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Voices of Health Equity in Chicago
Interview No. 15
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CENTER FOR COMMUNITY HEALTH EQUITY

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Center for Community Health Equity
The Center for Community Health Equity was founded by DePaul University and Rush University in 2015 with the goal of improving community health outcomes and contributing to the elimination of health inequities in Chicago.

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Voices of Health Equity in Chicago
Our *Voices of Health Equity* project collects the stories of people who have made health equity a central concern in their work. We are interviewing academics, clinicians, public health advocates, community organizers, and others to better understand how different disciplines and professions could work together to eliminate avoidable, unnecessary and unfair health disparities.

Tuesday May 8th, 2018
Interviewed by Amber Miller

Background: Chief Medical Officer, Paul Luning, MD, has been at PCC since 1995 when he completed the West Suburban Medical Center Family Medicine Residency program. Prior to this, he attended medical school at the University of Chicago – Pritzker School of Medicine. After three years with PCC, he went on to complete PCC's Fellowship in Community Medicine. He has been instrumental in the development and implementation of many programs at PCC such as the Performance Improvement Program and PCC's clinical program at the Boulevard (formerly Interfaith House), a local shelter for homeless individuals recovering from illness. He has received numerous honors and awards including the Distinguished Service Award from the American Academy of Family Physicians and Illinois Academy of Family Physicians; Teacher of the Year from the West Suburban Family Medicine Residency Program (2003, 2007, 2012); and George O'Neill Leadership Award from the Illinois Primary Health Care Association.

Paul: I'm a family doctor. I'm the Chief Medical Officer (CMO) at PCC Community Wellness Center, which is a Federally Qualified Health Center (FQHC) that serves the west side of Chicago. I grew up in Evanston, sort of a Chicago suburbanite. I went away to college to Yale for undergrad, and missed Chicago, so came back here for med school and I went to the University of Chicago. At that point, I knew I wanted to be a family doctor because I knew I wanted to care for the underserved. Being a family doctor seemed like the best way to go about doing that, so after the University of Chicago, I sought out a family medicine residency training program that would specifically trained me to care for underserved populations. So went to the West Suburban Family Medicine Residency Program, which is on the west side of Chicago- right on the border of Oak Park and Chicago. I went there specifically because the year that I started residency (in 1995) was the second year that West Suburban residents had the opportunity to spend their three-year outpatient educational experience at a Federally Qualified Health Center, which was PCC. So although I was employed by West Suburban Hospital, as I went through my three years of residency, I really got to know the Community Health Center very well. I stuck around there after I finished, I did a fellowship in community medicine that was sponsored by PCC; the two-year fellowship included getting a Master's in Public Health at UIC.

At the time, UIC I think was the only one major MPH program in Chicago. Northwestern had a version, and there were a couple analogous programs further out in the suburbs. But UIC was the perfect fit for me, with its emphasis on community-level public health. I've stayed at PCC ever since, in a variety of capacities; first as a site medical director, then Medical Director for Performance Improvement, and then for the last 12 years, I've been the Chief Medical Officer of the organization.

Amber: What does it entail to be a Chief Medical Officer? How does that position compare to the others you've done?

Paul: The executive level of our organization has five executive members: Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Population Health Officer, and Chief Medical Officer. So I'm at the highest ranking clinician among that group. I'm essentially in charge of the medical staff and medical programs. Our community health center has 12 sites. Each of those sites has a site medical director or clinic coordinator and those folks report to me. So it all sort of funnel funnels up to my area.

Amber: And you've been with them ever since residency, correct? And they started off with only one location within West Suburban back in 1980?

Paul: That's right. Well the first site was actually just a block down the street from West Suburban.

Amber: So how many locations did they have when you got there or how much has it expanded ever since? I believe now you then now you have 11?

Paul: Some of us count our sites as 12, but it's technically 11. One of our sites houses a continuity site and also our freestanding birth center. Most of us see the Birth Center as an independent entity but technically it's part of the 11 sites.

Amber: So you guys started just with providing basic, like primary health care at first?

Paul: Sort of. Before it became a Federally Qualified Health Center, there was a building in the place where my current office is, which was called the Parent Child Center. The Parent Child Center was started in the early eighties; it was essentially a three-room office providing walk-in prenatal care and pediatric care for women and children from Austin. It was staffed by residents from the West Suburban Residency Program. When a patient would walk-in, the staff would call up to the hospital and one of the residents would run down the alley and provide the pediatric care or the prenatal care. So it was not a very big deal. When the place became PCC, it greatly expanded its scope in order to be a Federally Qualified Health Center. The program was initially sponsored by West Suburban Hospital, who pumped a fair amount of funding into that small site to increase it - more exam rooms- and actually hire regular attending physicians to be the doctors there, to provide primary care across the age spectrum. So the Center had family doctors doing prenatal care, pediatric care, and geriatric care. But right from the beginning, as a Federally Qualified Health Center, we knew that behavioral health was an important part of the care we provided; so the first employees were a nurse, a front desk receptionist, two doctors, and a social worker. The social worker was part of our first group. From there it grew pretty extensively.

Amber: So from one to 11? I read that you do not just delivery primary care. PCC has a farm stand, yoga, diabetes education, reading programs... How did that happened? I'm just so interested in how it went from clinical care, all the way to yoga and doing these farm stands, how did that expansion come about?

Paul: It's a not atypical for an FQHC. FQHC's generally have a much broader perspective of health than traditional doctor's offices. So we see a lot of things affecting a patient's health besides the fact that they've got diabetes or high blood pressure. Their health is significantly impacted by their finances. And so, do they have a job? Do their kids have child care? Can they buy healthy food? Do they know how to fix healthy food? Are they too stressed out to be able to focus on taking care of their diabetes? Or, are they depressed and don't have any avenues for taking care of their medical conditions? Would they benefit from exercise and there no safe place to exercise?

So all those issues are addressed right from the beginning. Any FQHC that knows what it's doing (and Chicago is full of them) knows that just hiring a doctor and a nurse is not going to take care of somebody's health. As we kept seeing these needs for a particular area, we would develop a particular program to fill those needs.

Amber: You have been pretty instrumental in the development of some of these programs, is there one in particular, one project or program or initiative in particular that really stood out for you? In terms of addressing health equity?

Paul: We've got too many to even think of. I think a good example is actually one that I can't claim credit for it. My predecessor, Dr. Mark Loafman was the one that helped to set up PCC, and not coincidentally also set up our Maternal-Child Health Fellowship. So PCC sponsors actually two fellowships. There's the one that I did (our Community Medicine Fellowship), but our first one was a Maternal-Child Health Fellowship. And Mark set up that program. It is a program that trains family doctors, in an additional year of training, to do operative and high-risk obstetrics and high-risk pediatrics. At its most basic, it trains family doctors to do c-sections. There are lots of fellowship programs out there that train family docs to do c-sections. Mark established his from a very different perspective. He recognize the barriers that underserved patients found in engaging with healthcare, and his goal at PCC was to establish a connection between a primary care provider and a patient that would survive all these challenges and barriers; he wanted a patient to have their own doctor, who would with the patient through the entire spectrum of the healthcare system. At the time, it was just doctors, although we've since added nurse practitioners and nurse midwives, but the idea remains the same -- the goal is for the patient to establish a relationship with a health care provider that would be able to guide them through all these challenges that the healthcare system erects, but particularly for patients without insurance, or who speak a language that's not spoken in the place. Mark carried that to the extreme of training family docs to do c-sections so that if a pregnant woman came to the Community Health Center, they could meet a doctor who didn't have to hand them off to an obstetrician. Many family doctors could do their prenatal care, but couldn't do their vaginal delivery; in our case they could. And, in fact, if the pregnant patient went to the operating room, that same doctor could be their doctor and go to the operating room. And so that was sort of a way to address these challenges that our underserved patients found because frankly, if we had to hand them off to an obstetrician, at the time there weren't that many that we had confidence would treat our patients with respect and have the ability to overcome the particular challenges our patients faced.

Amber: Did you guys look at barriers to prenatal care and how that may be an issue with your patients?

Paul: He didn't have to analyze them, because he knew them. He had done an MCH fellowship himself at Brown and was very well versed with the statistics, and particularly the demographic and clinical statistics. So he knew what the barriers were. I remember he thought the best model to circumvent those barriers was to have a personal relationship. I mean, that was a big deal for Mark, and I certainly believe in that. Individuals providing care to other individuals. That relationship can really get you through a lot of very difficult challenges.

Amber: Right. What do you think are some of the biggest barriers to improving community health or health equity in Chicago?

Paul: Money. Money is a big one. I think there still are elements of racism, of discrimination against people of different ethnicities, of different national origins, of different languages, but I have to see money, the lack of it, is a huge challenge. Finding enough money to pay for our programs, for example finding enough money to pay for a job training program. You might have a great idea, a great program, but if you don't have the money to fund it, how are you going to get it out there?

Amber: I keep thinking about my experience with being in Oak Park versus the bordering Chicago neighborhood, Austin. I know Oak Park is where your office is, but I want to ask out of curiosity, PCC primarily serves mainly underserved populations, correct? So are you seeing many people from Oak Park or you don't really pay attention to where they're coming from? You're just looking at how to best serve? From the time I've spent in Oak Park and walking around, from what I've seen it's a very affluent neighborhood. That's not to say there were pockets of poverty in Oak Park. But I do still have that curiosity.

Paul: 95 % of PCC patients come from Chicago. I may have that statistic wrong, but it's an enormous amount. It happens to be an accident of geography that our administrative office is located in Oak Park. It's literally right where the Parent Child Center used to be, and we do like that the partnership that we have with West Suburban Hospital, which is a suburban hospital that, I don't know if you'd call it affluent, but it's certainly not a rundown inner-city hospital. It has resources that we are able to provide to our patients from Chicago. So that relationship works pretty well, but the majority of our sites are actually located in the City. Like I said, the vast majority of our patients come from the City, mostly from the West Side, with Austin as our primary service area. Austin, Belmont Cragin, and as far east as Humboldt Park, with a site in Norwegian American Hospital.

Amber: So you have some sites within hospitals?

Paul: We actually have three hospital partners. Each of those hospitals has a primary care site in its professional building. We go from Norwegian American Hospital to the east to the farthest west at Westlake Hospital in Melrose Park. And, of course, West Suburban Hospital.

Amber: This is maybe circling back to the beginning of you talking about your training, but you mentioned that you went to West Suburban because of their training. Was their training geared towards underserved populations? Can you explain a little bit more about that?

Paul: So I went to the University of Chicago for medical school, which is a fantastic medical school, but not a medical school that's built a reputation on caring for the underserved or for training family doctors. In fact, at the time that I went there, there were no family doctors there. There was no family medicine department at the University of Chicago. I went there because it was the best medical school that I got into. They trained me how to think rather than memorize, which I knew would be essential going into the field of family medicine. But after med school, I had no idea where I was going to do my training because I got very little exposure to family medicine.

Amber: But you knew you wanted to do family medicine opposed to maybe any other specialty?

Paul: I knew going into medical school I wanted to work with the underserved, and it just seemed to me that if I was going to be working with the underserved, I wanted to be able to take care of anybody that walked through the door. And to me that meant being a family doctor, taking care of the kids, pregnant ladies, the adults, the grandparents. So, that was very clear to me, I just didn't know where you would go to get that kind of training. So I did a student rotation at Cook County Hospital, which was a fantastic rotation, and a no brainer. I mean, if you want to work with the underserved in Chicago, everybody knows Cook County is a great place to do that. I got a little depressed when I was working there as a student because I saw all the residents working so hard, including at things weren't necessarily furthering their medical education. I mean, the place was so under resourced at the time. This was 30 years ago. The residents were drawing the blood and taking patients to X-Ray and sometimes running

the X-Ray machine. And I was committed to doing that if that's what it took to care for patients. But, I would have rather spent those three years learning the practice of medicine, clinical medicine, and how to interact with patients.

And so fortunately at the time there was another student that was during the rotation with me that was applying to this residency program at West Suburban. And I said, “Jennifer, I don't want to go suburban, I want to work with the urban underserved. Why would I want to go to West Suburban Hospital?” And she said, “No, it's in the western suburbs, but its right across the street from Chicago, and they're starting to do this thing with an FQHC, with their residents training in an FQHC.” I was persuaded that this was worth looking into. The residency program that has a particularly strong reputation for training family docs to do obstetrics, which I knew I wanted to do. And then I had a great interview with my mentor, Mark Loafman, who had just started the place at the time; he convinced me that that was the right place to do my training, and he was right. I love that model of care, that of an organization run by and beholden to the community. The Board of Directors is comprised mostly of patients that use the center. They're the ones that decide the direction of the center, rather than the city, the federal government or the state government, or a hospital, or a for-profit chain, or whatever. It's the community that runs that center, the idea of which I liked right away and ever since.

Amber: Why did you decide that you wanted to get an MPH? What drew you after so many years in medical school and residency?

Paul: Taking care of patients is what drives me, and it does still. That's my main job, of, you know, eight jobs. My main job is being a doctor, taking care of patients. But through the course of residency, I came to realize (or at least hope) that there were broader ways to serve the neighborhood that I was serving. Not simply that patient that was in front of me, but developing programs that could get a woman without insurance her mammogram; particularly on a bigger scale, to go into the community, make services available, and let women know what was available; that mammograms were a good idea, address their fears about breast cancer and breast cancer screening, and clarify any misconceptions they had. Community-level programming like that seemed to be very complimentary to direct patient care. The best way for me to learn this approach seemed to be a learning public health, particularly when we had this great organization like UIC. To this day, I am very pleased with my educational experience at UIC, because it's a public health school that was, and is, very committed to community-level programming and public health. So it was a perfect fit for what I wanted to do.

Amber: So now I want to talk a little bit about how you see health equity in the future, especially in Chicago. So are you optimistic or are you pessimistic about the way things had been going? Like where do you see things maybe in like 10 years from now?

Paul: I'm optimistic for sure. I think I am not a Pollyanna. I know that there are huge challenges. I don't think things are going to be completely fixed in 10 years. I don’t think things are going to be fixed in my lifetime. But I look around at other people in organizations in Chicago that are genuinely committed to making things better for those most in need, and I cannot help feeling optimistic. There are such talented people, both from the communities that are being served and external of those communities that it's going to get better.

Amber: I’ve found that many people try to stay optimistic because they sort of feel like you can't be pessimistic in this work because then you're going to have really no motivation to do your job.

Paul: Absolutely true. Every day. And I hate to say it, I see people that leave this field due to burnout. I see doctors that worked in my health center and it became too much; the work was too challenging, particularly in dealing with the stress our patients and families face. Stories that were much. These providers went into another field of medicine, sometimes leaving underserved areas altogether. I will say that many of those people that burned out eventually came back, they just needed a little break. They needed some perspective.

You can't charge into it and say I am going to fix poverty on the west side of Chicago and it's going to be done in five years. Of course, nobody thinks that, but I think deep down some people may be unduly optimistic, so you've got to temper that optimism with some realism and know that things aren't going to be fixed completely or right away. But every small bit that I see improve makes me glad that I'm doing this and energizes me to continue doing it.

Amber: And you've been at PCC for so long. Almost 30 years that you've been there? I believe you teach as well?

Paul: In addition to being the CMO at PCC, I'm also the associate program director for the West Suburban Family Medicine Residency Program (my alma mater), which I love. I think it's a residency training program does a great job, not just a training family doctors, but training family doctors to do the kind of work that I'm doing, to work with the underserved. I believe in that so deeply that I was very happy to accept a teaching position there, which is also very energizing for me. Working with a constant infusion of young doctors that are idealistic and believe they can do great things; that's great for me to be able to work with those people. It's also rewarding for me to have some part in molding those doctors the way I think the underserved patients that we take care deserve. That's a nice thing for me to do.

Amber: I am glad to hear that. I am especially glad because I am learning that many nurses and doctors are getting trained and educated in public health, and they are able to see beyond just the individual, just like your training at West suburban. That makes me optimistic.

Paul: That goes back to what you asked me earlier, whether I was optimistic that things were going to improve. And the answer to that is, absolutely. I do think we occasionally will take some wrong tacks -- for instance, what happened with the soda tax; Toni Preckwinkle was trying to do the right thing, trying to institute a public health measure and it ran afoul of big business interests. So definitely we take some wrong turns, but I think on the whole the direction's going to be the right one. In 25 years that I've been at PCC, I've seen Austin's health statistics get better. There are fewer teenage pregnancies, there are fewer people that are dying of preventable diseases. And so yeah, that's sort of the goal.

Amber: So do you have any advice for students who may read this interview? We know a number of students will, especially people in MPH or people in sociology that who may be starting their careers. Do you have any advice for them?

Paul: For sure, I have all sorts of advice. We were talking about optimism and realism and I think you need to balance the two. If you're starting out, you shouldn't start off pessimistic. I know are people that have that personality, but honestly, I think you have to have some ray of hope that the work that you're doing is going to make a difference without assuming that it's all going to fail, or assuming that if you do the best work you possibly can that the rest of the world is going to fall in line. I mean, it's not just your work. You have to partner up with other people who know what they're doing; you have to work

together in a concerted effort. You're generally going to be in good shape if you work with confident, realistic optimism in partnership with other people. I think that's probably the best thing for our kind of work.

The other thing is don't do it for the glory, don't do it for the money -- because you're not going to get either one of those things. There are people that are invested in the public recognition, but that's not the reason to do it. The recognition that's best is from the patient that's in front of you. And even then, that patient may not be grateful. I mean, they might not thank you for what you're done -- and that's fine, because that's not why you're doing it either. You're doing it to see the patient get better. That in itself is its own reward. I think that's the reason most of us do this, because we're interested in seeing other people get better.