Podcast Episode: Safety-net hospital group CEO Delvecchio Finley describes the challenges of COVID-19 for safety-net hospitals.

Alameda County is home to 1.7M diverse Californians who have long experienced health disparities. Alameda Hospital System (AHS) CEO Delvecchio Finley takes us inside the workings of AHS as they adapt to the COVID-19 outbreak. AHS is an integrated public health care system organized as a public hospital authority, and serves a 40% African American, 26% Latino, and 18% white population, over half of which are at or below the poverty level. Mr. Finley discusses challenges facing his and other safety-net hospitals across the country, and how COVID-19 is impacting their already strained finances, with Dr. Mary O'Connor.

All views and opinions are participants own.

Dr. O'Connor: Welcome to the Health Disparities podcast, sponsored by Movement is Life. My name is Dr. Mary O'Conner, Chair of Movement is Life and Director of the Center for Musculoskeletal Care at Yale School of Medicine and Yale-New Haven Health. As we continue our series on COVID-19, today we focus on the impact of this pandemic on safety-net hospitals. safety-net hospitals provide healthcare for individuals regardless of their insurance status or ability to pay and typically serve lower-income communities. Today, my guest is Mr. Delvecchio Finley, Chief Executive Officer of Alameda Health Systems in Oakland, California. Welcome, Mr. Finley.

Delvecchio: Thank you, Mary. I'm really excited to be here and I appreciate the opportunity to engage with you.

Dr. O'Connor: Well, we're delighted to have you, and I want to share with our listeners and audience a few words from your website, which describes your health system. As a long-time pillar in our communities, we lead in extending care, wellness, and prevention to all. We are a haven for the most vulnerable among us, an advocate for equitable, compassionate, and culturally sensitive care, regardless of social and financial barriers. We are in the vanguard of medical excellence and in a teaching hospital that draws the nation's best medical students. Delvecchio that is a beautiful description. Could you please tell our readers more about Alameda Health System and the community you care for?

Delvecchio: Absolutely and thank you for the kind words. I think it really is a reflection of both who we hope to be for our community and aspire to be as individuals who are privileged with the opportunity to serve this community. So, Alameda Health System is a safety net organization. We're an integrated delivery system, comprised of acute care hospitals, a level one trauma center, behavioral health services in psych emergency and inpatient psych, a couple of integrated community-based wellness centers where we provide primary and specialty care services, and a series of post-acute services, including rehab services, acute rehab, sub-

acute services, and several skilled nursing facilities. We're based in Oakland, California. We have about 4,600 employees and have over 800 beds across our system. We have about a thousand physicians and nearly 500 volunteers who serve our community through our organization and provide several hundred thousand visits in our outpatient facilities, in our emergency rooms, and just under about 17,000 discharges in our acute care facilities over the course of an annual year.

Dr. O'Connor: So, you have a very robust and comprehensive system?

Delvecchio: We do, we very much do, and we're fortunate to do that. We have our local elected officials who have a really firm value base that says that everyone in our community has the obligation, I would say, or we have the obligation to provide equitable access to a high quality of care to everyone in our community, irrespective of their race, ethnicity, ethnic background or their national origin, gender and their social-economic circumstances. Our mission here is Caring, Healing, Teaching, and Serving All.

Dr. O'Connor: That's another beautiful mission statement. There are many challenges to delivering on that mission. Can you share with our audience what some of those major challenges are for you just in normal life because I want people to have some appreciation and feel for what a safety-net health system is and provides and the kind of challenges that

you face in normal times, and then we're going to evolve into a conversation about the pandemic.

Delvecchio: Absolutely Mary. That's a great question. And sometimes we're so steeped in the work that we do that we actually lose track of the intricacies and the uniqueness of this great privilege that we have to serve our community. But having had the opportunity to work in several settings around the country or around the State and in particular, many of them similar to my current role with Alameda Health System, but also a few outside, I would say safety-net organizations serve a very unique role in our community. Some of the differences in terms of challenges that we often address within our community are that we have individuals who we serve a disproportionate number of people who are either uninsured or on public insurance of some form which generally is categorized as underinsured because of the nature of the coverage that they have may not sufficiently provide for sufficient reimbursement for the course of care that they need. A large part of that is because of what we have now aptly described as the social determinants of health in that we have a vast number of our patient population who are not just confounded with healthcare needs, sometimes some very serious health care needs in terms of acute conditions and chronic conditions like cancer or diabetes or heart failure and things like that, for any of us would be quite consuming and would be an intense sort of effort just to focus on caring for ourselves

in that context, but oftentimes our patients in our population are confounded by even a host of other challenges, like equitable access to housing or insufficient access to housing food insecurity, access to stable employment so that they can then provide for housing and other social needs for themselves and their families, transportation challenges, and the likes. So, we are often and again, are privileged and we have a great foundation and volunteers and donors in our community who help us, but the needs can often overwhelm the system and are very great in terms of not just providing for excellent high-quality care, but supporting the individuals to get to appointments, to maintain those appointments, to be able to have sufficient food so that they can take medicine that they may need to take, have access to those medications to keep them from being readmitted for avoidable reasons, getting them into reliable and stable sheltering and things like that. So, these are a lot of things that we have to do in addition to meeting our patient's care needs.

Dr. O'Connor: The pandemic, as we know, is hitting some regions very hard, and we also know that it's affecting certain communities disproportionately. Communities of color, both African American, Hispanic/Latinos as compared to some Caucasian communities. At least we're seeing this data coming out, particularly in urban areas. So, how has COVID-19 impacting, how is it impacting your community and your health system?

Delvecchio: Yes, so great question. And the premise that you have outlined absolutely is reflecting in our community as well. So, Alameda County which includes the City of Oakland as its County seat is one of the most diverse communities or diverse counties in the country. We have a significant representation of Hispanic and Latino populations, African American populations, Caucasian, as well as Asian, people of various Asian origins. We serve a population that is quite diverse in the ways in which we just described, but also the socioeconomic spectrum that we serve. And so, in our County, we've seen to date, a little over 1,100, I think, positive COVID-19 patients. Fortunately, not as many patients have been requiring hospitalizations but we've had a lot who have required hospitalizations and ICU stays and ventilation to support their course of care. We have not experienced a significant number of deaths, but obviously, our heart goes out to anyone who has lost their life relative to this viral pandemic or anything else. But we have had a very responsive public health system here, as well as the care delivery system here with our partners. But as it relates to race and ethnicity and the socioeconomic status our experience thus far seems to bear out with what we've seen around the country and at least within our own organization. And I think within our County the presentation of positive COVID-19 cases has been slightly greater in the Latino population than it has been in others, but that is followed by African American and Asian and other communities from there.

Dr. O'Connor: So, here you are, CEO of this basic safety-net health system, and along comes, COVID-19. Walk us through your thought process of how you were going to prepare your health system to deal with this major public health crisis. I mean, the likes that I mean, I've never seen it in my lifetime, and you have a responsibility to your employees and the patients and the community. I mean, this is tough stuff. So, how did you play this out in your mind? How did you think about the steps that you needed to take?

Delvecchio: Yes, it's a great question. So, our efforts for responding and preparing for the pandemic to present in a meaningful way in the United States started in late January, early February as we monitored things that were happening in China and other countries and starting to present themselves in the US. We have an emergency incident command system. It is a similar sort of response system for emergencies that hospitals and other entities use for mass casualties and other sorts of issues. We started ours virtually because at that time we had no presentation or at least no known presentations within our organization, but because we know how a viral pandemic can play out or are likely to play out from what we've heard, certainly didn't expect this. We started to do some of the things that we expected, which is just starting to take inventory of personal protective equipment that we had. Look at our disaster preparedness plans, start to prepare for looking at our facilities and seeing what sort of

things we needed in terms of things like ICU beds and ventilators based on what we were seeing in other countries. We were doing that work in earnest over the preceding weeks. We were actually preparing for and had submitted a request, fortunately for us fairly early on for additional PPE from the strategic national stockpile because, in early March, you may recall, we had our first known presentation of community spread in the Northern California area. And that happened concurrent to a Princess Cruise Line ship being just off the harbor here in the San Francisco Bay Area. So, we fully implemented our system just as the decision that had been made between the collaboration between the City of Oakland, the State of California, and the federal government to allow the cruise ship to dock in Oakland and to immediately appropriately disposition those patients on the ship who were COVID-19 positive, as well as people who had delayed care needs, whether they were US citizens or otherwise that may need to be treated in some of our facilities in the local area. So, we, obviously, you alluded to in your question, how to consider what we currently had in our inpatient facilities, what we were currently experiencing in our emergency rooms, and began to prepare to accommodate some of the needs that were going to come through supporting just that disembarkment of the cruise ship, and we were able to do that successfully. We didn't have to take the other sort of public safety interventions around sheltering in place and reducing our clinical load in terms of reducing surgeries, elective surgeries, and clinical visits during

that week, but it happened shortly thereafter. Effectively, the following week was when we started to see more incidents, particularly in our neighboring County, but starting to gradually come to our County as well, and I really want to thank the solid leadership and direction from some of our local leaders to begin sheltering and placing to implement measures that allowed us to ratchet up our planning, our response. I mentioned we had requested something from the strategic national stockpile fairly early. We got almost an instant contribution of masks and gowns and other personal protective equipment fairly early on that helped us in our response while we started to actively work to secure more to prepare for the surge.

Dr. O'Connor: So, how are things different for Alameda Health System today in terms of the clinical services that you're providing compared to normal?

Delvecchio: It's a great question. You know, one of my board members remarked that if we were looking for a refreshing thing during all of this, was that a lot of things that heretofore seemed a lot more complicated and difficult to do became a little less complicated as people aligned and work to make things happen. So, we had the good fortune, a few months ago, of going live on a system-wide electronic health record. A very tough endeavor that we prepared for about two years, but fortunately we were on that system that allowed us to have a nice platform to do telemedicine, and

telemedicine was something that we were doing a little bit of in terms of electronic consultations and working with our patients through patient portals, but not a lot of visits in an outpatient setting, as well as using telemedicine across our facilities. A part of that was hampered by the reimbursement environment, as I mentioned. We struggle. Often, we benefitted from supplemental funding and other things, but the gap is always there. Well, suddenly reimbursement for telemedicine was available, suddenly, dollars were directed to be used to convert as many visits as possible in support of social distancing to telemedicine, and we were able to mobilize our IT teams and some of our external colleagues and partners to be able to do a lot more of that in a very compact period of time to convert as many of our visits over that were appropriate to that sort of thing as possible. So, now we've done several thousand visits via telemedicine now. The patient feedback has been quite good. They are avoiding the commute. Some of our patients sometimes have to take two or three buses to get to us and then get back home. So, now, they're getting calls directly from their provider in their homes. Sometimes they're engaging their loved ones in a teleconference so that everybody's participating in supporting that person's care. And they're getting very as focused attention on their needs as they would have if they were in person, but obviously in this virtual contact. Some of that actually, including more proactive outreach on our part, because we recognize that people are sheltering at home and sometimes in situations where they're

the only person around and we're wanting to make sure they have what they need, and if they absolutely need to come to a visit that we do that. So, that's been a big part of how things are different.

I will say on the inpatient side, if I may, and in our EDS our community has responded to social distancing. We have less volume in our organization now than we normally would, which is refreshing because that means that people are at least okay - hopefully, it means that people are okay and they're taking care of themselves, and they're trying to make sure that they continue to be well. But at the same time, that means that as essential workers and we are deemed essential workers to be ready for the surge. We are losing a lot of revenue that we rely on, and so the cash flow is a bit of a challenge. And obviously, we are constantly struggling with access, reliable access to PPE, to protect our staff, and to protect the patients who are within our facility.

Dr. O'Connor: So, I want to follow up on the comment that you made about telehealth and I often think necessity is the mother of invention, right?

Delvecchio: Absolutely.

Dr. O'Connor: I mean, I could say a similar story. We've been talking here in my health system about televisits and telemedicine and all of a sudden, you

know what, we're able to do it. I mean, it really took this event to get the physicians and the nurses and everybody to really understand that, no, you just got to do it because people don't like to change and change can be hard. And it is helpful now that there is some reimbursement for the efforts.

Delvecchio: Absolutely.

Dr. O'Connor: One of the things that has been a concern is the digital gap or the digital divide that some people have referred to in terms of communities of color, perhaps being less comfortable or less savvy with technology, and that the telemedicine approach may actually widen disparities if you have communities of color or low-income communities because I think this could play out in rural America with white communities, right, that don't have access to the internet, they don't have good technology, then telemedicine isn't really going to work for them. So, at least for your population, do you sense that there are race ethnic barriers to engagement with telemedicine for those populations?

Delvecchio: Yes, it's a great question, and the premise, I think definitely has a foundation or basis in truth. You know, I think it varies in communities. I agree with you, it's not just urban communities and communities of color, but also rural communities. And a lot of that is around the infrastructure,

not just the access to the equipment or the level of technical facility. But if you have broadband access and it's reliable, if you're trying to do video visits, that's going to be a barrier if you don't. I was actually somewhat surprised that a lot of telemedicine is really telephonic. We are doing both, which is great because there are times when there certainly is a great currency to being able to visualize in - I forget the actual word, but basically in a synchronous way, having both the phone and the video so that you can interact with people and be present in that way, see certain lesions or other things that you need to check on if you're looking at dials on certain devices and things like that that certainly helps. So, for us, I feel like it's actually not been as pronounced as one might sort of initially suspect. And I think part of that is because a lot of it has been either if it is a synchronous video visit or a phone call, we've just been as flexible with our patients as we can to do that.

The other thing is we have, as I mentioned, we have gone live on our EHR, and one of the things we really try to push out and we had several tens of thousands of patients, not nearly our goal, but we were at least, well out of the gate with having people enroll in our patient portal. And we push out a lot of information via the patient portal. We're trying to make it as user-friendly as possible, but also as valuable to our patients. So, they don't just get lab diagnostics and results, but they can also send communications to their care team. They can schedule appointments and

things like that. So, we've been gradually, I think, closing that gap for our community, and also, I think the gap is a bit more pronounced, not just in a socioeconomic context or a racial context, but also there's an age-related context as well. So in many of our communities cell phones are sometimes more ubiquitous than food, unfortunately, but it's a means and a necessity of life. And I think people have understood that now having reliable access when people are using things like, I guess a call burner phones or phones that aren't just like an established phone with a longitudinal sort of basis, but one that you buy for the number of minutes and things like that, that can be a bit of a challenge, but we're doing that a lot more. One of the challenges for us internally, I would say on the inpatient side is the ability to invest in a lot of devices like iPads and other sorts of tools to be able to have within our system to support our patients. So, one of the things I'm really pleased to say, I just learned about this last night, we knew about other health systems that were getting donations of iPads, and that helped the providers to not only interact with their patients when they're in the setting and you want to minimize the use of PPE so you can actually have conversations even right outside a room with a provider and a patient but also in this period where patients aren't able to have visitors because we're protecting everyone to have them communicate with their loved one. We recently got a donation from a wonderful organization of about 30 iPads that we've primarily been using in our ED but also using in our inpatient setting. And we had this wonderful

story of one of our patients who is, I believe a Guatemalan immigrant, and we were able to connect that patient post-recovery or as he continued to recover from the coronavirus with his family in Guatemala via Facetime so just a wonderful, wonderful story of the way that our staff has been able to adjust their practices in support of a population that is really struggling with this, just as we are.

Dr. O'Connor: Yes, It's hard for me to even describe what it's like to take care of patients in the hospital. I've been doing hip fractures, surgeries. I mean, people are still breaking their hips and to have those patients be alone in the hospital, it's just thinkable. I mean, it's like a never event that would have been before and now this is just what we have to do, and it's difficult. I mean, it's very difficult for the patients, it's very difficult for their families and I mean, I find it's difficult for me too. So the sooner we can get through this, the better for all. I know everyone would agree with that statement. So, about your healthcare workers, have you had to lay off people, have you had to decrease their payment? I mean, we read about healthcare systems that are reducing compensation to their physicians and nurses, and I mean, different providers in their systems because of the significant financial impact. So, how have you been able to manage that in your system?

Delvecchio: Yes. Now, Mary, again, another great question. So far, the answer to that is no, we haven't had to take any of those measures at this juncture and we certainly hope to be able to avoid it, but the impact is real and what we have tried to do, our board is in support or I should say, in concert with our County partners has really stressed to our staff that the most important thing is our community and our preparedness to support that community. And we want to deal with that as our principal priority, and then we'll deal with finances and everything else when we need to, and as that comes and I have said to the staff, I certainly hope that we can avoid any sort of austere measures of that nature. We think that unfortunately with everything else that's happening in our economy, we may actually end up with more people who are on public insurance and programs, and that is a significant portion of our pyramids. And so, we could actually see an increase in people who are enrolled with plans that are assigning them or allocating them to our system or enrolling in our care at our system. So, we'll see what the future holds. The current situation though is quite tough. But it hasn't gotten to the point where we've had to either do layoffs or furloughs or any of that stuff. We have had staff who've had to take leave for various reasons whether to care for themselves or a loved one. We were exempt from the Family's First Medical Leave Act that Congress passed a couple of months ago because we're healthcare providers and essential workers. We took an approach as an organization that we really wanted to honor our staff and recognize the challenges that they're facing

in adapting to this in their family situations and their personal lives, as well as their professional lives, and try to remove as many barriers as possible to supporting them so that they could support the community. And so, we did extend those benefits to our workforce. And that quite honestly, has put a bit of a strain in certain parts of the organization that people have begun to use them, understandably so, to meet their personal needs. So far, we have not invoked any of those things. We have had staff who have generously volunteered to take leave as our volume has been down or to flex downward and we've been doing some of those things, but other people electing to use a vacation, a lot of our administrative staff, out of respect for the generosity of our taxpayers and make sure that we're being good, fiscal stewards. So, we're monitoring, we're obviously pursuing all the resources that we can through the federal government state, and others to support the organization from lost revenue and costs that we continue to incur and the benevolence of our donors, which we're hoping to receive more support. Our foundation has done a good job so far, we need more, and we'll see where we end, but so far, we've been okay.

Dr. O'Connor: I feel the need to comment on the vision of the leadership in your community and the support that you enjoy. No one is going to let your health system close or fail. I think that it's clear from your comments that your local political and community leaders understand that a safety-net hospital is as important to them as the police department or the fire

department. But I'm interested in advice that you would have for someone running a safety-net hospital, who doesn't have that level of backup support, not because people in the community may not believe that it's important to keep the hospital open but just because they don't have the resources to provide. And I asked that question because it was a couple of weeks after we had stopped doing elective surgeries here and I was speaking with a colleague of mine who practices at a small hospital in Kansas. And she told me that they were still doing elective surgeries, and I was really taken aback. And I said, “Well, how's that working?” And she said, “Well, you know, we screen patients.” “What do you mean you, screen patients? There's no testing.” I mean, we don't have enough tests. “We'll check their temperature.” Now, we all know that that's not an effective way of really screening patients. And she said to me that the balance here is this community needs this hospital and in order for this hospital to survive, we have to try and generate as much financial revenue as we can to support the hospital or the hospital will close. And when we get over this pandemic, there will be no hospital for the community. And I think it was a very important perspective because I'm not sure that a lot of people in this country understand that we have seen a record number of safety-net hospital closures, and not just in inner cities, you know, everyone can think about Hahnemann in Philadelphia last year, which was still shocking to me. I went to medical school in Philadelphia. I mean, I couldn't imagine Hahnemann closing. We see record numbers of rural

hospital closures, so, what advice would you give the CEO of that hospital or health system that doesn't enjoy as much support as you do?

Delvecchio: Yes. Great question and let me be clear. We have challenges and we have quite a lot of them and our tax base is what it is, and we try, and we do our best. And so, there isn't probably a week, certainly a week, but almost a day that doesn't go by where we're trying to stretch a dollar a bit more to serve our needs and trying to be thoughtful about that, like, keeping someone healthy and well in the community. If you do it in a thoughtful, strategic way, it can oftentimes be a lot less than a very significant and avoidable hospitalization for a medical need or behavioral health need, and otherwise. So, we struggle with that here, but I would say, and you may know, I've been fortunate to serve on a couple of industry-related boards. So, the American Hospital Association, I work closely with America's Essential Hospitals, which is local or exclusive to or focus predominantly on hospitals that serve disproportionately underserved communities, safety-net hospitals, and otherwise teaching hospitals and the like, as well as Oakley in California. My advice would be - obviously my colleagues of which I know a lot of, we understand the importance of the mission and we understand the immense responsibility that we have for those providers, as nurses, as doctors, those nonclinical providers who are committed to serving this population, oftentimes because they come from these communities like I do myself. So, it really is

a calling just as it for others, but really a calling and a privilege to serve these communities. So I think we take that in, and it really, the case makes itself.

We have an obligation to work with our local leaders, but our state and federal leaders too, to be that voice, to give a voice to what's happening in our communities, and to provide the best advocacy we can to say, the absence of resources to support an integrated delivery system, whether that is all within one system or a collaboration between others, not just to truly keep a hospital open. I have to say that, I mean, that is incredibly important in some communities is much more important than others, because it can be not just the largest employer, but sometimes the main driver of the economy for those communities. So, I totally respect that. I think we have a responsibility to advocate as fiercely, I should say, as we can for those communities. And at the same time, work closely with our communities to say, this is community trust, whether it's a public hospital a safety-net or not-for-profit, or even a private hospital. And because of that, we have to work with the community to say, how do we scale it to be able to serve the communities, but how do we look at this in a much more robust and integrated fashion too, so that we're not just serving the need of the organization and saying the hospital has to stay open, and it has to be the size that it is, it has to have the services and the configuration that it has, but let's work with everyone to say, you know if it makes a lot more

sense to have a robust ambulatory infrastructure here, scale this back, maybe not close it completely because we want to sustain as much as possible or make it as sustainable as possible. Then we have an obligation to be doing that, and that's really tough. There are no easy answers here by any stretch of the imagination, but that's what we have to do. And I think we'll engender the type of support and Goodwill as much as we can because we're not advocating for ourselves. We're advocating for the community and at the end of the day, that's who we serve.

Dr. O'Connor: That's exactly who we should all be serving, right? It's our communities. Let me ask, we will get through this pandemic. We're going to come out on the other side at some point. What is it that you would like to see happen, would help make us more resilient to the next pandemic?

Delvecchio: That's a great question, a really great question.

Dr. O'Connor: If you had a magic wand, and you could wave it and say, I'm going to make this better, what would you want better? Because it's probably unrealistic for us to think this is the last pandemic. I mean, this virus can mutate, I mean, who knows and how do we be better prepared in terms of the health of individuals? We can look at PPE, we can look at vaccines, we can look at supply, we can look at all kinds of things to hopefully be better prepared if heaven forbid we have another pandemic, but what

would you want to have happened in terms of health in communities that would make your whole system be able to be less burdened, have fewer patients on ventilators? I mean, what would you want to have changed?

Delvecchio: So just to nod to what you just said though preparedness is certainly something that we have always espoused and in fairness have done. There are a lot of things that we have, unfortunately, endured in this country around you know, either mass shootings or other forms of mass casualty, where our resources and the might of our delivery system have really shown up, you know, people, the heroic nature of our providers, our doctors, our nurses, and everyone really can rise to that occasion. I think this pandemic and a viral epidemic or pandemic like this really does underscore your heroism only goes so far if you're not addressing the structural basis of what's happening in your society. So, to me, your question raises that point. We have talked a lot about, and we've done and made some strides in many areas, some more than others around health equity and inclusion. And it is certainly something in our organization we have struggled with, but I submit that we have to continue to struggle with that. We say that our interpretation of what it means to advance population health is that the people who we serve, aren't just the recipients of our care, but they're conduits and the facilitators of the care that we offer to them. And I think in that way, that means that we are doing things to truly

acknowledge those underlying disparities that they face and dealing with them in a much more holistic way.

So, not just a handout as the ad says, a hand up. And it's tough when you think about it from a healthcare delivery perspective because I understand many of my peers and I say, that's just not my expertise. You know, my expertise is getting you that surgery that you need, getting you, that diagnostic test that you need, getting you in and out, and up and on your way in three to four days and avoiding that hospital acquired infection. That's my wheelhouse, that's my technical expertise. And that's absolutely vital. We've got to find a way to make sure that where that other expertise lives which are absolutely in the community with our public health partners and make sure that the investments in those areas are substantial enough that collaboration can happen in a way that that expertise is leveraged and combined with ours and the community is better for it. I think this really just called that out. Some people think that we need a lot more hospital beds, we need a lot more ventilators, we have to be ready for the next one of these, and maybe there's some argument to the calibration of those things and how we coordinate making sure that we can marshal them and coordinate that better is absolutely the case. But I worry that if we do, if we lean too much in that direction, knowing how expensive that is and how much it takes to sustain that, that we may inadvertently be furthering the very disparities that we're trying to address, which is we need to get more

upstream, we need to take care of people better, we need to make sure there's equitable distribution of resources that are consistent with need and not just with, you know, where their infrastructure already exists, or where the resources may already be robust because that may, again, just to be exacerbating our problem. We have to get upstream and we have to serve communities that are marginalized in ways that brings that floor up to a level that it may not be where everyone else is, but it can't be so low that when we see these things happen, we're just completely caught flat-footed and I think that we have a responsibility to do a better job at that.

Dr. O'Connor: I could not agree more and I think addressing the underlying health status of individuals in our communities, and really targeting those lower health status, individuals or groups to try and get them healthier will be us to help them be healthier. But when we think of it from a health system, I mean, think of the resources that we could save and of course the lives that we… and we can think of how a pandemic or some horrible flu season could be shortened because people are fundamentally more resistant to getting sick. And really, I think getting our minds around how we're all connected in this, and we cannot feel that we're isolated. So, I mean, money, position, affluence, doesn't protect you from this virus and everybody has some risk and some exposure, so let's all be healthier so that everyone's risks can be lower. Anyway, that's what I hope, we would come out on the other side with more people aligned with that vision of

how we need to, and you know a rising tide lifts all boats, right? Make everybody healthier.

Delvecchio: I couldn't have stated it better. I think you hit the nail on the head and I hope, I really truly hope that that is one of the key takeaways we take from this experience. And I believe we will get to the other side, but we have to avoid having this level of an impact and a disproportionate impact the next time this happens whenever that is.

Dr. O'Connor: Delvecchio, as we close this podcast, I'd just like to ask you how you're holding up through all this. There's a lot of stress involved in this pandemic for our healthcare professionals and our healthcare leaders like you. So, I'd just like to do a check-in with you, how are you doing, how's your family doing?

Delvecchio: Well, thank you so much for asking. I have to say that I'm incredibly blessed and fortunate to have the support of a loving wife and a beautiful daughter, and they have they've been sheltering in place for a number of weeks and my daughter's homeschooling now. She is about to turn seven, but I check on them every day to make sure that they are giving each other space because the temperature can get a little hot in the house, but they are doing wonderful, and as a result of that, they have been incredibly supportive of me. Since this has happened, you know, we've

been running an incident command seven days a week. And that has resulted in me largely consistently doing six to seven-day rounds here at the hospital and as I mentioned to you earlier, I'm in a polo shirt here and a hat because I've been rounding with our EVS staff and assessing our practices around cleanliness and making sure that they are safe and really valuing the incredible role that they play in making sure that our patients and our staff are safe as well. And so, you know, really, I draw my strength from them and seeing people be so selfless and to really stand up and honor this community and their expectations of us to be here, to serve them when they need us even more than they normally do has just been, it's been reinvigorating for me. It's been inspiring for me. I share with our organization, and as I said, I heard as a kid and my chief operating officer reminded me of, and it was that, “Adversity doesn't build character, it reveals character.” And my commitment every morning is to show this organization who I have the privilege of serving and leading that my character is one that has seen a lot and has gone through a lot. And I've survived all of that. And my commitment is to show them that I'm with them and we will survive this as well. So, through that you know, it's tough. I will concede that, but we are doing, and our hearts go out to our colleagues in other parts of the country who've experienced this pandemic including our colleagues in Connecticut, New York and the Tristate area, Seattle, and certain parts of the Southeast. Our hearts are, and our thoughts are with you all. And we draw our strength from you too, and we

really are committed to just being here together. So, so thank you for asking.

Dr. O'Connor: You're very welcome. I just think that is just a small example of the quality of your leadership that you are rounding with all the different groups and checking on them because I know how valuable that makes your staff feel and that they can sense that you appreciate them. And sometimes those actions, I find them very powerful and so meaningful and so kudos. That's fantastic. So, I know we need to come to a close. I want to thank you, Mr. Finley, on behalf of Movement is Life for the generosity of your time and for your leadership in American medicine. I know your community is fortunate to have you. And to our audience and listeners, thank you for joining us. We look forward to bringing you additional podcasts related to this horrible pandemic until then stay safe and be well.

(End of recording)