Dr. O’Connor: Welcome to the latest episode of the Health Disparities Podcast from the Movement is Life Caucus. We are a cross-functional initiative committed to eliminating musculoskeletal health disparities across race, ethnicity, gender, and zip code. And of course, we cannot do that without seeking to expose the root causes of these disparities and understanding the multiple determinants of health. I'm Dr. Mary O’Connor, chair of Movement is Life. I'm also the Chief Medical Officer for Vori Health, a healthcare startup on a mission to empower humanity to lead their healthiest life. Prior to co-founding Vori Health, my career was in academic medicine as Professor of Orthopedics at Mayo Clinic and at Yale School of Medicine. A recently published article in Kaiser Health News, talked about how many hospitals, wealthy hospitals enjoyed a banner year with federal bailout income. But at the same time, some of our most needy hospitals struggled to keep their facilities open during this pandemic. Today, we welcome our panel of three guests for a round table discussion about the pivotal role played by safety net hospitals, and the care of their local residents and the challenges that they face and how aspects of the pandemic bailout may be distributed inequitably. I'm going to first start by introducing our panel. We have Dr. Nur Nurbhai, who's a board certified, and fellowship trained Orthopedic Surgeon at the Phoebe Putney health system. Dr Nurbhai by specializes in hand upper extremity and microsurgery. He's been a member at Phoebe Orthopedics since 2012, and recently joined us on the steering committee at Movement is Life. Welcome to the podcast, Dr. Nurbhai.

Dr. Nurbhai: Thank you very much, Dr. O'Connor. A pleasure for me to join this and it's an exciting topic that you have come up with. I think it's critical in this time for us to have this discussion. So, thank you very much for having me.

Dr. O’Connor: Well, you're very welcome. Excited to have you with us. Next, I'd like to welcome Dr. James E. Eddie Black, an emergency physician and Phoebe Putney Health Systems Medical Director for Emergency Services. Dr. Black has been on the front lines of the COVID-19 fight from the beginning, leading the team in Phoebe's main emergency center as they treated an overwhelming number of COVID-19 patients. He was recognized as the 2020 physician of the year by his health system. Congratulations and welcome, Dr. Black. We're delighted you could join us today.

Dr. Black: Thank you, Dr. O'Connor for the invitation. And I look forward to the discussion.

Dr. O’Connor: And last but not least our legislative affairs and rural health expert, Bill Finerfrock, who is president of Capital Associates and a leader at the National Association of Rural Health Clinics. Bill joins us again after recently hosting several podcasts. Bill, it's good to see you again.

Bill: Good to see you, Dr. Connor and Dr. Nurbhai and Dr. Black. And look forward to today's discussion.

Dr. O’Connor: Okay, let's get into it because this is such an important topic. Dr. Nurbhai, first let's define for our listeners what do we mean by a safety net hospital.

Dr. Nurbhai: The safety net hospitals are critical to rural communities as well as urban communities. And for me essentially is a hospital that's providing care for uninsured or low access patients. We have a large community of Medicaid patients here that we provide extensive care through the system.

Dr. O’Connor: And Dr. Black, how does this impact your work as an emergency room physician and leader in terms of you working at a safety net hospital?

Dr. Black: Well, as Dr. Nurbhai alluded to, we have the mission of taking care of all of the patients, where some of the health systems may have the luxury of not sharing in the burden of providing anything under their basic needs to those patients that may present to them. And we pride ourselves on giving those patients with limited access or that are underfunded the same care we give anyone else. So, it does present a challenge, especially during tough economic times and certainly when there's a shift in either you're mixing a payer source, or we feel the

brunt of that because we still want to maintain our mission of taking care of everyone.

Dr. O’Connor: Bill, I think that people in rural America face particular challenges. And how do you see the role of safety net hospitals in terms of rural America?

Bill: Well, as Dr. Nurbhai and Dr. Black have both alluded to, they're critically important. Very often, they're the only healthcare provider in an area, which means that even if they wanted to, they really can't afford to turn anyone away because otherwise folks have no access to care. And so, they tend to have a much higher percentage of their patient volume is Medicare or Medicaid in particular. And those two payers relative to commercial insurers are not generally viewed as better payers. And so, because of the unique situation in their communities of being the only provider, their inability to turn away patients because of their mission and the reality that they are the only game in town, means that they're particularly vulnerable to lower payments from a payer challenging and jeopardizing their very existence.

Dr. O’Connor: I'm going to take a step back and try and put myself in the position of a listener who doesn't really understand medical insurance and medical payment models. If people have insurance, then don't doctors and hospitals get paid? I mean what's the problem? What's the

difference between commercial insurance and Medicare or a Medicare Advantage Program or Medicaid?

Bill: What an insurance company is going to pay is going to vary from company to company and payer to payer. On any particular procedure, the differential could be thousands of dollars where a commercial insurer may pay $10,000. Medicare may pay $5,000 for that same procedure and Medicaid may pay $2,000 for that procedure. And so, you have that variability. If you're in an area with good insurance and you're getting the $10,000 for every patient, you're in good shape. If you're in an area with a lot of Medicaid and you're getting $2,000 for that same procedure, it's financially challenging. So, depending upon the type of player and how much they're going to pay for a procedure, is where that all comes into play. Yes, you may get paid, but it could be a differential of three, four- or five-times difference, depending on who's making the payment.

Dr. O’Connor: And Dr. Black, as an emergency room physician, you take care of everyone. Do other hospitals not take care of everyone regardless of their ability to pay?

Dr. Black: Oh, well, as an emergency department, no matter which hospital you are in, you're required by law to give anyone a medical screening exam. And so, you can determine that somebody's condition does not necessarily warrant an emergency department visit, and then they can

refer to a primary care office that day or a later date. When you're dealing in areas where there's difficulty with access or difficulty with funding, a lot of people don't have offices that they can turn to. They don't have a primary care physician and they can't afford to pay with clinics we charged them, and the clinics have the ability not to treat them until they produce payment. So, you know, while we could screen away patients and tell them to seek care elsewhere, a lot of times we have to do the evaluation and work up in the emergency department, which is probably the most expensive way to access healthcare. But when there's no follow-up, we kind of feel obligated to make sure that we do as much as we can for them within reason during that visit. And then that leads to a bunch of, basically, a bunch of charges that are not filled and patients don't pay those bills, but we continue to see them. I hate to use the word abuse because a lot of times patients will have anywhere else to turn and we recognize that. But it does lead to sometimes making you have to take in addition to the people who may have a truly emergency condition, you're also managing some that has less than, emergent conditions and it can clog up the system. But when you are a safety net hospital, you really, have to take care of the patient and you try to think about strategies about how to direct those patients in a more efficient manner, access healthcare but it can be difficult to navigate for people.

Dr. O’Connor: So, in that situation where you have a patient who comes into the emergency room, and you're not confident that they could have

follow-up care the next day, say with the primary care physician. And so, you feel obligated to order tests that you otherwise wouldn't order?

Dr. Black: In some instances, yes.

Dr. O’Connor: Right, okay.

Dr. Black: Absolutely.

Dr. O’Connor: All right. So, now, you're in a situation where if the patient had a primary care doctor that you knew could see them the next day, you would be comfortable sending that patient home and saying follow-up with your primary care doctor tomorrow.

Dr. Black: Without question.

Dr. O’Connor: But since the patient doesn't have the ability to do that because they have no primary care doctor or there's no primary care doctor who will see them because of the insurance that they have right, you end up having to do more tests in the emergency room than you otherwise would. And when you do those tests, who pays for those tests?

Dr. Black: Very good question. If they are paid, you know some we will help patients with financing and sometimes they are just allowed to pay the minimal amount every month but in general, there's a significant

amount of uncompensated care that we provide. In addition to providing extra tests, on some occasions, you might even end up admitting a patient that would otherwise go home if they had someone to follow up with. So, it goes beyond just the testing, those patients actually may be admitted to the hospital because we're not confident they're going to be able to achieve follow-up.

Dr. O’Connor: And that of course then further escalates the cost of their care.

Dr. Black: Without question.

Dr. O’Connor: If they're admitted to the hospital, when in a different scenario you'd be comfortable sending them home, knowing that they were going to have proper follow-up. So, Dr. Nurbhai, put your kind of administrator hat on for me for a minute and walk me through, how is the hospital handling, providing this care for which there's very little payment or no payment? How can the hospital stay afloat when this is happening all the time in safety net, hospitals?

Dr. Nurbhai: The situation is kind of very dismal because we're kind of dealing with the spiral of funding and the amount of care that we have to provide, especially with COVID last year, it came more to light throughout the country and especially in our area where we were really inundated with these patients. So, a lot of times you're relying on state support, you're relaying on local and federal support to help you during these times

and the stimulus packages there were sent out were not properly distributed and that's the issue that we have been dealing with here. The three issues that I kind of discussed with the administration here, when it comes to payments, is really preauthorizing these treatments that these patients require. So, there's been really a push towards proper pre-authorization and proper coding to collect the money for the patients who have been admitted and procedures that have been performed on them, the tests that we have talked about, and then with the COVID situation, the supply chain, the equipment necessary, the kits necessary to do these testings have been difficult to find. So, I think that amounts to really increasing the cost.

Dr. O’Connor: So, I think that the government, that the country, as a whole recognized that hospitals were in trouble, particularly at the beginning of the pandemic. And Bill, I want to turn to you for a second and say, fundamentally why were hospitals in trouble when they're full of COVID patients right. The hospitals were not empty.

Bill: Right.

Dr. O’Connor: They just became filled with different patients. So why were hospitals not making lots and lots of money when they're full of COVID patients?

Bill: Well somewhere, just not the right hospitals, but it's a great question and it's a valid question and it's kind of interesting. You can almost look at the calendar and March 15th of 2020, the bottom fell out of the healthcare delivery system in terms of patient volume. You had a combination of patients who didn't want to go to the hospital who didn't have COVID, who were afraid to be around sick people. You had states and others saying, we're going to cancel non-essential surgeries and procedures in order to preserve beds, equipment, and personnel to deal with the expected surge of patients due to COVID. So, yes, you're right, those beds got filled but what happened was they got filled with patients who were consuming large amounts of resources at that institution, and they were taking beds away from patients who, from a financial standpoint, we're more profitable. If I have a bed with Patient A, and it's costing me $5,000 a day with all the things I have to do to maintain that patient, and I have another Patient B who could be in that bed, but it's only costing me 2,000, I might've wanted to have that bed filled with Patient B. But because of COVID, all my beds are being consumed, all my resources. And so, hospitals like any business, it's a balance. You have certain patients who are profitable, and you have certain patients who are less profitable. Meaning, the margin between what it costs me to provide care and what I'm going to get paid, some is greater than others. COVID patients were very narrow if any margin. In orthopedics, you tend to have a more attractive margin. So, if you lose, if you take a bed that would have been filled with an orthopedic patient, and now you fill it with a COVID patient, that's not good. Dr.

Nurbhai, also his volume is now tanked. You know, he maybe had a number of surgical procedures he had scheduled that he's now not able to do, so his revenue just dries up and goes away. Even in the emergency room, we saw volumes drop significantly in emergency room patients, because they were afraid. There were a lot of people who might've gone, “Oh, I twisted my knee. Maybe I should go to the emergency room. Well, I don't want to go to the emergency room. I might be around all these COVID patients. I'll suffer, I'll stay.” So, beginning mid-March, we just saw this huge drop in volume and that created tremendous financial hardship for doctors and hospitals and the entire healthcare delivery system.

Dr. O’Connor: Dr. Nurbhai, tell us about your experience during that time when the volume dropped.

Dr. Nurbhai: So, we were essentially in the emergency mode where the elective cases and the clients that come in your clinic were stopped. They weren't coming because of the fear and the injunctions, and the mandates. So, we were essentially in an emergency boat mode as an orthopedic practice because we are associated with Phoebe Putney Hospital, we were employed by them. We were essentially dealing with trauma cases that would come in. And with that also the toll of using the equipment, appropriate assignments of the COVID patients in appropriate facilities, that took us tremendous resources as Bill was

saying. So, all of that was concentrated in gearing up for the COVID pandemic and the aftermath that we're still dealing with.

Dr. O’Connor: So, if I have a COVID patient in the hospital, that patient is requiring so much care and so many supplies and resources, that the payment I'm getting from their insurance company is simply not covering, in general, the cost of that hospital and health system providing care for that patient.

Dr. Nurbhai: That’s correct.

Dr. O’Connor: Is that your agreement on the panel?

Dr. Black: On top of that, if I may add, we used the hospital, we have a sister hospital, a sister building on another campus that we typically turn into a COVID facility but in order to stand that hospital up, we had to hire physicians and nurses, respiratory therapists, and the like, and at premium rates. Not only are they're not reimbursing as well, but they're also costing you more in order to take care of. And, you know just to be clear, we never thought of doing anything differently because of cost, but it's just a reality that it costs, there’s not a profit in general taking care of coronavirus patients. And also, if I could just provide a little, I guess context for this, early on you referenced the March 15 date, we actually had our first few coronavirus patients before then. And you know, we thought that we had been planning, but we thought since he

was somewhat isolated off of I-75, we thought it was going to be a big city problem and we'd watch to see what the large hospitals did. And we took stock of our resources and we setup our command center and we said okay, we're going to watch it and we're going to be ready. And we did, and we said we had six months of supplies. Well, we had a young man that came down from Atlanta to a funeral home that was servicing two funerals and it began an outbreak in our community. And at one point in time, I believe March 27th, we had vaulted to number four in the world and behind Wuhan, China, Lombardi Providence in Italy and New York City. So, it's not the way you really want to be vaulted to the world stage.

So, some other things that you might not realize going on at an early point in time, we could not, we filled up quickly. Our numbers exploded exponentially, and we were trying to transfer patients out and we had hospitals that refused to take our patients because they did not want the COVID patients coming there and they also knew what it would mean in terms of, for us, we shut down our elective surgeries early on. Turned [inaudible 20:09] into ICUs, but other hospitals didn't want to do that. And you know and also talking with some people there, there were hospitals, they're reluctant to release any information about coronavirus patients, because they didn't want the patients to stop coming there. They did not want to shut down the elective surgeries because of the impact it would have financially. We chose to be very transparent about it, as we thought it was the best way to take care of

our community but just realizing that not everybody was so forthcoming with information and certainly not forthcoming with help early on. So, we bore a lot of that brunt, I guess in terms of response, we were fortunate that the state stepped in and helped us with so many resources, but it put a big toll on the hospital and certainly transformed what we're doing. As an aside, though, we did get a lot of help from orthopedic surgeons who were volunteering to come down to the emergency department and help out in any way they could. Never thought I'd see the day, Dr. Nurbhai, but he would always come down. And you know instead of him groaning when I called him, he was like, “Hey, what can we do to help?” And you know, “Can we set up here? We'll see all the orthopedic patients.” So, it really shows a lot of people helped us, too. A lot of people just stepped in, in ways that they had not done in the past and in trying to redefine how they're going to help combat. So, that's the one good thing about being in a community like ours, in a community our size, but it was definitely trying.

Dr. Nurbhai: That's absolutely right.

Dr. O’Connor: Well, Dr. Nurbhai, If I could give you Orthopedic Surgeon of the Year Award, I would do so. I know a lot of orthopedic surgeons, you know stepped up and helped and we saw that particularly early on in the pandemic, with orthopedic surgeons and residents supporting the intensive care unit teams by basically becoming teams that would turn the patients, because the patients required frequent turning. And just

being able to go in and support the intensive care unit team with doing that physical work of being skilled and knowledgeable on how to turn a patient who's intubated. I mean that was important. And at the end of the day, you know we should all be here to help serve our patients and our communities.

I want to go back and explore a little bit more detail the payments because we know that we've seen some hospitals and health systems record banner financial years and others struggling. And even hospitals closing right at a time when their communities need them the most. So, I'm going to start with Bill and ask Bill to try and explain, I mean is it possible to make sense of how the federal bailout program to hospitals worked and why some hospitals, it's almost like the rich got richer and the poor got poorer.

Bill: I guess the best way to try and explain it is the federal government made a lot of money available. You hear talk about the CARES Act and some of the other resources and folks that at the Department of Health and Human Services reached out to myself and others in the health policy community and said, look, we've got this money. How do we get it out there as quickly as possible? And that was really a singular motivation of we don't want to sit on this money. We know that people need it. And how can we get it out the door as quickly as possible? We don't want to spend a lot of time trying to figure out formulas and methodologies and go, okay you know, four weeks later we've got the

perfect methodology for distributing the money. But oh, by the way, 200 hospitals closed while you guys were trying to figure out how to design the program.

And so, they did a very simplistic, give me the percentage of whatever your revenues were for Medicare for last year and we'll give you an amount equivalent to, you know, 2% of that, just to be able to get the money out the door. Well, if you happen to have a lot of Medicare patients, you did great. If you didn't have as many and because of, it wasn't at all correlated to the COVID volume at that point that you were seeing in your community. And so, you had communities like the communities we're talking about here, Phoebe Putnam, who had a crazy percentage of patients who were being infected by COVID but the money that they were getting bored no resemblance to what they were experiencing at that level. Meanwhile, other hospitals that we're not seeing the COVID infection were getting money based on their Medicare and again, no correlation. So, I think at its core, that was part of the problem, but I can't fault the folks at HHS for wanting to get the money out the door and not wanting to sit and make the good be the victim of the perfect. I think they subsequently tried to come back and figure out through second and third tranches how to get some of that money, better aligned with need but in those early stages, it was, let's get this money out the door. It's not doing anybody any good if it's sitting in the treasury. Well, we figure out the best formula we could have.

Dr. Black: And along with that, as they found out better ways to try to manage that, the rules on how to spend that money changed and it actually got a lot of hospitals into trouble, because especially the smaller the organization in theory the less, or let's just say hospitals with less cushion. And as they were getting this aid, they were spending it on things that they thought were appropriate according to what they understood. But later on, the rules kind of changed how you could spend the money, so some organizations found themselves having to return those funds if they have spent them, against the change in the rules as opposed to saying, well we know you spent it under this set of guidelines. It's okay, the guidelines changed, and people had to pivot on how they spent the money and, in some cases, returns them. So, if a hospital had very little cushion, especially some of the smaller hospitals, they found themselves in as bad or worse shape after figuring out that money had been spent, not according to the change.

Bill: Yes, I think Dr. Black is absolutely right. That you know, as the program evolved and these started getting people in there who were concerned about, well was the money spent for what it was intended? Are there concerns about fraud and abuse and are we going to get blow back, if somebody finds out that a hospital didn't spend it on COVID? And so, they came out with an initial, statement on, well this is how you're going to determine whether you spent the money correctly and whether or not you have to pay us any back. And then the hospital

community said, wait a minute, that's not what you told us initially, that's not what we do with the money. And so, the government in the fall came back and said, all right we're going to be a little bit more flexible. I think it would be unfortunate if anybody did turn money back because I think at the end of the day, the government will figure out how to make sure you didn't have to pay it back.

Dr. O’Connor: Dr. Black, one of the hospitals in your region recently closed. Can you tell us about that and the impact of that closure to the community?

Dr. Black: One of our neighboring communities has, I guess for lack of a better word, there's a hospital building that houses not only an acute care hospital, but a nursing home as well as an emergency department and they're associated with a couple of physicians clinics. And due in large part to the coronavirus pandemic, they experienced a significant financial challenge and were unable to continue operations with the acute care hospital or the emergency department, so those have closed. The nursing home is still functioning, albeit at a lower census than it has been, and it's devastated the community as it is the largest employer in the community and the largest economic driver. And so, we've seen that play out more than once, in this part of the state but certainly that was one that hit close to home, so we're in fact seeing higher volume from that region as they've lost, essentially a lot of the

healthcare services and the two physician's offices in that region, as well.

Dr. O’Connor: And so, when a hospital, you've experienced this type of hospital closure in your region how much further do people, patients, members of that community have to travel to access care?

Dr. Black: From that hospital for some of the resources, they traveled to our hospital, which is about close to an hour, 50 minutes to an hour. And there's another hospital, our size about another hour on the other side of them. So, they would have to travel about anywhere from 50 minutes to an hour in any direction to get acute care services. You're also talking about people with sometimes not a lot of choices as far as transportation and so forth, and it's really putting a tax on them. So, in addition to, and I think Bill talked a lot about some of the challenges we had in taking care of patients due to coronavirus and fears surrounding it. On top of that, you later run into people who, there may be some mistrust of healthcare. And now, you put in a barrier like travel, and time and distance is causing, it's taking a toll on people, maybe waiting an extra day or two, or week or two on conditions and in effect, making them worse.

Dr. O’Connor: Dr. Nurbhai, I want to come back to you because I think that a lot of people think of orthopedic surgeons as primarily treating conditions that are non-urgent right. I mean sometimes there's a

fracture and that requires something more urgent in terms of an evaluation or treatment. But share with us your thoughts about how these delays either a delay in the patient being able to access services, because now they've got to drive an hour right, to get to the closest emergency room and the impact of delays because of the pandemic with patients not coming in for timely care. How do you see that impacting the health of your community?

Dr. Nurbhai: Yes, so we have seen directly where our census dropped in our clinics because of these issues and then this recent closing or another hospital. So, what is happening is either these patients have to wait, we do telehealth to try to help them and connect and at least sorting out some semblance of treatment for them when they can't make it to us. And but unfortunately, they have to rely on the emergency routes in the local areas for us to get them in a safe area to be evaluated by appropriate healthcare. But there's a lot of it in communities here where people will wait, and they'll wait and wait until the conditions get worse and that's when they will come to the hospital. So, this is something we could have taken care of two weeks ago. Like you said, now they've just waited, and the condition is worse and that puts more burden on the system, taking care of things more urgently because the conditions have progressed. We see that quite a bit here, a combination of transportation getting here to the clinics, as well as just being able to be accessible to our inundated facilities already.

Dr. O’Connor: So, when they wait longer, when they delay care, their care ends up being more complex, which means it's more expensive, which also means there's a higher risk to the patient in terms of an adverse outcome. Is that an accurate summary?

Dr. Nurbhai: Yes. Yes. A lot of these can, we can treat it acutely in an outpatient basis, efficiently in clinics but if they're far gone, they'll require hospital admissions that will definitely increase the cost of care.

Bill: If I could add, I think that also then becomes significant from a payment standpoint, when you look at a lot of the new payment models that are predicated on an expectation of an average patient, average length of stay average cost. Now you take the patient who might have met those parameters, they are more complex, potentially requiring a lengthier length of stay, more involved, post-hospitalization rehab but you're not going to get paid anymore because the payment was based on the average patient. So, that delay has also created a financial problem for you because the cost has gone up, but the payment doesn't go up commensurate with that.

Dr. O’Connor: All right. I'm going to ask the panel one more question than we're going to ask for some, thoughts on action items. But the question I want to ask is why do we view hospitals, or let me say access to acute medical services, any different than we view a fire department or police department in terms of essential services for a community. I

mean we wouldn't think of not having police services or fire department services for people, but yet, somehow, we think it's okay that there's nobody to evaluate you if you have an acute medical need. Dr. Black, I'll let you comment on that first.

Dr. Black: That's a very complex question, I think it arises out of a few different things. And I think that number one, we at least in the emergency department think that we service that acute care need much like the fire department or the police department. As a matter of fact, we think that a lot of people consider us, that's the go-to place, and indeed we are certainly when there's an acute need. I think the thing that complicates it as far as what's necessary in the inherent thought that it should be supplied like the police department, like the fire service is that there's also a component of healthcare that is not essentially emergency based. You know, we don't call the fire department out to help us water the garden. They're there if there's a fire, although they have tons of water, we think. And for healthcare, certainly if I'm having chest pain or stroke like symptoms, we expect primarily the hospital personnel with EMS to come and pick us up, come to the hospital and be treated in an expeditious fashion. And we're going to obviously going to treat everyone, but along with that, there's also a component of health care that has joint replacement that is less than urgent and not always the only option. I guess you know if somebody can live with chronic pain, there are other options or reconstructive surgery or cosmetic surgery, things that are somewhat elective in nature.

So, there's an elective services component that can be very profitable for healthcare that I think when people are trying to parse it up, yes there's a part that we think everybody that'll be, ought to be taking care of and the perception is that's being done by the emergency department. The rest of healthcare is a moneymaking venture or a moneymaking entrepreneur. So, it's hard to separate the two as to why people don't want to provide overarching healthcare. Did I make sense with that?

Dr. O’Connor: No, that's a great comment. Dr. Nurbhai.

Dr. Nurbhai: Yes, I think I echo exactly what Dr. Black says. There's that financial incentive for hospitals to have providers in town and the healthcare team that will bring in the money for the hospital and for it to sustain itself for situations just like where there is not going to be enough payers to pay and for low-income persons. So, there's a balance that has to be created between really having efficient hospital that will take care of well and treat patients. At the same time, having a strong component of providing care for the low income. So, that's always been the dichotomy that we have to deal with.

Bill: Well, I'm going to respond using a phrase that you've often quoted a former nun.

Dr. O’Connor: Sister Generose.

Bill: There you go, and her famous saying was, “No money, no mission.” And this has always been the ying and the yang in healthcare. The mission part of healthcare and why so many people go into healthcare to help people, to make people better, to keep people healthy, but you need the money in order to be able to do that. And the other thing I don't think we can ignore is that we have as a society, for a lot of good reasons, chosen to highly compensate individuals who provide healthcare and that makes it difficult for a lot of people, communities to be able to afford. I mean if you use your police-fire analogy, I could probably hire six or seven police officers for what it would take me to hire a one orthopedic surgeon. So, we can't afford to put an orthopedic surgeon in every community, but we can't afford to put police or fire into a lot of communities. But it really is, and I don't think we as a country have really reconciled this idea between mission and money. We, as a society I think believe that everyone should have access to healthcare, but we haven't set up a financing mechanism to back up that vision, that goal of healthcare available to all. And so, I think we're going to continue to struggle with that challenge of trying to make sure people have access, but how do we figure out how to pay for it?

Dr. Black: You know, I think that everybody needs, I mean define basic healthcare and if everybody has access to basic healthcare, where does basic stop? And you know does it cover gallbladder surgery, acute appendicitis sure. Does it cover a tummy tuck? Maybe not. Does

it cover hip replacement? You know there's going to be people parsing the line and I think the thought of denying some segments of healthcare to some is not palatable to people. You know, whether or not you set limits on dialysis, maybe you stop dialysis at 70. And I think that we have never had to deal with the possibility of denying any aspects of healthcare to any but if you're going to start to manage costs in a better light, you're going to have to say that some things percentagewise, we're not going to offer to everyone.

Dr. O’Connor: Dr. Black, I just want to follow up with my comment, that we in essence want to embrace the concept that we are providing healthcare for all, at least some measure of healthcare for all. But the reality is, is it through our systems and our structures of systemic racism and institutional racism in our healthcare systems and our payment methods, we essentially deny healthcare to many. That is the reality of what's happened and that's why we see safety net hospitals closing because we have a payment system that doesn't reimburse to a level that supports financial viability of that hospital or organization. And then, when that safety net hospital closes, those patients are basically denied a certain level of care or certain level of access. So, we are still not really facing the music about the reality of our system, from my perspective.

Bill: And it leads to something we've talked about, which is this question of zip codes and when you look at a zip code and why do some people in

zip codes, is the mortality rate so much higher, in some codes compared to others. If that safety net hospital closes, the community that it is serving does not realistically have access to the suburban hospital that has a much better payer mix. And so, those communities go without care, problems deteriorate, and people end up dying prematurely, simply because they cannot get care that they need to resolve medical problems that are easily treatable, but people just simply don't have access to the healthcare delivery system because geographically there isn't any place to go.

Dr. O’Connor: That is this true and very sad statement. Dr. Nurbhai, take us to a more positive place. What do you think are solutions for our safety net hospitals? If you could wave your magic wand and make a change, what would you change?

Dr. Nurbhai: First thing should start from the actual federal level where the expansion definition of safety nets should be changed. I think you should be including hospitals that are low safety net hospitals to high safety net hospitals in terms of the burden that they have to carry. So, that stratification that I've read about has to change. The other is for the individual states to really control the funding to the hospitals. Now at Phoebe Putney, I know that Georgia, the state of Georgia has really helped out during these times and the hospital associations have really helped out. So, I think the onus should be on the States to really recognize the safety net hospitals and put more funding into it. The

other is to have the insurance companies recognize these hospitals as not so much as a money generator, but systems that will provide general preventive healthcare in order to prevent acute situations to arise. And I think there's a cost benefit there in promoting preventive healthcare.

Dr. O’Connor: Dr. Black, if you had your magic wand, what would you change?

Dr. Black: We need several magic wands. You know, I think that's the emphasis and I think healthcare in general has to continue and we're already doing this, but pivot in the direction of providing healthcare to the patient in the ways that they can receive it. So, you know it used to intrigue me when people say, well, we'll have access to healthcare. I'm thinking, well, the emergency department is open 24 hours a day in most places. So, people have access, but in addition to physically having a location, people have to be able to access healthcare. So, that might be transportation limited, it might be trust limited. There are a lot of different factors that we in healthcare have not really addressed as far as the community is concerned. So, I think we have to pay better attention to the community and involve them in decision-making and throwing up another hospital in the neighboring county doesn't necessarily fix access, so determining how best to deliver healthcare to the individuals. And as Dr. Nurbhai alluded to and I think we're all very familiar with, we really have to shift our response to acute care. And it's kind of funny coming from me because that's what I do, I respond to

acute care emergencies. But emphasis has to be on health and health maintenance, preventing a lot of the long-term effects that we see. So, until more energy is devoted to that, well I think that's one of the things I would like to see is a lot more energy devoted to health maintenance as opposed to episodic healthcare, which is basically what I provide in the emergency department.

Dr. O’Connor: Absolutely. I've said this before, you know sick care belongs in the doctor's office, but wellness care belongs in the community because that's the key to creating better health. It's not the patient going in to see the doctor, it's the patient being able to get fresh fruit and vegetables at a reasonable price. That they're not living in a food desert, that they can go out and walk safely in their neighborhood for exercise, that they're not breathing horrible air and having higher rates of asthma. I mean, it's a whole constellation of the environment with where we live that contributes to our health and wellbeing. So, Bill, I don't want to forget you and your magic wand. So, what would you do with your magic wand?

Bill: Well, I was thinking about it. I remember as a kid, remember you would get, there was a genie in the bottle and you rubbed the bottle or the thing, and you'd get.

Dr. O’Connor: You're dating yourself.

Bill: The genie would pop up. No, I'm not talking about, “*I Dream of Jeannie*”, but you know you'd rub the lantern, and you get three wishes. And I always thought, okay well, you know, good health, good income and then I want three more wishes. Why didn't they ever ask for more wishes as their third wish? So, my magic wand is going to not only solve it but ask for additional magic wands that Dr. Black and I can do all the other stuff that we want to do. One, I think it has always struck me as odd, when I talked earlier about some procedures are more profitable than others. And like okay, well, why is that? Why is the payment system not designed so that procedure, any procedure is profitable? In other words, if you look at any other segment of our economy, if you were to ask someone to go out and produce something and say, oh, by the way, I'm going to pay you an amount that doesn't cover the cost of you producing that, and then expect people to produce it, it doesn't make sense. But in healthcare we do that, we take some procedures, and we say, if you do this, you're going to make a ton of money. If you do this, you're not going to make any money at all. Well, why is that? So, I'd like to see number one, that we figure out why we pay, we price certain procedures so that they are financially losers, and we price other procedures, so they are financial winners. I think we have to do a better job on prevention.

Dr. O’Connor: Bill, can I interrupt for a second.

Bill: Yes.

Dr. O’Connor: Is it the pricing or is it the reimbursement, right? Because a hip replacement on a patient who is healthy and not overweight, who can be discharged the same day and go home right, costs a lot less.

Bill: Right.

Dr. O’Connor: Than me doing hip replacement surgery on the obese patient whose BMI is 40, who has diabetes and hypertension who needs to be in the hospital for two or three nights, and then maybe even be discharged to a skilled nursing facility.

Bill: Then let's pay for that. I mean it's the fundamental flaw of this, we've designed a system where we want to make the payment based on the average patient. And the fact of the matter is the average patient only exists on paper. You know you should get paid more, if you have that patient who's more complex, who's going to require more consumption of resources, who may require post-hospitalization, but the system isn't designed to take that into account. Now, that's something we've talked about and there's a lot of discussion now to some of the points that have been raised here of recognizing that healthcare is more than just the discreet delivery of care based on a diagnosis that's in front of you. There are all these environmental social factors that contribute to the cost of healthcare to healthy lives and to try and look at how the system is designed to begin to take that into consideration. There is an

access component in terms of geography, how do we improve access to healthcare so that individuals have reasonable access? Now, we focused a lot on personnel, but now we have technology. How can we better use technology? Whether it's telehealth, in terms of the ability to actually engage a patient in the same way that we're engaging here over this electronic communication, why can't we have that same kind of communication more available to individuals and healthcare professionals?

I think we have to look at expanding the types of healthcare professionals that are available. The original system was designed on doctors, but now we have a plethora of different health professionals who are out there. The system has to expand and recognize that there are a lot of different people who can contribute to the health and betterment of society and also help to lower the cost of healthcare and equity. I think we have to also insert this concept of equity or equitable healthcare to ensure that it is available to everyone.

Dr. O’Connor: Well, that would be a beautiful magic wand, Mr. Finerfrock. Exactly, I love that one. So, I want to thank our panel. Dr. Nurbhai, Dr. Black and Mr. Finerfrock for joining us today and helping us to have a better understanding of some of the challenges facing our safety net hospitals. And I want to thank all of you for listening to this episode of our podcast. We appreciate you being part of our growing audience

and this broad movement standing for health equity. Be safe. Be well.

And we look forward to seeing you the next time.

(End of recording)