Dr. O'Connor: Hello and welcome to the Movement is Life Health Disparities podcast. My name is Mary O'Connor. I'm honored to chair Movement is Life, and I am so excited today to have Dr. Wayne Riley with us. Dr. Riley is the President of SUNY, that's the State University of New York, Downstate Health Sciences University. Dr. Riley is an internationally renowned physician leader, and he's here to talk to us about many of the challenges that we're facing, particularly related to safety net hospitals, Dr. Riley, welcome.

Dr. Wayne Riley: Good to be here, Dr. O'Connor, what a wonderful opportunity and pleasure it is to be with you.

Dr. O'Connor: I have to share with the audience too, that Dr. Riley and I actually went to college together. We overlapped. And so, it's always kind of refreshing to encounter someone that you went to school with way back when. Dr. Riley, tell us a little bit about your journey from undergraduate to where you are now and in terms of how you developed this passion for health equity in the work you're doing today?

Dr. Riley: Well, thank you again, Mary. You know, I'm the wonderful beneficiary of having had a physician father, which is a very special sort of situation to be born into. I was born during my father's sophomore year of medical school, and he was my first hero. And the reason why he had such an

impact on me is that he was tremendously, even though he was a surgeon; surgeons tend to be a little more analytical, a little more you know, by the book, but he was a wonderful humanitarian as a surgeon as well. But more to the point of how I got interested in this work, this important work that this conference and you are highlighting is the fact that he was an inner-city doctor. He took care of people who didn't have insurance. He had a lot of his patients were on Medicaid. His practice struggled because he was a pretty much 80% Medicaid practice. But he loved every minute of what he did to serve the community in New Orleans, where he grew up. He felt a strong tug to return back to New Orleans after his training, after we moved around the country during his residency years, he felt a strong tug to return to his roots, which he did. And I didn't realize it until many years later that that was a difficult decision for him, but he understood how impactful he could be in working in New Orleans and trying to help improve the healthcare of inner-city communities.

Dr. O'Connor: Well, that is wonderful and I'm sure that he and your mother were both very proud of you. And although I suspect that maybe he teased you a little bit that you didn't become a surgeon and that you went into internal medicine.

Dr. Riley: Well, he teased me for two reasons, you'll get the first one. He often used to say, oh my, gosh, well, let me tee it up this way. My father was a graduate

of the University of Michigan for his undergraduate degree. So, he'd always tease me and tease me in front of his friends, and said, oh, my son's a failure, he went to Yale. So, Mary and I, Dr. O'Connor, shared our Yale experience but he'd always tease me. Oh, you're a failure son, you went to Yale, you know, just in a very loving way. Again, the foundation that he and my mother provided, I'm the oldest of five, set the tone for why I've undertaken this tremendous opportunity to be of service. And that's the way I look at my daily life based on my background, my passion for this topic that this conference and all of you and the organizers and all the great speakers are really passionate about. So, this is in my wheelhouse.

Dr. O'Connor: Well, I suspect it was a little easier on your dad because Yale never played Michigan in football.

Dr. Riley: Thank God.

Dr. O'Connor: You didn't have to pick any sides on the athletic front. Alright. Let's talk about your leadership and the challenges that the health system that you have led faced in the early parts of the pandemic because you all were really at the epicenter of when things got bad first.

Dr. Riley: Absolutely. I remember it so well, Mary. I was in a conference in Atlanta, Georgia and it was just after MLK Day January 2020. And like many of us,

I get these little email alerts from CNN. And I kept getting these alerts from the New York Times, Washington Post, CNN about the first case identified in Washington State. And I said, oh, no, that's not good because I had been following the Chinese experience with Covid that was going on before the holidays in late 2019. And again, the Chinese experience was that this virus, which was unnamed at that point, was really focused like a laser beam on patients who had a lot of chronic conditions, diabetes, hypertension you know, COPD, et cetera. So, it hit me like a ton of bricks. Oh my, gosh. If this is on our shores, then the community where we work, where I have the wonderful opportunity to lead an institution that serves underserved, predominantly black, black Afro-Caribbean patient population in central Brooklyn with lots of comorbidities, I said, this is going to be bad for us. And so, I left the conference hustled back to New York. Within a week, I think we had our first case that late January and it just mushroomed from that point on. I just remembered that day, sitting in that conference and saying, oh, no, this is not going to be good and unfortunately, my intuition was correct. New York was heavily hit in February, March, April, and May of 2020. The then governor of New York designated our teaching hospital, University Hospital, Brooklyn as a Covid only hospital. We had to decant the hospital overnight, Mary and for those listeners, decanting is a fancy word to say, we had to discharge patients to other hospitals or get them home. We had to empty out the OB ward with women who were about to deliver because we had, per the governor's

order, we had to just basically turn on a dime and get ready for Covid patients. So, at one point, we had over 400 Covid patients in-house at one time, which again, none of us, you and I never had any inkling that in our medical careers, we would deal with a worldwide pandemic. Yeah, we heard about it in our classes, of course but, you know, we heard about Ebola and some SARS and all that, but I don't think any of us really realized that we would experience what we did in the early days of the pandemic.

Dr. O'Connor: Tell us about how you supported your staff, because we understand that as healthcare providers and this of course was pre-vaccine when people certainly felt a lot more stress about getting sick themselves. And even if it wasn't so much that I was going to get sick, I worried that I was going to bring the virus home to my family or my 99-year-old mother-in-law who lived with us that it would surely have killed her. So, the angst that your staff must have felt and the courage for them to come in every day and do their jobs, people don't always remember those moments now that we're in this time of vaccine mandates.

Dr. Riley: Right. Unfortunately, the memory of this is ephemeral, if you will. But in the early days people were scared. They knew that there was not a vaccine, there were just discussions about a vaccine that would be a year later in the spring of 2020, before we would see a vaccine, and there was no well-

established treatment. You know the therapeutics for these types of viral illnesses were very primitive in a sense. The techniques of mechanical ventilation, meaning how do we take care of patients with respiratory distress, were very different for Covid patients versus other respiratory diseases. They were scared, they were scared because we were low on PPE. I remember I spent hours each day, Mary calling around to vendors, "Hey, I need N95 masks. I need surgical gowns, I need gloves." And they were scared. And they said, oh my, gosh, we only have10 days' worth of gloves in the whole hospital on a normal time, we'd have 50 days of gloves. So, I was really concerned about the physical safety of our staff. Secondly, I was worried about the emotional toll because a lot of them then began to have family members who got sick. And I remember so vividly walking through the hospital and visiting with our respiratory therapist and they were just all in a corner bawling. And I said, "I'm sorry, what happened?" She said, "Well, one of the spouses of one of the respiratory therapists had just succumbed in the hospital that very morning to Covid." And I tried to be as comforting as I can, but it was a gut punch that this was very serious.

So, I worried about our staff. I worried about their physical wellbeing. Like I said, we got on the PPE thing. We turned a part of our student residence hall into quarters so that our staff would not go home after working because of the situation you just mentioned, with a 99-year-old mother at

home, many of our nurses have intergenerational families and they were worried about bringing it back home. So, we said, no, we've got one hundred rooms over at the student dorm, go there. So, we tried to anticipate as much need as we could. The other thing, just in terms of taking care of patients, we were starting to run out of oxygen because think about it, no hospital has 200 people on oxygen, even on a bad day, you maybe have 40 people on oxygen. But this is where you had 200 people on oxygen and oxygen supplies were in short supply. I had other hospitals in Brooklyn calling me. Wayne, do you have any oxygen to spare? So, like I said, I think people underestimate the severity of this whole pandemic in that early phase,

Dr. O'Connor: I could not agree more. And I think that people, well, I hope that one of the lessons that we learn is how critical the supply chain is. And we're hearing comments about supply chains now because people can't, you know, maybe get every gift that they want to buy for the holidays but I'm talking about serious supply chain issues for hospitals and necessary medical equipment and supplies to keep people alive.

Dr. Riley: Correct. It came down to simple things. Remember the swabs for testing?

Dr. O'Connor: Oh yeah.

Dr. Riley: Those were in short supply Mary, at a point. Now we take it for granted, you can walk into any CVS and get a Covid test. But in the early days we didn't have enough swabs to perform Covid-19 testing. So, you're right. Supply chain was not something we thought about at the top of mind in many healthcare facilities, because we had been all trained to do what's called just-in-time inventory. You don't keep a hundred days' worth of gloves in your hospital. You keep about 40 and then when you need more, you order more because you knew that it was always there, but during COVID, you couldn't do that because it wasn't there beyond the 40. So, now we have a better appreciation of how to think about supply chain, how to be prepared better. So, that is a good learning, amongst other good learnings too. But that is one that I think is going to be with us forever.

Dr. O'Connor: I hope so because that was a very painful lesson for all involved. Let's take this concept of how critical hospitals have been in the pandemic and view it a little bit broader in terms of what I call safety net hospitals and their role in serving vulnerable populations. And of course, you lead a hospital that serves vulnerable populations, and we know that there have been a record number of hospital closures. Last year had the highest number of hospital closures across the nation. We've seen a lot of closures in rural America, which I hope our listeners... we talk a lot about disparities, not just in urban America, but also in rural America. And so, I hope our listeners to the podcast have a greater awareness of this, but

this is certainly an issue across the country. So, I'm very interested in your thoughts about the role of safety net hospitals in serving vulnerable communities and then we'll talk more about some disparities relative to that.

Dr. Riley: Absolutely. You know, safety net hospitals, first of all, not all hospitals are the same in terms of, sometimes the offerings, but more specifically, the patients who visit that hospital. Safety net hospitals tend to be hospitals that take care of a high percentage of patients who are on Medicaid. They tend to take care of patients who are...

Dr. O'Connor: I'm sorry. For our listeners who may not know what Medicaid is.

Dr. Riley: When I used to teach this, Mary, to our students, I'd call it the M&Ms, Medicare and Medicaid. So, Medicare is for those 65 and above or disabled or on dialysis that most Americans, once they reach 65, if they've worked a certain number of quarters in their life become Medicare eligible, almost automatically. Medicaid is for those who are deemed you know, economically, disadvantaged based upon a percentage of the federal poverty level. It's a state/federal partnership where the federal government provides two thirds of the resources for Medicaid and then each state and territory provide, one-third. So, it's sort of more state specific, but it's focused on those who have high medical needs, inability to get private

insurance. Many times, they're not Medicare eligible yet because they're not 65 or disabled or on dialysis. So, Medicaid is a critically important safety net program for those who can't afford private insurance or aren't old enough to gain access to Medicare.

Dr. O'Connor: Your hospital served a higher percentage of Medicaid patients than other hospitals in the greater New York region.

Dr. Riley: That's correct. For example, we call it the case mix. About 65% of our patients are Medicaid, about another 15% are Medicare, meaning 65 and above, and the rest are regular insurance or commercial, as they say. So, as you can see, most of our patients are Medicaid populations. Medicaid populations tend to have a lot of comorbidities, Mary, they have high rates of diabetes, high rates of cancer, high rates of pulmonary problems, high rates of heart disease. And again, these were the diseases that the virus was laser beam focused on. So, a lot of safety net hospitals really became very important community assets because they were the trusted partners in their community. For example, in our community, in central Brooklyn, again, heavily Afro-Caribbean, African American population, you know, going into Manhattan across the water is not something they're comfortable with because they prefer to get their care in the community in their neighborhood, et cetera. But the problem is safety net hospitals and

as you've mentioned, rural hospitals sometimes don't have all the resources that the bigger shinier hospitals have.

Dr. O'Connor: Meaning all the specialists or some very fancy expensive equipment for a diagnostic test, something like that.

Dr. Riley: Correct. Something as simple as private rooms, we don't have private hospital rooms at our safety net hospital. It's still two bunks to a room, whereas the private hospitals, better resourced, hospitals have all private rooms by and large. So, you could see there is a little disparity there. And I'd like to mention, you know, to folks, when I talk about the pandemic, look, the pandemic has not just revealed that we have issues of health disparities, but we have health disparity in terms of hospital resources that the pandemic has really revealed as well. You have a hospital like mine, a hospital like the one I trained in Houston, Texas, Ben Taub General Hospital, a famous public safety net hospital. Those hospitals became critical because they were community trusted partners. Equally, so, in the rural areas, remember disparities are not just black, white, Latino, or Asian, they're urban, rural they're suburban exurban. And we worry about the rural hospital closures too. I guess the synonymous safety net hospital in a rural area is called a critical access hospital, and we've seen a lot of problems with critical access hospitals. Critical access hospitals, as you know, are about 25 beds, very small hospitals, but very important in rural

areas. So, these two types of hospitals became really important, and I would argue this pandemic has highlighted that we need to invest more in rural critical access hospitals, rural hospitals, and urban safety net hospitals.

Dr. O'Connor: I could not agree more, but I'm going to ask a question that I think some of our listeners would ask because to someone who doesn't have a lot of knowledge about the finances of medicine, it doesn't make any sense that hospitals are closing. We're in a pandemic, unfortunately, we're still hopefully coming out of a pandemic. But if we had a record number of hospital closures in the past year, and we've had a record number of people dying from Covid and hospitals being overwhelmed, it is not that the hospitals are lacking patients or they're lacking business. So, if the hospitals are full, there are patients that need care, then why are hospitals closing?

Dr. Riley: Yeah, that is very complicated, but let me sort of explicate it this way. For example, I mentioned that hospitals that do a lot of Medicaid, the payment rate for Medicaid doesn't match the private insurance rates. In other words, Aetna, Blue Cross, United, they tend to pay hospitals a higher rate. For example, if a certain procedure, we'll just use round numbers, if a procedure in a more commercial hospital is about a thousand dollars for that procedure, in a safety net hospital, it is only maybe reimbursed at the

$600 level. So, remember that's a $400 delta or gap but remember safety net hospitals have to have the same level of nurses. The nursing wages by and large are not that discrepant between that at a better resource hospital and that safety net hospital. You have to have doctors like you and I who've been through training and board certified in both hospitals. You have to pay doctors a living wage, you have to pay nurses, respiratory therapists. So, the labor cost is one of the big drivers of hospital closures because again, the lack of resources compared to the better resourced hospitals makes that margin gap sometimes insurmountable where unfortunately, communities have to make a tough decision to close a hospital, which is very painful, very disruptive to many people's lives and very disheartening. So, you're right that it is a trend that the pandemic has exacerbated this gap between the finances of better resource hospitals and those of safety net hospitals.

Dr. O'Connor: You know, it reminds me one of my famous quotes and as you know, I trained at Mayo Clinic in Rochester, Minnesota, and actually my first day of my residency program, I met Sister Generose who was the last nun, the last sister who was an administrator of St. Mary's Hospital, which was the largest hospital there. And she is famously quoted as saying, "No margin, no mission," meaning you have to make money in healthcare in order to keep your doors open to serve people. But the second half of her quote,

that's not always included, is, "No mission, no need for margin," which I always include no margin, no mission.

Dr. Riley: But people forget that.

Dr. O'Connor: No mission, no need for margin.

Dr. Riley: That's right. And again, I think that good sister elucidated it very well that everybody knows about the no margin, no mission, but if there's no mission, there's no need for the margin. Safety net hospitals have a mission. Mary, they have an historic mission to take care of immigrants. You know during early parts of our lives taking care of African Americans because they could not go to certain hospitals in the Deep South because of segregation you know, others in communities who are struggling; that's in the DNA of these hospitals is that they're incredibly mission focused and they want to carry out that mission but they know that the margin pressure is significant.

Dr. O'Connor: So, how have you managed that? I mean, you are an example of success in such a challenging situation, right? Like I would think people would want to clone you and don't just take you to other safety net hospitals and say, okay, here's Dr. Riley 2 or Dr. Riley 3.

Dr. Riley: Well, thank you, so kind, but no, there are many others around the country, in addition to me and my wonderful team back at Downstate who cared deeply about that mission focus. You know this is not a solitary pursuit. I know the good sister would remind us all that it does take a lot of people to buy into the vision who just don't want to look at healthcare as a way to make money, or to build shiny buildings. At the end of the day, the reason why we have our jobs, our responsibilities as physicians, as administrators in healthcare, is to take care of people. And this is what I tell the medical students from day one, I tell our nursing students from day one that you and I are in the people business, and safety net hospitals are in the people business for those who are most vulnerable amongst us.

Dr. O'Connor: So, we appreciate that the healthcare system is really a system that takes care of sickness, and that focusing further upstream on how we can promote better health in our communities, more of a wellness approach, so people don't get so sick, they don't need to be in the hospital, is certainly something that I feel strongly is a direction that we should move. How do you see that fitting into your vision of SUNY Downstate and how can you afford to do that when so many of these efforts of outreach into communities for community-based programs are not reimbursed by anyone, you don't get paid to do it, and you're already in a financially challenging situation?

Dr. Riley: Well, a great example, and I'll highlight it in my presentation is, we have a wonderful group of students, faculty and staff who have become very passionate about plant-based diets. And, you know that is a different way of thinking for many of our communities. But I think it's a manifestation of how safety net hospitals and academic health science centers can go beyond sickness stuff that we do well and to try to get to a focus on wellness and by improving the diet and the nutritional status of many communities with a more plant-based diet can really pay dividends down the line for all sorts of diseases, heart disease, musculoskeletal diseases you know weight management, et cetera. So, that little simple mini mega trend that our safety net hospital and our community have embraced that to me is a harbinger of things that we can continue to do to pivot a little bit away from taking care of people just when they're sick, but trying to prevent, you know, we always hear about prevention. You and I have heard about prevention since we were pre-med students and with varying levels of success, but even in terms of just a plant-based diet, that could be preventative. That's huge.

Dr. O'Connor: That's huge, it is huge.

Dr. Riley: If you had asked you and I would plant-based diets get any level of traction or embracing in certain communities 10 years ago, no. Now, people are saying, wow, that makes sense. You know, cutdown on meat eat more

plants, fruits and vegetables. My cholesterol goes down, my risk of cancer drops, I'll lose weight, I feel better. So again, that's one thing that we can do. And other things too, is obviously safety net hospitals have to play a role in screening and preventive services. And one of the unfortunate aspects of Covid is we know that people have stayed away from hospitals in general, they passed on their mammograms, they passed on their blood pressure checks, they passed on their eye exam, they passed on their prostate examinations. So again, safety net, hospitals in our community have really leaned in to getting people to come back for their preventive health maintenance. Or as I used to tell my patients, their well-baby visits, you know, in pediatrics, it's a well-established thing, you know a young child, a toddler goes to pediatrician at one month, three months, six months, and those are considered well baby visits, because the baby's not having any problems; they're getting a few shots, they get checked, they checked their growth chart. You know, I used to tease my adult patients, I want to see you in six months for your next well baby visit. But I was making a point that look, come back and see me, you and I are going to be partners in getting your mammogram, getting your blood pressure checked, checking your cholesterol, et cetera.

Dr. O’Connor: And you know, Wayne, I'm just so excited to hear about this program that your team is doing on the plant-based diet. I'll share a story. So, our community-based program called operation change, there was one

woman, and I was so taken by this. We would do the program, an 18-week program, three hours a week, an hour of education, an hour of movement, an hour of motivational interviewing in small groups. So, part of the program would typically include food preparation, right? And it would be aligned around ethnically related foods that they would be cooking at home. So, one of the women who was Latina started to make a healthy dish for herself while she would still cook all the traditional food for her husband and children just like normal. And her husband would make fun of her cooking this healthier dish just for her. But she, to her credit, and her bravery, she persisted, then her children started eating what she was also cooking for her. She still made the other food, but now there's also an additional option. Eventually, the husband started to eat it. And I thought she is the pebble in the pond. This is the power of one mother, not just changing her health, but the health of her children and her husband, which then changes the health of a community.

Dr. Riley: The family, the community and the nation, ultimately.

Dr. O'Connor: Correct. And whether that's a mother or a father, I'm not trying to be sexist here with my statement. The concept is that one person can be that pebble in the pond and that ripple effect will go out. And that's how we make change.

Dr. Riley: I agree. And it goes back to the old starfish thing, you can't save every starfish but if you save one, it makes a big difference. And so, you're right, don't underestimate the power of individuals to create health behavioral change.

Dr. O'Connor: Wayne, it has been such a pleasure interviewing you for our health disparities podcast. I want to close with asking you what you think are the most important calls to action that people can embrace to help us move the needle on health equity?

Dr. Riley: Well, I think the first thing, Mary, first of all, thank you, wonderful conversation. I'm honored to be with you. Don't be put off by the enormity of the health disparity issue if you will. This we can do, and I've always taken the approach that health disparities will never get them to zero. But if we, the medical professionals, the physicians, the healthcare leaders, the public health advocates, the community-based health advocates, each one of us in our various spheres of influence can lean into, first of all, acknowledging health disparities, and acknowledge and understanding them and then having, you know, the passion and the mission focus going back to the good sister, to do our part in whatever sphere we are, to address health disparities, over time we're going to get there. I firmly believe we're going to get there. So, I take a positive optimistic view of the challenges of health disparities and think about the progress we've made

already, just in our medical career, Mary. We've made tremendous progress in some issues in health disparities, but you and I both know more can be done. So, take the long view, take the positive view.

Dr. O'Connor: Well, I agree with that, and I'd like to pull that positive energy of the universe into this space and put those positive thoughts out there, while at the same time being realistic as to the challenges and the work that we have to do. But I do believe that yes, we have made progress. We have a lot more to do, and we're grateful that we have healthcare leaders like you, Dr. Wayne Riley, President of State University of New York Downstate here with us to help lead those changes. So, on behalf of all of the Movement is Life family. Thank you.

Dr. Riley: Thank you, Mary.

(End of recording)