Dr. Detmer says.

Nearly 800 people were murdered in Chicago in 2021. Most homicide victims are young Black men in poor majority-Black neighborhoods like North Lawndale, but collateral victims are all ages. "You can tell people they should exercise four times a week, but if they're afraid to come out of their homes because of the violence in their communities, that's not going to happen," Dr. Detmer says. LCHC, which works to address the upstream engines of health disparities in addition to providing healthcare services, operates a fitness center to bring physical activity inside for its North Lawndale community, "to give people a chance to come together and live life, which most people in our country experience naturally," Dr. Detmer says.

Committing to the Community

Rush University Medical Center adopted a health equity strategy in 2016. Looking at the neighborhoods in its primary service area of half a million people, leaders saw a 14-year life expectancy gap between the wealthiest, the Loop, and the poorest, East Garfield Park, says David Ansell, MD, Rush's senior vice president for community health equity.

Rush determined to do whatever it took to reduce the gap. Poverty was a core issue; Rush decided to be proactive about helping the poorest residents it serves build personal wealth. Among the largest employers on the West Side, an "anchor" to the community, Rush committed to hire locally and give those employees opportunities for advancement; to hire local workers for capital projects on campus; to buy and source locally; to invest locally and provide retirement savings plans for employees. Other big health systems have adopted this "anchor" approach, too. Rush was also part of the group of area healthcare and civic organizations that created West Side United, a regional racial health-equity collaborative. West Side United was an early partner in the city's RERRT; its goal is to cut the life-expectancy gap in the area in half by 2030.

When Covid-19 hit, Rush invoked the fundamental principles of its health-equity strategy, accepting desperately ill patients from safety-net hospitals, including many Black and Hispanic patients, Dr. Ansell says. The hospital suffered financially from this aggressive approach, he says, but "we had no racial gaps in outcomes." What Covid helped demonstrate is that "we can narrow these gaps and we think we can eliminate them," with an effort both "holistic and community-led," he says.

Increasing the number of Black doctors, and culturally competent White doctors, is also going to be important in engaging Black Chicagoans in the health system, healthcare leaders agree. The University of Illinois College of Medicine (UICOM), with campuses in Chicago, Peoria, Rockford and Urbana, graduates more Black physicians than any other American medical school that is not within a historically Black college or university, says Trevonne Thompson, MD, UICOM's associate dean of admissions. Since 1969, UICOM has operated a program to help underrepresented students not only gain admission but also find support once in school. UICOM's overall goal is to serve the state's diverse population; the Rockford

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campus recruits and trains prospective physicians interested in working in rural areas as well.

"A Balanced Consideration" of Medical Students

In the most recently matriculated class at UICOM, 40% of students reflect groups that are under-represented in medicine, including Black people, Dr. Thompson says. The school looks beyond test scores to assess students in a holistic way, which he defines as "balanced consideration given to experiences, attributes and academic measures, considered in combination with how the individual might contribute value as a medical student and future physician." Everyone benefits from a diverse medical-school environment, learning from one another, he says.

But equity in medical education is just one of the equity goals of the University of Illinois (U of I), Dr. Thompson says. Its Urban Health Program has been working to level health disparities since 1978 "through outstanding education, research, clinical care and social responsibility," he says. Other U of I education programs include applied health, dentistry and nursing.

Northwestern University Medicine (NM) is situated in an affluent white area on the Near North Side, but Clyde Yancy, MD, vice dean for diversity and inclusion at Northwestern University's Feinberg School of Medicine, says Northwestern is working to reduce inequities as well. For one thing, Northwestern has acquired a number of suburban hospitals in recent years that have shaken up the demographics of its client base. And, the system intentionally hires and purchases from vendors in at-risk zip codes; one in four of its medical students, and one in five residents, are now from under-represented minorities; and Northwestern offers enrichment and support to promising younger students through the Northwestern Medicine Scholars Program at Westinghouse College Prep High School in East Garfield Park.

"What we've learned from Covid-19 is that we can do a lot of things better," says Georges Benjamin, MD, executive director of the American Public Health Association (APHA), a UICOM graduate whose Washington, DC-based organization aims to make the United States "the healthiest nation in one generation."

Georges Benjamin, MD, executive director of the Washington, DC-based American Public Health Association, and graduate of the University of Illinois College of Medicine.

Chicago healthcare leaders agree that they have learned a great deal, not only from Covid-19, but also from partnering with communities, prioritizing vulnerable populations, addressing upstream causes of poor health, and other initiatives that will help create a fair and equal healthcare landscape in our city.

"These big medical centers will have done their work if the demographic stays the same while the clinical outcomes improve," Dr. Benjamin says.

Delia O'Hara is a Chicago freelance health and science writer.

Terminology Primer

HERE ARE some of the terms commonly used to talk about the differences in health and healthcare outcomes among different populations of society:

- **Health disparities** — greater disease occurrence and/or worse outcomes among certain population groups than others.
- **Social determinants of health** — the conditions in which people are born, grow, live, work and age. These include the inter-related factors of socioeconomic status, geographic location, housing, education and job opportunities.
- **Social risk factors** — certain adverse social conditions associated with poor health, such as food insecurity and housing instability.
- **Health inequities** — unfair and avoidable differences in health status seen within and between populations. These inequities may be the result of poverty, and/or race, ethnicity, gender, sexual identity, age, disability or other characteristics.
- **Systemic racism** — the web of established procedures and processes throughout society that disadvantages certain groups, particularly Black people.

Sources: Healthy people.gov, US Centers for Disease Control and Prevention, Health Affairs