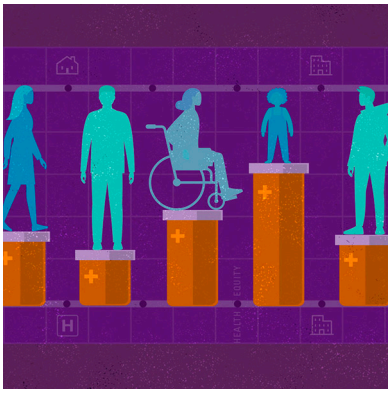
NEJM Catalyst | Innovations in Care Delivery

IN DEPTH

Health Equity as a System Strategy: The Rush University Medical Center Framework



David A. Ansell, MD, MPH, Darlene Oliver-Hightower, JD, Larry J. Goodman, MD, Omar B. Lateef, DO, Tricia J. Johnson, PhD

Vol. 2 No. 5 | May 2021

DOI: 10.1056/CAT.20.0674

Rush University Medical Center adopted a health equity strategy in 2016 in an effort to address the large life-expectancy gaps in its primary service area. The center named structural racism and economic deprivation as among the root causes for neighborhood-based racial health inequities and proposed an organizational anchor mission and equity strategy to begin to address the social and structural determinants of health that underpinned these racial health inequities. A dedicated senior executive team with experience and credibility and support from the board and the civic community are critical to the success of such an initiative. Listening sessions in the community and a commitment to share decision-making with community leaders are foundational to the strategy and necessary to overcome historical mistrust. Rush's community efforts are guided by the voice of the community: "Nothing about us without us."

Despite more than a century of literature documenting racial and ethnic health inequities,[1-5] few health systems have made the achievement of health equity a central pillar of their strategy. The confluence of the disproportionate Covid-19 case and mortality rates in people of color and the murder of George Floyd and the subsequent civil unrest have once again thrust the issue of racial health inequities to the fore. We explain why Rush University Medical Center (RUMC), a Chicago-based academic health system, initiated a health equity strategy in 2016 to address racial health inequities. We discuss: (1) Rush's launching of a health care equity strategy; (2) the creation of the Rush health equity framework, including expansion into the community via the creation of West

Side United (WSU) — a regional racial health equity collaborative aligned with the City of Chicago's Healthy Chicago 2025 public health plan[6]; and (3) the adaptation of the health equity strategy in response to the Covid-19 pandemic and the implications for the future.

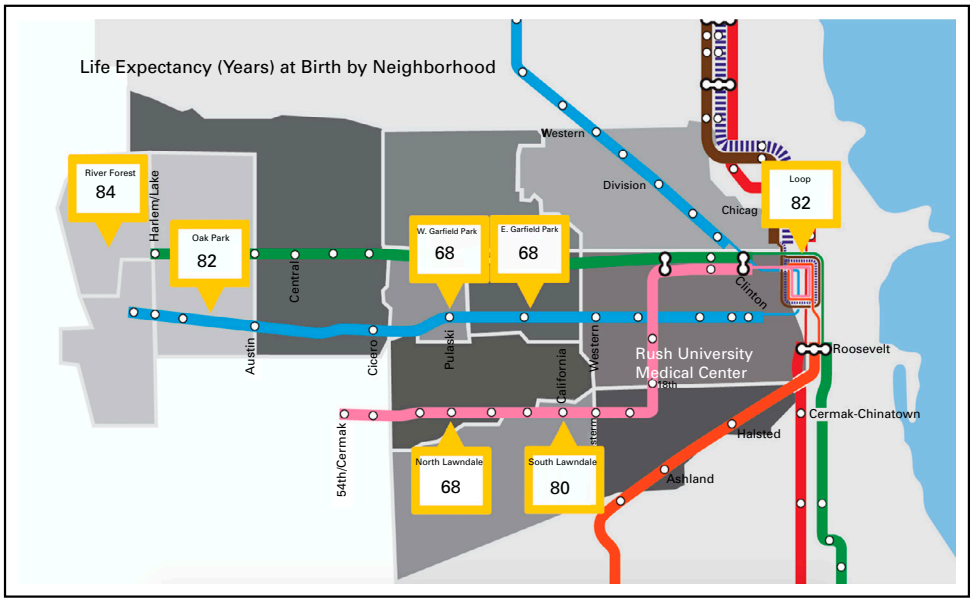
Launching a Health Equity Strategy

The context for the decision to launch this new equity strategy was the long-standing racial health and life expectancy gaps in Chicago. In fact, Chicago has the largest racial mortality gaps among the 30 largest U.S. cities.[7,8] The requirement, under the Affordable Care Act, that Rush and other not-for-profit hospitals conduct triennial community health needs assessments (CHNA) helped surface these startling health gaps to Rush leaders. The Rush CHNA identified eight (ultimately 10) Chicago West Side neighborhoods, geographically close to the medical center and comprising more than 500,000 individuals within Rush's primary service area. An analysis of the major causes of premature mortality in these neighborhoods identified that common chronic diseases such as cardiometabolic disease and cancer were responsible for a significant proportion of premature deaths.[9] These low life expectancy communities were largely racially segregated neighborhoods of concentrated poverty, with substandard housing, food deserts, unsafe streets, and poor educational outcomes. To illustrate the stark gap between the largely white downtown and the West Side neighborhoods, we depicted the life expectancy along the tracks of the elevated transportation system known as the Chicago "L" (Figure 1).

FIGURE 1

Life Expectancy Along the Chicago Transit Authority Tracks

This map illustrates the significant variation of life expectancy among communities that are close to each other, all of which are near the Rush University Medical Center campus.



Source: The authors. Based on 2017 Chicago Data. Chicago Health Atlas. Accessed March 18, 2021. https://www.chicagohealthatlas.org/.

There is a 14-year life expectancy gap between the Chicago Loop in the downtown commercial area (median household income, $107,246) and the East Garfield Park neighborhood (median household income, $22,818) — just two stops on the Chicago Transit Authority Blue Line from Rush. The Rush CHNA report named structural racism, economic deprivation, and other social and structural determinants of health as among the root causes of the poor life expectancy outcomes in the West Side neighborhoods. As a health system and a national leader in health care quality and safety, this CHNA report forced us to ask: What more could we do to address the social and structural determinants of health inside and outside our doors?

Potential solutions were laid out in a book on neighborhood racial life expectancy gaps, "The Death Gap: How Inequality Kills," written by one of the authors of this article (David A. Ansell).[10] This book advances the idea that structural violence is a root cause of low life expectancy in marginalized communities — structural because it is designed into our laws, policies, procedures, structures, and norms and a form of violence because people are harmed and die early as a result.[11] Health improvement would require a commitment to a community-partnered approach with clear metrics focused on the complex root causes of poor health.

Like many other health systems anticipating the shift to value-based care and population health, Rush changed its mission from an exclusive focus on health care delivery to one that aimed "to improve the health of the individuals and diverse communities we serve through the integration of outstanding patient care, education, research, and community partnerships." The focus on creating healthy communities and community partnerships in this mission statement was new. Rush had many community partnerships aimed at individual health improvement, but these programs were never designed to move the needle on community health outcomes.

> *"If structural racism, economic deprivation, and neighborhood conditions were afflictions at the root cause of health inequities, we had an obligation as an academic health system to name these as the first step in identifying ways to address these inequities."*

However, we were able to identify two associated programs that have had a significant impact on racial health inequities by addressing social and structural determinants of health along with health care interventions. The Metropolitan Chicago Breast Cancer Task Force (now Equal Hope) used a quality improvement approach to reduce the Black-to-white breast cancer mortality disparity in Chicago by 20% (from 51% to 41%), an outcome not seen in any other American city studied.[12-14] Another program, the Ruth M. Rothstein Core Center — an interdisciplinary HIV/AIDS prevention and treatment center and a public-private partnership between Rush and Chicago's Cook County Health — improved retention of patients with HIV/AIDS and outcomes in Black and Latinx patients.[15] Both of these programs involved complex partnerships, addressed social determinants of health, tracked health outcome measures, and led with ambitious aims.

For Rush to be successful with a new health equity strategy, we would need to adapt the lessons learned from these programs to address the neighborhood social and structural conditions that

were contributing to poor health outcomes. The problem statement and case were clearly articulated, and, furthermore, trusted senior leaders on the strategy team had significant experience in the field. Moreover, the ideas were built on the foundation of many grassroots programs that were developed over decades by Rush students, faculty, employees, volunteers with community and academic partners. They created a culture of community outreach, volunteerism, and collaboration that made this system strategy the next logical step. The enthusiastic support of the Rush Board of Trustees was a critical element in moving this strategy forward. Important as well to the deployment of this strategy was the appointment of a senior executive as the strategy leader, reporting to the system CEO and accountable to the Government and Community Affairs Committee of the Board of Trustees. Finally, executives are held accountable for organizational performance on diversity and equity through an institutional Diversity Index linked to executive pay.

The Rush Equity Framework

Rush developed a multipronged equity framework featuring five pillars to support the health equity strategy:

1. Name and eliminate racism
2. Adopt an anchor mission
3. Create wealth-building opportunities for employees
4. Eliminate health care inequities
5. Address the social and structural determinants of health

To build the strategy framework, Rush leaders partnered with the Civic Consulting Alliance (CCA), which is the pro bono consulting affiliate of the Civic Committee of the Commercial Club of Chicago. This consulting group had a reputation for building strategy and solutions for complex civic problems. Moreover, as an arm of the business community in Chicago, this group's engagement brought implicit support from many key leaders of that community. The CCA's engagement brought great skill, resources, and credibility to the initiative as well as reassurance to the Rush board and leadership team. From their input, we realized that the equity strategy required an internal and external approach. The Rush equity strategy has been guided by this variation on the Robert Wood Johnson Foundation definition of health equity: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups."[16]

Pillar 1. Naming Racism

Our comfort in naming racism and poverty as root causes of poor health arose from our long-standing approach to quality and safety rooted in, among other things, performing effective root cause analyses when harm occurred in the hospital or clinics. In a root cause analysis, the review often leads to multiple findings of why an untoward event occurred. These are named without prejudice, and a plan is created to reduce the risk of something similar happening again. Similarly, if structural racism, economic deprivation, and neighborhood conditions were afflictions at the root cause of health inequities, we had an obligation as an academic health system to name these as the first step in identifying ways to address these inequities. Finally, we clarified for our teams the difference between disparities and inequities, the latter being unjust and, therefore, creating an urgency to correct.

Pillar 2. The Anchor Mission

In January 2017, Rush launched an Anchor Mission (the second pillar) to hire, purchase, invest, and volunteer locally. Anchor institutions are nonprofit or public place–based entities, such as universities and hospitals, that are rooted in their local community by mission, invested capital, or relationships to customers, employees, residents, and vendors. They are important, sometimes critically important, economic drivers for these communities. However, we concluded that this impact could be applied in a much more purposeful way by focusing our business units on promoting economic activity in our anchor neighborhoods. The five initiatives of Rush's Anchor Mission are depicted in Figure 2.

FIGURE 2

Source: The authors.

Rush is among the largest employers on Chicago's West Side with a robust supply chain, yet we had never directed our business enterprise to focus on community health and wealth-building. We discovered the work of the Democracy Collaborative, particularly the Greater Circle Living project conducted in collaboration with the Cleveland Foundation, the Cleveland Clinic, Case Western Reserve University, and University Hospitals to promote economic vitality in Cleveland, Ohio. This community development model was potentially replicable.[17] The aim of the Rush Anchor Mission strategy was to target and measure employment from our anchor communities, increase local purchasing and business development, create local impact investment in community-building efforts, and increase local volunteering. The impact of the RUMC Anchor Mission initiatives has spanned a range of areas. Some examples:

- RUMC spending on its Anchor Mission initiatives was $7.9 million in fiscal year (FY) 2019, $8.4 million in FY 2020, and has reached $4.1 million through Q2 of FY 2021.

- RUMC has invested $6.0 million over 3 years in West Side social impact projects.

- RUMC has opened 16 employment application hubs in Anchor Mission communities to support local hiring.

- RUMC hiring of individuals from Anchor Mission communities has increased over time: from 16.1% of all hires in FY 2018 to 18.2% through Q2 of FY 2021.

- The percentage of RUMC employees contributing at least 6% of their income to a 403(b) retirement plan has increased from 68% in FY 2019 to 80.1% through February 2021.

Rush set annual goals for local hiring, purchasing, investment, and volunteering and maintains a dashboard to track our outcomes. There was no road map for health care institutions to embark on an anchor strategy, so we documented the work as we progressed. Ultimately, this road map was turned into the Rush "Anchor Mission Playbook," which was published with the help of the CCA and the Democracy Collaborative.[18] As the strategy was developed, Rush had the opportunity in early 2017 to be a founding member of the national Healthcare Anchor Network. This allowed Rush to share best practices and methodologies with other health care institutions and informed the strategy deployment.

In January 2017, we organized an internal Anchor Mission committee that set targets for local hiring, career pathways, local spend, and volunteering, with twice-yearly reporting to senior leadership. We hired a small team to support the anchor work across departments. Rush allocated $6 million, or 1% of its unrestricted reserves, to invest in local West Side projects, partnering with Community Development Financial Institutions, (funded by the U.S. Department of the Treasury.) Effective internal communication up and down the organization was, and still is, essential. To be successful, the health equity strategy had to be well understood and supported at all levels of the organization. Rush created a position within communications to focus exclusively on health equity communication strategy using a multi-media approach. Ultimately, Rush's health equity communications playbook was published in partnership with the Democracy Collaborative in The Anchor Mission Communications Toolkit.[19]

Pillar 3. Our Employees Are Our "First Community"

The third pillar of our community health equity strategy was to create wealth-building opportunities among employees. In adopting health equity as a strategy, we needed to address inequities that existed within our organization, from our staff to our patients. To do so, we named our employees our first community. Many of our employees who reside in our anchor neighborhoods became a critical sounding board and touchstone for the authenticity of this work; this was supported through a formally organized employee resource group. In dialogue with our employees, we realized that many experienced extreme financial distress and were not saving for retirement. Few internal pathways for career growth existed.

Naming our employees as our first community had the added benefit of bringing the health equity strategy home. Those of our employees who lived in the neighborhoods with the lowest life expectancy, largely Black and Latina women, experienced the most financial distress (as measured by lack of 403[b] participation, withdrawal from the 403[b] for purposes such as evictions and utility payments, and wage garnishments) of all of our employees. The beneficiaries of our equity strategy were not just residents in our anchor neighborhoods, but our own employees — people we worked with every day.

> *"In dialogue with our employees, we realized that many experienced extreme financial distress and were not saving for retirement. Few internal pathways for career growth existed. Naming our employees as our first community had the added benefit of bringing the health equity strategy home."*

We conducted internal listening sessions, so that our first community could guide our internal and external initiatives. Furthermore, we initiated a pension reform program to significantly increase retirement savings, raised entry hourly wages to $15, launched health care career pathways for incumbent employees, and offered financial wellness and credit training. At the same time, our long-standing Diversity Leadership Council made achieving demographic parity in leadership positions a critical part of the strategy. It was not enough to support low-wage employees: our medical center leadership representation needed to better reflect the demographics of our communities.

Pillar 4. Address Health Care Inequities

The fourth pillar of Rush's health equity strategy was to address health care inequities. A multidisciplinary Health Equity Governance Committee was created to report into the Performance Improvement Oversight Committee to provide input for performance improvement projects that address racial, ethnic, gender, and age inequities in health care outcomes among our patients. The organizational performance improvement plan was rewritten to include a section on health care equity. We initiated screening patients for the social determinants of health: food, housing, utility, transportation, and access to primary care.

We began home visiting programs for homebound patients with chronic illness and another for postpartum mothers who lived in neighborhoods with low life expectancy. Last, we began reporting health care outcomes by race, ethnicity, and language and initiated improvement projects aimed at eliminating inequities. In 2018, we published our first state of health care equity report,[20] tracking patient outcomes across a number of clinical outcomes by race, ethnicity, and language. We have also initiated performance improvement projects in hypertension and maternal infant health based on gaps identified in this report.

Pillar 5. Addressing the Social and Structural Determinants of Health: WSU

The fifth pillar of the Rush health equity strategy was moving this work into the community. WSU was established as a community-engaged racial health equity collaborative. Rush leaders understood from the onset that if Rush, alone, adopted an anchor mission, it would not be large enough to have the desired economic impact on the West Side communities. But if every health system on Chicago's West Side joined, it would have the combined economic power comparable to the largest corporation in Illinois. Together, we could have a collective impact on community determinants of wealth and health. The CEOs of AMITA Health, Cook County Health, Lurie Children's Hospital of Chicago, Sinai Chicago, and University of Illinois Health each had significant commitments to the community and quickly agreed to join Rush and coordinate resources to improve outcomes. The West Side Anchor Committee was formed to establish standard operating process, common goals, and best practice sharing and to create a shared anchor mission dashboard across the health care anchors. But a shared partnership with the community was needed.

In early 2017, the health systems convened a kickoff meeting that included West Side residents, community-based organizations, citywide social service agencies, educational institutions, community health care networks, public sector agencies, national subject matter experts, and foundations. The goal was to discuss the possibility of aligning the health systems in partnership with community-based organizations on Chicago's West Side to tackle the social and structural determinants of health together. This gathering was followed by a months-long series of community meetings and listening sessions to obtain feedback. The results of the listening sessions were published in a report, "What We Heard."[21] Despite the fact that there was historic wariness of health care institutions in the community, residents were hopeful and open to the idea of a collaborative with the hospitals. But residents made it clear that they were the experts on their communities. They understood the challenges and opportunities in their neighborhoods better than anyone else, and they knew best what solutions would and would not work. "Don't make top-down decisions and then invite everyone to something that has been already decided," said one.

> *Despite the fact that there was historic wariness of health care institutions in the community, residents were hopeful and open to the idea of a collaborative with the hospitals. But residents made it clear that they were the experts on their communities. They understood the challenges and opportunities in their neighborhoods better than anyone else, and they knew best what solutions would and would not work."*

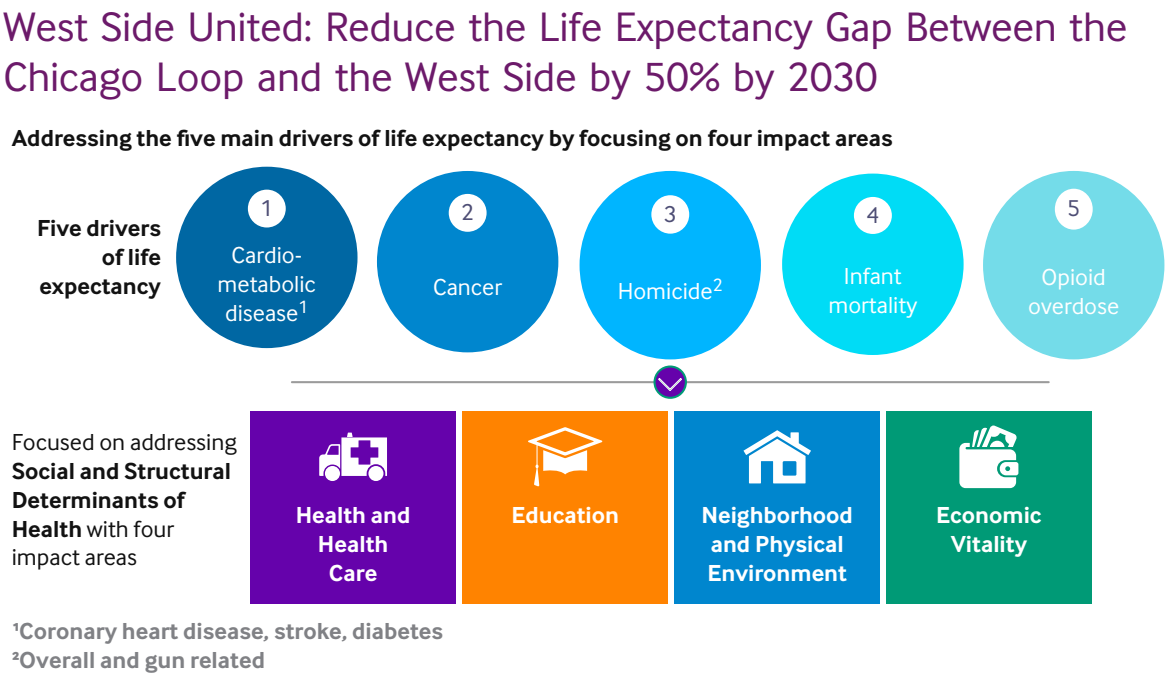
The listening sessions identified three things needed for WSU to succeed. One, it should be owned by residents, with a representative governance structure and community accountability. Two, it should strike a balance between cocreating a shared long-term vision for the West Side and achieving quick wins to build a track record of community trust and momentum. Three, rather than launching new programs that might duplicate ongoing efforts, the collaborative should identify opportunities to make existing organizations and collaboratives more effective where there were current gaps. At these community meetings, applications for a planning committee were solicited. It reinforced the notion that these community listening sessions were not just feedback sessions. The Planning Committee included community leaders who were paid to participate. Their task was to develop the outlines of a plan for a new organization comprising hospitals and community members that would collectively address the social and structural determinants of health on Chicago's West Side. Importantly, the collaborative that was forming realized that the remedies went well beyond access to health care, and, therefore, our solutions needed to reflect that.

In March 2018, WSU was launched. It is governed by an Executive Leadership Council of six hospital executives and six community representatives who are paid a stipend for their time. WSU's mission is to build community health and economic wellness on Chicago's West Side and build healthy, vibrant neighborhoods. WSU's goal is to reduce the life expectancy gap between residents of the Loop and the West Side by 50% by 2030.[22] The citing of the life expectancy improvement goal as a meaningful, aspirational, specific, and time-limited aim of the collaborative resonated with community members. The naming of WSU was purposefully neutral. In fact, it is that neutral identity, separate from that of any single organization, that supports the idea of unity, equity, and strength of common purpose. WSU operates through a number of staffed committees and subcommittees with shared decision-making between the community and health systems.

WSU identified four components of its work: Health and Health Care, Neighborhood and Physical Environment, Economic Vitality, and Education. Each component has its own metrics and goals. These guided specific initiatives, such as local hiring goals, impact investing, healthy food access, and small business grants. A Metrics Working Group composed of epidemiologists and health service researchers from the WSU hospitals and the Chicago Department of Public Health created a logic model for health improvement and performed a deconstruction analysis of the causes of death on the West Side and their drivers. They identified five causes of death that accounted for 50% to 75% of the premature mortality in every West Side neighborhood, with cardiometabolic disease and cancer the leading causes in all neighborhoods. The measurement framework ties initiative-specific

outcomes to the overarching goal. The metrics are informed by the strategic direction of WSU. They are meant to create accountability and alignment around shared goals across hospital and community stakeholders. The WSU metrics framework is presented in Figure 3.

FIGURE 3



Source: West Side United Metrics Working Group decomposition analysis.

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

It was also recognized that the six hospitals had an enormous economic footprint. Combined, there were 43,000 employees and 6,000 annual hires, $4 billion in annual procurement, $5.4 billion in spending potential of employees, and $3 billion in unrestricted investments, not to mention 2,000 hospital beds and 89,000 annual admissions. If just 1% of this spend could be directed to the community, the effect could be enormous. The hospitals were asked to set goals to hire more people from the West Side, support more businesses, and invest more money in the local economy.

In its first 3 years, WSU and its member hospitals invested $7.6 million in impact investments in West Side projects (by combining the investments of hospitals and the American Medical Association); raised $3 million to establish four career pathways in health care; launched health outcomes projects targeting hypertension control and maternal infant outcomes across West Side hospitals, clinics, and support for community-based organizations; hired more than 2,000 West Side employees; and raised $835,000 to support local businesses. In addition, WSU offered business development support across 640 West Side businesses and supported 60 community-based not-for-profits in business and operational support. In March 2020, WSU launched a new 3-year strategy to expand the anchor initiatives across the six hospital systems, increase the support to local businesses, expand career pathways, and further reduce community health inequities while continuing to act as a neutral convener for efforts on the West Side.

> *"The naming of West Side United was purposefully neutral. In fact, it is that neutral identity, separate from that of any single organization, that supports the idea of unity, equity, and strength of common purpose."*

For the health care partners, the value of WSU lies in the collective economic impact, community engagement, and shared health care projects of the collaborative. Among the six health care organizations, there is a mix of public and private entities, safety-net hospitals, and academics, none of which had ever been in this type of organization together. While not every institution will participate in all of the initiatives, all get credit collectively for the successes of the whole collective. For community members, the partnership with the health systems provides an opportunity to bring needed resources to neighborhoods. WSU's regional health equity strategy influenced Chicago's 5-year public health plan, Healthy Chicago 2025, released in August 2020.[6] Similar to WSU, the citywide plan names structural racism and poverty among the neighborhood root causes for the life expectancy gaps in the city.

WSU, Covid-19, and the Racial Equity Rapid Response Team

When the Covid-19 pandemic hit Chicago in the second week in March 2020, WSU was forced to pivot and focus more directly on the urgent needs of the community.[23] WSU provided $110,000 to support local businesses and not-for-profits as well as $210,000 for food pantries. In partnership with the American Medical Association, WSU organized the delivery of 1,000 blood pressure cuffs to vulnerable community members to self-monitor blood pressure.

When the news of the disproportionate Black deaths from Covid-19 were reported in early April 2020, the Mayor's Office reached out to WSU. Up to that point, the focus of the city's emergency preparedness team had been hospital emergency and intensive care capacity. "Those numbers take your breath away," said Chicago Mayor Lori Lightfoot in early April 2020, when she learned that 70% of the first 100 deaths were Black Americans. "This is a call for action for all of us."[24]

The city asked WSU to co-convene a Racial Equity Rapid Response Team (RERRT) with the Mayor's Office. The RERRT comprised health care providers and community-based organizations around a common table to coordinate community-level Covid-19 responses. Rush was asked to cochair the provider workgroup, and leaders from all of the WSU hospitals served on the RERRT steering committee. The RERRT has been coordinating many aspects of the local community response through a racial equity lens, from the provision of basic resources like food and masks, to testing, to Covid-19 vaccination access.[25] Community health workers were trained by hospitals to do 75,000 wellness checks across the city's Black and Latinx neighborhoods. WSU launched a program called Live Healthy Chicago that provided millions of dollars in community-based relief grants to local organizations supported by substantial donations from the Oprah Winfrey Charitable Foundation, the Chicago Community Covid-19 Response Fund, and others. The RERRT's adoption of the WSU model of health providers coplanning with community leaders has facilitated rapid

coordination between and among hospitals and community clinics and community-based organizations to address community-based needs.

2021: Rush and the Evolving Health Equity Strategy

When Covid-19 hit the United States, RUMC was prepared for an onslaught of critically ill patients. The downtown hospital was specially built in 2012 as a regional resource to handle a mass health crisis like a pandemic, with advanced critical care capabilities.[26] An outgrowth of our health equity strategy was our plan to reach out to hospitals serving Chicago's marginalized communities to arrange for transfers of the sickest patients. On the basis of early information concerning Covid-19, we knew that these historically disadvantaged communities were especially vulnerable, and all the more so as the nation was woefully unprepared to face this calamity.

> *"The Racial Justice Action Committee has five overarching recommendations: to make racial equity a system strategy, to identify a cohort of senior leaders as equity champions, to have actionable timelines for change, to tie equity outcomes to leaders' performance goals, and to have an annual system progress report."*

As Covid-19 hit Chicago, Rush leaders reached out to the CEOs and Chief Medical Officers of Chicago's safety-net hospitals and took hundreds of Covid-19 transfers, many requiring advanced critical care. [27] At the same time, we expanded our community health initiatives to coordinate the city response to those experiencing homelessness in Chicago. The Chicago Homelessness and Health Response Group for Equity (CHHRGE) was formed at Rush at the beginning of the pandemic and had become the entity planning the coordinated Covid-19 response to the homeless population with the city health department, shelter providers, and health care institutions that number more than 100 organizations.[28] Rush launched one of the first mobile Covid-19 testing teams in the city, testing vulnerable individuals in homeless shelters, nursing homes, and the Cook County Jail.[29] Rush providers also established an isolation center for Covid-19–positive homeless people, with 24-hour clinical staffing. Work with the homeless population included providing safe housing for older people, and the isolation of Covid-19–positive homeless individuals was able to reduce the Covid-19 positivity rate in shelters. In addition, Rush partnered with the City of Chicago to create a data hub for all Covid-19–related health data, community-based Covid-19 testing, and vaccination sites.

The Rush Racial Justice Action Committee

The Covid-19 pandemic with its racialized disproportionate case and death rate coupled with national incidents of racial injustice and protests provided an opportunity for Rush to focus our own antiracism and equity efforts more deliberately. With the support of the board and senior leadership, building on the work of a longstanding Diversity Leadership Council, the health equity leadership convened a multidisciplinary Racial Justice Action Committee (RJAC) to develop a road map for the Rush System for Health to address institutional racism. RJAC's specific charge was to

help further Rush's efforts to ensure that Black lives matter inside and outside of Rush's walls, deepen these efforts in our communities, and identify new ways that we all can work together to advance social and racial justice along with health equity.

The RJAC has five overarching recommendations: to make racial equity a system strategy, to identify a cohort of senior leaders as equity champions, to have actionable timelines for change, to tie equity outcomes to leaders' performance goals, and to have an annual system progress report. The RJAC serves as a command center for system implementation of the antiracism and other equity initiatives. In addition, Rush leaders helped formulate a statement published in the local papers, signed by 36 Chicago health care providers and many national health care systems, naming racism as a public health crisis.[30]

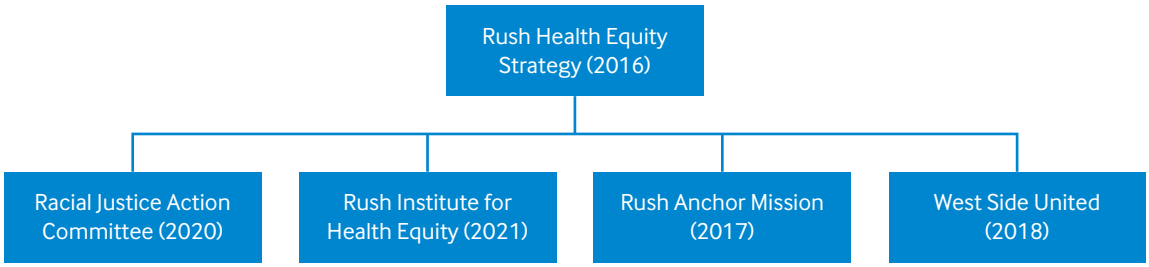
Looking Ahead: New Models of Community Health Delivery

Rush's long-term commitment to a health equity strategy is now manifest in the creation of a new Rush BMO Institute for Health Equity (RIHE), supported by a philanthropic gift from the BMO Financial Group. The RIHE will help coordinate the health system's health equity efforts, from educating and training the next generation of health care providers, to enhancing equity-guided community-based research, and to developing new models of community-based practice and engagement guided by the authentic voice of the community. The RIHE will incubate and accelerate strategies to eliminate health inequities (Figure 4).

FIGURE 4

Initiatives and Entities that Flow from the Core Health Equity Strategic Vision

The Rush Health Equity Strategy, developed in 2016, has driven the creation of initiatives and entities within the Rush University Medical Center community and throughout Chicago's West Side communities.



Source: The authors.

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

A core element of the philosophy of the RIHE is what we are calling bidirectional learning, an acknowledgement that both the university/hospital system and the community have knowledge and experience to share with each other. This "all teach, all learn" strategy will include community voices and leadership embedded at all levels of Rush's equity efforts. The institute will be formally launched in the summer of 2021.

Increasingly, at Rush, as our health equity strategy has matured and our community-based health and social programs have expanded, we have leveraged intersectional multipartner approaches that integrate health care delivery in novel community settings. These initiatives are consistent with holistic models of health such as the Culture of Health model promoted by the Robert Wood Johnson Foundation.[31] These include expanding school-based health centers, community-based nursing clinical practices, in-home primary care for frail homebound patients and postpartum mothers, primary care in shelters for those experiencing homelessness, community behavioral health interventions, and health programming in churches and community-based organizations.

> *"A core element of the philosophy of the RIHE is what we are calling bidirectional learning, an acknowledgement that both the university/hospital system and the community have knowledge and experience to share with each other. This "all teach, all learn" strategy will include community voices and leadership embedded at all levels of Rush's equity efforts."*

The colocation of clinical, social care, behavioral health, and wellness services has not been the traditional domain of academic medical centers and hospitals. Current models of health care financing in our private insurance and delivery system that purport to value population health outcomes instead focus on the health costs and outcomes of those empaneled within one insurance product or another. However, health, wellness, and illness arise from exposures within and across communities over a lifetime. Community health equity initiatives have the neighborhood as the focus of intervention and address the neighborhood impact on individual health, unlike most population health initiatives that are clinic-, hospital-, and insurance-centric. The current payment models have kept most health care systems mired in traditional delivery modes, particularly when it comes to addressing the place-based social determinants of health and modifiable life expectancy gaps. The Covid-19 pandemic represents a stark demonstration of the flaws in our health care financing and delivery system that rewards elective surgical procedures over improving the health of both the individual and the community.

Health care leaders at Rush and elsewhere are still in the early days of thinking through these new delivery models, but they have become central to Rush's strategy to address community health inequities. While we are navigating our way, we are sustained by the words of Martin Luther King, Jr., who, upon bringing his civil rights movement to Chicago, noted, "It is reasonable to think that if the problems of Chicago … can be solved, they can be solved everywhere."[32]

Although we have had some early successes and have made good progress in building trust, we have much work yet to do, and we certainly do not have all of the answers. We understand that tackling systemic racism, economic inequities, and other social and structural afflictions with their concomitant toll on our communities, patients, and staff is simultaneously a necessary and daunting long-term task. Importantly, one cannot be selective about a commitment to equity. Although the central focus of Rush's health equity strategy is to eliminate racial health inequities,

we also have focused on women's advancement, the LGBTQ+ community, people with disabilities, and veterans , each with strategies that emphasize inclusion and purposeful steps with metrics to reduce inequities. In each case, the terminology, process, and language are similar, and the goal is to reduce/remove inequities; there is a commitment to measurable progress, and the groups most impacted help design the strategy.

We look forward to hearing about other, even more effective, models. The creation of a health equity strategy and realignment of the resources of an academic health system to achieve that strategy, including the formation of a large health equity collaborative, carry some unique challenges. However, these changes also provide an opportunity to solve big problems and, therefore, articulate a truly inspirational vision. This, in turn, provides everyone associated with these efforts something of incredible value — hope.

David A. Ansell, MD, MPH
Senior Vice President for Community Health Equity, Rush University Medical Center, Chicago, Illinois, USA

Associate Provost for Community Affairs and Professor of Internal Medicine, Rush Medical College, Chicago, Illinois, USA

Darlene Oliver-Hightower, JD
Vice President, Community Health Equity and Engagement, Rush University Medical Center, Chicago, Illinois, USA

Larry J. Goodman, MD
President Emeritus of Rush University, Chicago, Illinois, USA

Retired CEO, Rush University Medical Center and the Rush University System for Health, Chicago, Illinois, USA

Omar B. Lateef, DO
President and CEO, Rush University Medical Center, Chicago, Illinois, USA

Professor, Department of Internal Medicine, Rush Medical College, Chicago, Illinois, USA

Tricia J. Johnson, PhD
Professor of Health Systems Management, Rush University, Chicago, Illinois, USA

Acknowledgments

The authors would like to humbly acknowledge the many Rush University students, faculty, Rush employees, trustees and community partners who have contributed to the Rush health equity strategy and apologize for any omissions. In particular, we would like to note Lisa Barnes, Cheryl Lullias and the Medical Home Network, Cynthia Boyd, Stephanie Crane, Sheila Dugan and the Women's Leadership Council, Angela Freeman, Susan Freeman, Sherine Gabriel, Sharon Gates

and the Rush Community Service Initiative Programs, The Center for Community Health Equity, Chicago Department of Health, Fernando DeMaio and DePaul University, Reverend Steve Epting and Marshall Hatch of the Alive Faith Network, Redia Homan and the West Side Employee Resource Group, Niranjan Karnik, Sally Lemke and the Rush School Based Health Centers, Brittney Lange-Maia, Elizabeth Lynch, Vijay Patel, David Sanders and Malcolm X College, Diane McKeever, Angela Moss and the College of Nursing Practice, Wrenetha Julion and colleagues in the College of Nursing, Terry Peterson and the Diversity Leadership Council, Janice Phillips, Steven Potter and the Rush Board, Erin Shelp, Christopher Nolan and the Alliance for Health Equity, Steve Rothschild, Raj Shah, Shweta Ubhayakar, Marilyn Wideman, Sophia Wrobrec, BMO Financial Group, among many others.

Disclosures: David A. Ansell, Darlene Oliver Hightower, Larry J. Goodman, Omar B. Lateef, and Tricia J. Johnson have nothing to disclose.

References

1. Du Bois WEB. The Philadelphia negro: a social study. Philadelphia, PA: University of Pennsylvania Press, 1899.

2. Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care. Washington: The National Academies Press, 2003.

3. Office of Disease Prevention and Health Promotion. Healthy people 2000. Washington: U.S. Department of Health and Human Services, Public Health Service, 1990. DHHS publication no. (PHS)90-50212.

4. National Center for Health Statistics. Healthy people 2010 final review. Hyattsville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001. DHHS publication no. (PHS)93-123201.

5. Washington HA. Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present. New York: Doubleday, 2006.

6. Chicago Department of Public Health. Healthy Chicago 2025: closing our life expectancy gap 2020–2025. Chicago: Chicago Department of Public Health, 2020.

7. Benjamins MR, Silva A, Saiyed NS, De Maio FG. Comparison of all-cause mortality rates and inequities between black and white populations across the 30 most populous US cities. JAMA Netw Open 2021;4: e2032086 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775299 https://doi.org/10.1001/jamanetworkopen.2020.32086.

8. NYU Langone Health. Large Life Expectancy Gaps in U.S. Cities Linked to Racial & Ethnic Segregation by Neighborhood. June 5, 2019. Accessed March 18, 2021. https://nyulangone.org/news/large-life-expectancy-gaps-us-cities-linked-racial-ethnic-segregation-neighborhood.

9. Rush University Medical Center. Community Health Needs Assessment Report. June 8, 2016. Accessed March 18, 2021. https://www.rush.edu/sites/default/files/2020-09/rush-chna-august-2016%284%29.PDF.

10. Ansell DA. The death gap: how inequality kills. Chicago: University of Chicago Press, 2017. https://doi.org/10.7208/chicago/9780226428291.001.0001.

11. De Maio F, Ansell D. "As natural as the air around us": on the origin and development of the concept of structural violence in health research. Int J Health Serv 2018;48:749-59 https://journals.sagepub.com/doi/10.1177/0020731418792825 https://pubmed.ncbi.nlm.nih.gov/30092699/ https://doi.org/10.1177/0020731418792825.

12. Hirschman J, Whitman S, Ansell D. The black:white disparity in breast cancer mortality: the example of Chicago. Cancer Causes Control 2007;18:323-33 https://link.springer.com/article/10.1007/s10552-006-0102-y https://pubmed.ncbi.nlm.nih.gov/17285262/ https://doi.org/10.1007/s10552-006-0102-y.

13. Ansell D, Grabler P, Whitman S, et al. A community effort to reduce the black/white breast cancer mortality disparity in Chicago. Cancer Causes Control 2009;20:1681-8 https://link.springer.com/article/10.1007%2Fs10552-009-9419-7 https://pubmed.ncbi.nlm.nih.gov/19688184/ https://doi.org/10.1007/s10552-009-9419-7.

14. Sighoko D, Murphy AM, Irizarry B, Rauscher G, Ferrans C, Ansell D. Changes in the racial disparity in breast cancer mortality in the ten US cities with the largest African American populations from 1999 to 2013: the reduction in breast cancer mortality disparity in Chicago. Cancer Causes Control 2017;28:563-8 https://link.springer.com/article/10.1007%2Fs10552-017-0878-y https://doi.org/10.1007/s10552-017-0878-y.

15. Sherer R, Stieglitz K, Narra J, et al. HIV multidisciplinary teams work: support services improve access to and retention in HIV primary care. AIDS Care 2002;14(Suppl 1):S31-44 https://www.tandfonline.com/doi/abs/10.1080/09540120220149975 https://pubmed.ncbi.nlm.nih.gov/12204140/ https://doi.org/10.1080/09540120220149975.

16. Braverman P. A New Definition of Health Equity to Guide Future Efforts and Measure Progress. Health Aff (Millwood). June 22, 2017. Accessed March 9, 2021. https://www.healthaffairs.org/do/10.1377/hblog20170622.060710/full/.

17. Wright W, Hexter KW, Downer N. Cleveland's Greater University Circle Initiative: An Anchor-Based Strategy for Change. Democracy Collaborative. 2016. Accessed March 9, 2021. https://democracycollaborative.org/sites/default/files/downloads/ClevelandGreaterUniversityCircle-web.pdf.

18. Ubhayakar S, Capeless M, Owens R, Snorrason K, Zuckerman D. The Anchor Mission Playbook. Rush University Medical Center and The Democracy Collaborative. August 2017. Accessed March 9, 2021. https://www.rush.edu/sites/default/files/2020-09/rush-anchor-mission-playbook-091117%282%29.pdf.

19. Healthcare Anchor Network. Anchor Mission Communications Toolkit. Rush University Medical Center and The Democracy Collaborative. 2020. Accessed March 9, 2021. https://healthcareanchor.network/wp-content/uploads/edd/2020/04/Anchor-Mission-Comms-Toolkit-Final-March-31-2020.pdf.

20. Lange-Maia B. 2018 Health Equity Report: Patient Care Through an Equity Lens. 2018. Accessed March 9, 2021. https://healthequitychicago.org/wp-content/uploads/2019/08/2018-Health-Equity-Report.pdf.

21. Rush University Medical Center. What We Heard: Coming Together to Improve Health and Wellness on Chicago's West Side. July 2017. Accessed March 9, 2021. https://www.rush.edu/sites/default/files/2020-09/what-we-heard-july-2017%283%29.pdf.

22. Goudie C, Markoff B, Fagg J. The Challenge to Cut Chicago's 30-Year Life Expectancy Gap in Half by 2030. ABC7 News. November 20, 2019. Accessed March 9, 2021. https://abc7chicago.com/life-expectancy-average-us-in/5710399/.

23. Kantor RM, Stramaglia P. West Side United: Hospitals Tackle the Racial Health and Wealth Gap. Harvard Business School Case 321-026. August 2020. Accessed March 9, 2021. https://www.hbs.edu/faculty/Pages/item.aspx?num=58846.

24. Flynn M. 'Those Numbers Take Your Breath Away': Covid-19 Iis Hitting Chicago's Black Neighborhoods Much Harder Than Others, Officials Say. The Washington Post. April 7, 2020. Accessed March 9, 2021. https://www.washingtonpost.com/nation/2020/04/07/chicago-racial-disparity-coronavirus/.

25. Tucker D, Assad S, Thompson C. How A COVID-19 'Rapid Response Team' In Chicago Is Working To Fix Decades Of Neglect In Black, Latinx Communities. CBS Local News. August 1, 2020. Accessed March 9, 2021. https://chicago.cbslocal.com/how-a-rapid-response-team-in-chicago-is-working-to-fix-decades-of-neglect-in-black-latinx-communities/.

26. Guarino M. This Hospital Was Built for a Pandemic. The Washington Post. April 9, 2020. Accessed March 9, 2021. https://www.washingtonpost.com/health/2020/04/09/rush-hospital-coronavirus/.

27. Schorsch K. The Pandemic Revealed Another Gap in Chicago Health Care: Hospitals Are On Their Own to Transfer Patients. WBEZ Chicago. June 29, 2020. Accessed March 13, 2021. https://www.wbez.org/stories/one-chicago-hospital-called-for-8-hours-to-transfer-covid-19-patients-thats-problematic-for-future-outbreaks/1ecd60f3-f185-4deb-ae65-3e3ca25f0063.

28. Chicago Homelessness and Health Response Group for Equity. The CHHRGE Report: Building an Effective Cross-Sector Partnership to Address COVID-19 Among Vulnerably Housed Populations of Chicago. 2020. Accessed March 9, 2021. https://chhrge.org/.

29. Ghinai I, Davis ES, Mayer S, et al. Risk factors for severe acute respiratory syndrome coronavirus 2 infection in homeless shelters in Chicago, Illinois—March–May, 2020. Open Forum Infect Dis 2020;7: ofaa477.

30. Goldberg S. 36 Chicago-Area Hospitals Name Racism a 'Public Health Crisis'. Modern Healthcare. June 21, 2020. Accessed March 10, 2021. https://www.modernhealthcare.com/safety-quality/36-chicago-area-hospitals-name-racism-public-health-crisis.

31. Robert Wood Johnson Foundation. Building a Culture of Health. 2021. Accessed March 13, 2021. https://www.rwjf.org/en/cultureofhealth/about/how-we-got-here.html.

32. Carson C. The autobiography of Martin Luther King, Jr. New York: Grand Central Publishing, 2001.