Fixing Healthcare Podcast Transcript

Interview with Stephen Shortell

Jeremy Corr: Hello, and welcome to the sixth episode of season four of the Fixing Healthcare podcast. I am one of your hosts, Jeremy Corr. I'm also the host of the popular New Books in Medicine podcast and CEO of Executive Podcast Solutions. With me is Dr. Robert Pearl. For 18 years, Robert was the CEO of The Permanente Medical Group, the nation's largest physician group. He is currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business, and author of the bestselling book Mistreated: Why We Think We're Getting Good Health Care—and Why We're Usually Wrong.

Robert Pearl: Hello everyone, and welcome to this final episode of the current season. This season we focused on big ideas and the people behind them. We had presidential candidates, heads of the FDA and VA, CEOs of major companies like Apple and 23&Me and a Pulitzer Prize winning author. Each of our guests have made major contributions in a broad range of fields and all were invited due to their unique expertise specific to the coronavirus. For those of you wanting more details about Covid-19 you can listen to our biweekly show titled: Coronavirus: The Truth. On it we provide the most up to date information on this pandemic. You also can check-out my website RobertpearlMD.com. There you'll find links to articles on the virus itself, along with information on its economic and social consequences of COVID-19. Once there, I encourage as many of you as possible to participate in the reader survey about the impact this pandemic is having on you and your love ones. Once again, that's RobertPearlMD.Com.

Jeremy Corr: Our guest today is Stephen Shortell. He served as the dean at the Berkeley School of Public health from 2002 to 2013. He currently is a professor at both the U.C. Berkeley Graduate School of Public Health and the Haas School of business. There he co-leads the Center for Healthcare Organizational and Innovation Research. and the Center for Lean Engagement and Research in Healthcare. He has published over 350 peer reviewed articles and 10 books. He and his colleagues have received many awards for their research. He brings broad expertise on healthcare policy, clinical quality outcomes and the public health aspects of the current coronavirus pandemic.

Robert Pearl: Steve, let's begin by having you tell the listeners some of your history at both the Berkeley School of Public Health and the Haas School of Business.

Stephen Shortell: Sure, Robbie, happy to do so. Been at Berkeley about 22 years now, both in the Haas School of Business and here in our school of Public Health. And came here in 1998. I became dean of our school here in 2002 and served the school for about 11 years as dean, and then returned full-time to the faculty. Head up two research centers here, one on healthcare innovation, organizational innovation research, and then the other one on the application of the Shingo principles to managing and improving healthcare, the lean management system, if you will. So my first love has always been research, trying to contribute. I like teaching a

lot, as well. Don't do too much of that anymore, mostly focused now on the research side.

Robert Pearl: This episode is the last season four, and the perfect transition to next season that'll focus on the culture of medicine and the consequences for patients. You have tremendous experience. What are your thoughts? What is right about American healthcare, and what is wrong?

Stephen Shortell: We have a very high variance system here in the United States reflecting our history and culture. We certainly have pockets of excellence, there's no question about that. But in my own view, things are moving too slow and the incentives are not strong enough for change. A big question is going to be whether the COVID-19 is going to be the burning platform we need to move the system forward, not back to what it was before, but really moving it forward. And that's going to take a lot of change on multiple fronts, Robbie. On the one hand, we need to totally change the way we pay for healthcare in this country. It's just crazy, as you well know, you practiced in a system at Kaiser-Permanente that for six or seven decades had the incentives right. And so what we need are all-payer, risk-adjusted, capitated global budgets that create incentives for providers, and insurers, and their networks to keep people well. And that is currently lacking in our system for the most part, and that's one of the major changes I think that are going to be needed in order to move us forward.

Stephen Shortell: I think another point I would make is that also creates the incentives to redesign care. I was part of the Crossing the Quality Chasm report 20 years ago of the then Institute of Medicine, now National Academy of Medicine. I led a subgroup of that. Yt was a great experience, expertly led at the time by Don Berwick. We pointed out six things that are still valid today about we need care that is effective, efficient, personalized, timely, patient centered, and, most of all, equitable as well. And really strives to do the right thing at the right time. And we're still far from that in too many parts of the country.

Stephen Shortell: So a simple way of thinking about it, but you can unpack it in its complexity, is incentives times capabilities, or incentives plus capabilities. Yes, we need to change the payment incentives in this country, pay for wellness, pay for health, but at the same time we have to take into account the capabilities of providers to succeed under the new incentives. I personally come down on the side of we need to move faster. Others will say, well, gee, what about the independent practitioners, you don't want to blow up the system, and so on. I understand that, and so we also need to have funding for technical assistance to increase the capabilities of the independent practices and others in order to really meet patient centered care, and to succeed under a global budget kind of system.

Robert Pearl: Steve, you've been a big proponent of evidence based approaches to medical care. From a cultural perspective, why do you believe it's so hard for doctors to follow the best evidence based approaches, or phrased differently, why do

physicians provide so much care that's been shown to add little or no value, and what can we do about it?

Stephen Shortell: Great question, I was just on a webinar earlier today in which one of the presentations was on low value care. And they've got a paper under review, I think I can share the findings though. One third, one third of Medicare beneficiaries receive one or more low value services. Some data will come out in some article probably in the future. We know about choosing wisely, for example, we know about the figures on waste, probably 25, 30% of it being waste. Why is this? I think there's a couple of reasons. One as you well know, physician training, the clinical training, residency, you get into certain patterns of practice, you go into practice and you're very much subject to a lot of how you've been trained most recently. And it becomes difficult to keep up on the literature these days and the new advances, because they're happening so rapidly. And that's the fact that therefore, it's very difficult to practice medicine today unless you are part of an organization that has ways of scanning these new innovations coming along, processing them, distributing them, creating incentives, and the peer pressure to adopt them more rapidly than we've seen in the past.

Stephen Shortell: So a lot of this now is team care, it's a team sport, it's not just the individual physician, as you well know. And it's a matter then of learning how to use these well trained health professionals, nurses, pharmacists and others, community health workers now, to benefit the patient. Patients often relate better with other members of the team who are from the same culture than they may with their primary care physician.

Stephen Shortell: So I think this is beginning to change, and needs to change more quickly, and what will help with that is this movement towards paying for health, and paying for well-being and not by the piece, not by individual procedures, the old fee-for-service.

Robert Pearl: As the former dean of the Berkeley School of Public Health, you're a world expert on the social determinants of health, and the massive impact they have on clinical outcomes. What do you see our nation able to do to address them and how likely do you believe we will do so?

Stephen Shortell: I think, Robbie, in the last year or so we've understood better how much of health is really produced by the social determinants, and the problems when you have food insecurity, and housing with the homeless, and lack of education going back to poverty and structural racism and the underlying root causes of all of this. We know and we've known for 30, 40 years now that 60-70% of health is produced by social determinants, where we live, and how we live day by day, and not by the medical care or healthcare system, which is basically a fix-me-up system. Which is important, I don't denigrate it at all. And we need to do a lot of work there as we've already talked about to do a better job of that. But it really is in the linkages to the social determinants.

Stephen Shortell: So what I see, and what we're beginning to see across the country in pockets, are closer ties, closer networking between the healthcare system and these other systems. The housing sector, the transportation sector, the community development sector, certainly the educational sector. Kaiser Permanente investing $250 million in housing, and others beginning to follow course, because they're understanding now that if we're going to have some kind of global budget, I have so much money, I better figure out the root causes of why these people are coming to me, because I make more money now if I don't put them in that hospital bed, or if they don't even need to make a face to face visit we can do it through telehealth. Or better yet, if they can manage their diabetes themselves at home, maybe with some decision support tools that I can give them through email or whatever, that's money in my pocket. Because the goal is to keep people well now, right?

Stephen Shortell: And so with that kind of incentive, that gives you motivation to reach out to these other sectors to develop these partnerships. So a couple specific examples that have promise. One is the Accountable Communities for Health. We have about a dozen of them here in California, there's others around the country as well. There's a number of other initiatives around healthy homes, and hospital at home, that are also being looked at. And so I think as we learn more about these, I think they're going to begin to spread.

Stephen Shortell: I'm currently working with some people at Brookings and colleagues here at Berkeley on developing a concept that I call whole person development networks (WPDNs). It adds to the current emphasis being given to housing and food insecurity, and the need for mental health resources integrated with primary care, to really link it to early maternity care, childbirth, the first five years of life, healthy adolescent development, job training, vocational training, because at root of this is the income inequality that is so tied in with the differential health statistics we have for black, brown, and other peoples of color. And so I'm trying to extend this to say we need to put over the Accountable Communities for Health and some of these other initiatives that are cropping up a whole person development network. And I don't have that fully formed yet, but that's just another example of something I think is going to be emerging.

Robert Pearl: In the aftermath of the killing of George Floyd, and in the context of the coronavirus, the disparities in healthcare that you're alluding to have come very much to the fore. Those parts that are under the control of the physician and the healthcare system, how do you see us eliminating those disparities going forward, mortality rates four times higher as you've pointed out for women of African American origin, or the fact that we're seeing four times the number of deaths in the coronavirus itself in black members from the community. What are your thoughts about how the healthcare system can address these disparities?

Stephen Shortell: I think the healthcare system can address those disparities to some extent directly, but largely indirectly through the partnerships that I mentioned earlier.

So the medical community, the health systems involved, I think they have to take up responsibility not so much just for making changes when they encounter patients when it comes to their doorstep or the emergency room, but being a part of the larger community that's trying to work on the underlying root causes as you point out. The racism that is involved that has been involved for centuries in our country, and how that's manifested.

Stephen Shortell: So I don't absolve the healthcare system of playing a role, but it's going to have to be in joining up with these partnerships with others who can perhaps at times play the more direct role. But when it does land in the health system's doorstep, we have to address it by incorporating more culturally sensitive medicine, being much more aware of differences in culture, implicit bias, and greater use of language interpreters. There's a wonderful book, it's now fairly old, called The Spirit Catches Me and We All Fall Down by Anne Fadiman.It was written a number of years ago and describes the vast cultural differences in the Modesto area of California, between the Hmong culture that came in and the medical community at Modesto Medical Center. Well meaning doctors and nurses just couldn't get the Hmong people and this girl who had epilepsy to make a meeting of the minds and get enough overlap in the sense of the Venn diagram to deal with the situation. I think it's improved and changed over time.

Stephen Shortell: And so there's still that in healthcare where we're not enough patient centered. If you think of health reform, I think we've got to go in more depth on the question, not is it what our healthcare system and providers need post-COVID, but what do patients and the community need? That should be primary. And then what does the healthcare system and providers need in order to serve that primary need. And so it's not just a matter of recapturing revenue from bringing the elective surgeries back and so forth and so on, but it's really let's listen to this wake up call of George Floyd, and let's listen to the community and find out what they really need and try to meet that response. And then can we line up the payment systems and reguations to reinforce that.

Stephen Shortell: Yeah, the only thing I would add, Robbie, is of course in terms of medicine and the other health professions, it's going to help a lot to the extent we can have a more diverse healthcare workforce. And more African American, Latino, Latinx physicians, American Native Indian, and so on. I think that's beginning to occur, but the numbers as you know percentage wise are still very low. We don't look like America, we don't look like America's citizens when it comes to our professional workforce.

Robert Pearl: Steve, what's your perspective on the impact that the Affordable Care Act has had, both the positive and the negative, and how would you amend it to improve it?

Stephen Shortell: Well, the Affordable Care Act clearly was a compromise and "gerrymandered", but it got done, and so at least for a while it increased coverage and that's good.

Absolutely we need universal coverage for all, period. I am certainly not convinced it needs to be single payer, that's one approach to it, there could be the public option that Biden seems to favor at the moment as one option. But I think you could have still a role for private insurance companies, and still employer based care. I think it's too big a leap politically and operationally to make those changes overnight. But there could be a glide path towards single payer if some of the intermediate changes don't work.

Stephen Shortell: So let me describe a few thoughts on some of the intermediate changes that are needed. So universal coverage with a benefit package equivalent to what is in the Affordable Care Act. Certainly cover the pre-existing conditions, but restoring and expanding the subsidies that would be needed for certain populations. Expansion of Medicaid as well, and making that equivalent to the ACA provisions are needed through waivers, or whatever means might make that possible.

Stephen Shortell: Then I think what we need if you're still going to have private insurers as a part of this, is Medicare Advantage, not Medicare For All, Medicare Advantage for All. And the key difference as you know is the capitated payment. Medicare Advantage is per member per month, creating that upfront revenue stream, predictability, a cash flow for providers, a recovery from COVID. So Medicare Advantage would be great to have as Biden's public option, or at least one part of it rather than just Medicare For All as it is still fee for service, or fee per DRG. So I think moving in that direction would be an intermediate step. To make it concrete, therefore, you would have all payer, risk adjusted, per member, per month, payment creating budgets based on negotiations between the insurers and networks of providers. Here in California we have four big ones - Kaiser-Permanente, Anthem Blue Cross, Blue Shield, and Centene/HealhtNet, plus others. They would negotiate. They can argue what that number will be, but it's going to be risk adjusted per member, per month to create that incentive now to keep people well. And that's the way it would be on the exchange, Covered California here, where they do already have cost and quality metrics in order for insurers to be on the exchange.

Stephen Shortell: And so then people, if they're unemployed or whatever, could chose one of those plans and the plans and their provider networks would be held accountable on the quality metrics as well as i having the incentive to keep the cost down. They can't cheat on quality because they also have the quality metrics that they have to meet before there's any shared savings or rewards for continuing improving performance

Stephen Shortell: So the glide path could be state by state experimentation with this kind of risk adjusted per member, per month capitation. I point out Vermont is already beginning to get there, Maryland has already done it on the hospital side at least and I hear they're extending it to physician and ambulatory care. Pennsylvania has done it for their rural hospitals. California, we've got the data through the Integrated Healthcare Association, where those that are in an HMO-ACO kind of model, risk adjusted per member, per month cap, have significantly higher quality of care on the usual

measures and they're lower cost, significantly so than the fee for service kind of provision.

Stephen Shortell: So this is what I describe as some other ways you can get universal coverage, but different ways of paying for that, reimbursing it, and organizing it without necessarily overnight going to the government being the single payer.

Robert Pearl: The coronavirus has created havoc across the United States from a medical, economic, and societal perspective. What did we get right, what should we have done differently, what can we learn from that experience going forward?

Stephen Shortell: I think we can learn from those who have handled this better than those who have handled it not quite as well. As it turns out, some work that I and others, mostly others, have been doing have learned that those hospitals and health systems that had some kind of standardized management system, call it what you want, the LEAN management system or the Shingo principles, in which they had several years experience in using tiered huddles, where they would meet every day and go over things, and anticipate patient needs have done better. They have years of experience of using quality improvement techniques, plan, do, study, act cycles very quickly to be able to figure out what worked. Who had visual management, data boards feeding it back on a daily basis, who had leadership that would go to the front lines and say, "What can I do to remove your problem today?" And so on.

Stephen Shortell: They did better than those that did not. And there's a couple articles coming out about that, and we've interviewed some people as well. There's examples here at Stanford now, and very early on, maybe you know this story, down at Stanford they have had off and on experience with LEAN management, but they had quite a bit of it, even in primary care. And within about two or three days they figured out how to use a combination of a nurse instead of a primary care doctor, and have drive through to speed up the testing.And they reduced turnaround time and throughput I think by fourfold within about four days or so. That's just one example. Cleveland Clinic, the Cleveland Clinic and their health system has done wonderful work in dealing with COVID-19 as a result of their experience with, if you will, the LEAN management system, or standardized management.

Stephen Shortell: So they have those protocols in place, they knew each other, not everything worked buy they quickly figured out what worked, if they needed to do something with the ventilators, how do you get two for one on a ventilator safely? If they didn't have enough PPE, where they could get the PPE, etc. And how they could protect their people, their own staff as well. Cleveland Clinic has long had something they call l I forget what they call it, but where the caregivers, doctors, nurses, and others can say, "I'm stressed out," and there's a support team that comes to them and says, "Well, what do you need? Or maybe you need to take an hour or two off, or maybe you need to take a couple days off, we need to get into the backup pool."

Stephen Shortell: So those are the kinds of learnings, I think, going forward. Clearly telehealth, absolutely. But we need to look beyond just the obvious of going forward to creating a future in which 10 years ago no one knew much about telehealth, now it's here, what is it going to be 10 years from now, five years from now, when we face the next pandemic? What tools might we have? I think they're going to come mostly from artificial intelligence, AI, it's already being used but I don't think we really can imagine even some of the uses of that going forward.

Stephen Shortell: So I think these are some of the learnings from COVID-19 of why some were able to do better than others, but of course it's within the larger context of our challenges as a country facing this pandemic.

Robert Pearl: What are your thoughts on how to address the rapidly rising cost of drugs?

Stephen Shortell: Well, certainly negotiation by the payers with the drug companies would help if Medicare were allowed to do that. That's on kind of the macro side of it. On the micro side, Kaiser Permanente's done it for years where you have regular look at the new drugs coming down the pike, and the way the evidence of generic versus brand name drugs, and you really, as long as the generic can do the job you have incentives to use that. If you have the right payment model, right incentives, more providers and provider organizations will look more carefully. And then it would go down the food chain, or the supply chain as it were. The big purchasers, since most hospitals now are a part of systems, for example, and increasingly physician practices, in their negotiations with the insurers on what are you going to cover and with the manufacturers, etc. etc. we need to reduce or keep our prescription costs at now or only increase of 1%, in turn putting pressure and competition on the pharmaceutical companies, the Pfizers of the world, etc. to compete because now their customers, right, are saying, "We no longer are going to pay you this same price for these drugs."

Stephen Shortell: So we've got to align, it's a domino effect, we've got to align the entire supply chain, the entire food chain to begin to use drugs more effectively. And I think, God, the lessons from the opioid epidemic really make that as a startling example.

Robert Pearl: Steve, hospitals are struggling in almost all but the most affluent areas of our country. What direction do you believe they need to go? Are they broken, is the system broken? What would you do if you were advising the next president about the hospitals in the United States?

Stephen Shortell: I think the hospitals in the United States, again, there's high degree of variability, those that are parts of systems of which about 65, 70% of hospitals are parts of systems, are going to recover more quickly. Systems can spread some of the pain, so to speak, they also have more resources to shore up some of the ones within their system that have been more impacted by COVID-19 than others. So I think as we see the bounce back here, you're going to see it more among the systems and even within the systems there will be quite a bit of degree of variance between some of the smaller ones and some of the larger,

more experienced ones, the Intermountains of the world, and Geisingers, and Mayo Clinics and so on.

Stephen Shortell: I have a particular concern, Robbie, for the rural hospitals that I think are going to be very difficult in terms of the impact of COVID-19 and what it has meant for them. So some of them will go under, I don't have any precise estimate. I think it's an opportunity for direct infusion of dollars where you still need some rural hospital beds. And also maybe to create incentives for the nearest urban or regional hospital system to in effect adopt, I don't know if that's the right word, but to bring that rural hospital under its umbrella in terms of its resources, in terms of what they need, and in terms of electronic health records, and so on. Much as Virginia Mason and others have done around the country, Mason's in Seattle, but for decades they've had rural outreach to rural hospitals across the Cascade Mountains, there's other examples of that as well. Mayo Clinic's done some of that in rural Minnesota and rural Wisconsin.

Stephen Shortell: So I think there needs to be more incentives for that. The other thing I would say about rurals that goes beyond hospitals is we need to figure out how to get broadband out there. You talk about patients and the community and patient centeredness, a lot of rural America doesn't have the broadband to have access to telehealth and so on. So that's a related concern as well.

Jeremy Corr: I live in Iowa, I grew up very, very rural, and my parents still can't get super high speed internet where they're at either, and I know a lot of places don't even have access to the kinds of speeds they can get. I mean, it was very recently that they were able to get like even usable speeds by modern standards.

Jeremy Corr: That being said, how can we make rural communities feel like they're not forgotten about? I'm sure you heard about that big storm in Iowa in the Midwest a couple weeks ago, it went through it was probably the biggest natural disaster we've seen in my lifetime, and it barely made the news, yet entire farmers and entire cities, entire crops are gone, people were without power for weeks. I think a lot of people in these areas just feel frustrated and forgotten about.

Jeremy Corr: And from a health policy perspective, how are we able to l How would you recommend we make people in rural communities feel like they're A, not forgotten about and B, ensure that they're getting the same level of care as their more urban counterparts? And essentially how do we address the social determinant, or the social determinants of health in these more rural communities as they have their own unique sets of problems?

Stephen Shortell: Yeah, it's a great set of questions, Jeremy, and I've been part of a group, maybe you're familiar with it, if not I recommend it, it's called Healthcare in the Rural West. And it's a group led by Phil Polakoff and others, past presidents of the Rural Health Association, I believe. And it's exactly trying to address and get national attention on what you've just raised. It remains to be seen how successful they're going to be.

Stephen Shortell: First point, I wonder if the COVID-19 pandemic that's been so disruptive to so much, the food supply chain and so, will finally amplify, at least a little bit or raise the visibility of how important rural America is to the country at large, to the rest of us who live in urban areas or everything that happens every day, the food we get on our plate and so forth and so on, the restaurants we eat out at. Whether or not that's going to occur, I don't know, but there's the possibility that could be raised to greater attention. So that's the first point I would make, and then also if you Google on Healthcare in the Rural West, they've come out with a policy statement in which they have, I believe, about nine or 10 recommendations along those lines.

Stephen Shortell: The second thing I would say besides extending the broadband that we covered already, is a different care delivery model for people in rural Iowa and so forth. I have a colleague here who founded a company called Caravan, and you may know of them, they're an aggregator of rural ACOs. In other words, as we all know if you're a physician practice or a small rural hospital, you don't have enough enrollees to take on risk based capitation or participate in CMS payment. But, if you aggregate up and you can do that, and so she's aggregated up to about 100,000 or more enrollees working with rural hospitals and practices throughout the country.

Stephen Shortell: And the magic sauce is she embeds a population health nurse into the rural physician practice. And that nurse does several things. One, knows codes and helps that rural provider code visits correctly and so forth so they get reimbursed more than they have been. But secondly, a big emphasis on prevention and outreach in the rural community, usually this is a resident of the rural community, has a lot of respect and credibility, etc. to get the patients in early and so forth, and get taken care of so they don't have to be sent off to the urban medical center, and may not even need to be admitted to the rural hospital. Third, is on the possible referral, the urban center, she's able to work with them. Most of the population health nurses are women with credibility in the local community and working with the primary care doctor decide that more care could be provided in the rural hospital community. It's jobs for them, they're a major employer.

Stephen Shortell:

And so we've done some work, we have a grant from the Commonwealth Fund, and our early analysis suggests that hospitals in rural America that are part of an ACO, the financial viability of those hospitals has not been hampered so far. The ACO incentive is to keep patients out of hospitals, so you might have thought well, that's going to hurt the rural hospital even more. Not so, not so far. Because we think what they're discovering is maybe more illness that in fact can be treated in that rural hospital, and that's why at least at this point in time the financial viability of the rural hospital isn't negatively affected by ACO

Stephen Shortell: developments.

So that's another response in terms of redesigning how care is delivered in that area. And the fourth thing I would say is the Virginia Mason model of trying to expand that, where there is a connection between the rural community and the more urban community. I don't know, Iowa would be between rural Iowa and the health systems in Des Moines, for example. And Illinois, downstate versus

the Chicago area or Springfield, for example. You could play that out in a lot of other rural states as well.

Stephen Shortell: So I think rural, it's only 20% of our population, I guess. But it's I think a larger influence on our economy.

Robert Pearl: Let me push you a little harder, some public health critics have said that the systems have done well because they've consolidated markets, gained market control, and raised prices rather than implementing any type of centers of excellence, or true centers of excellence, consolidation of services, or otherwise operational efficiency. How do you see the hospital industry across our nation?

Stephen Shortell: Yeah, the evidence that they raised prices is there. My colleagues have produced some of it. So Elliot Fisher (at Dartmouth) and I, (we at Berkeley)are part of a Center of Excellence with colleagues at Dartmouth in the last five years, funded by the Agency for Health Research and Quality. We recently came out with a paper in Health Affairs this past month in which we tried to address the issue of well, yeah, there's evidence that hospital systems and particularly after they consolidate further raise prices, is there any offsetting evidence of improvements in quality as they will often claim. So we did a large national survey of over 2,000 physician practices, many of whom belong to these systems, about 700 hospitals belonging to these systems, and then several hundred systems themselves.

Stephen Shortell: And the long story short in looking at a number of evidence based or at least strongly recommended process measures of quality, such as having care management programs for patients with multiple chronic illnesses,, electronic decision support, screening or clinical conditions, social screening for the social determinants that you mentioned earlier, and participating in value based payment programs. And three or four other things like this. Long story short, we could find very little evidence of any offsetting quality advantages. That is that they were engaging in these behaviors. And we compared complex systems, that's a system in which there are owner subsidiaries, like the Ascension Health System, just using them as an example. Simple systems, in which there's no subsidiaries at all. I think Intermountain would be an example, Sutter would be an example. And then we had organized medical groups versus independent practices. And we made comparisons across all of these on these various dimensions.

Stephen Shortell: So there's not a lot of evidence out there at this point in time that documents offsetting quality advantages. It may be there, but it has yet to surface.

Robert Pearl: Like you, I'm a big proponent of Medicare Advantage. The truth is that Medicare Advantage still pays about 90 cents on the dollar compared to commercial that's paying 120 or 130 cents on the dollar depending upon the study that you read. What's your perspective on this issue, and what changes would you make going forward if this became central to our nation's healthcare policy strategy?

Stephen Shortell: Yeah. If it becomes central, Medicare Advantage or that kind of payment, I think it puts positive pressure on the healthcare delivery system to deliver more value based care and eliminate that 25, 30% of waste. So now you have to operate at 90 cents on the dollar, you've been operating and cost shifting to the commercials to 120. Medicaid as you know pays even worse, of course. And Medicare doesn't pay as much I guess as Medicare Advantage. So I think appropriately we need to begin to realign, redistribute how much we spend in this country on mostly after-the-fact, fix-me-up care versus 3% on public health and prevention and the social determinants of care.

Stephen Shortell: So I would say 90 cents on the dollar, we should be able to deliver really good care 90 cents on the dollar, and that's why I go to the risk based, all payer, negotiate up front the per member, per month, that creates your budget. And now you have to deliver within that. And you have quality things to meet as well, so you can't stint on care. So I wouldn't personally worry a lot about 90 cents on the dollar , although in the negotiations it may be more than, that, versus you can get more now with commercial carriers, of course. Assuming of course we have the standardized benefit package and all of that, and assuming of course, and it's imperfect, that we can risk adjust to the extent we can. And you have enough people in the pool so that you don't have that problem.

Stephen Shortell: Another thought related to that, you haven't asked it, but what about the idea of a tax on the wealthy in this country, name a figure, five million annual income or more. And you use that tax for a nationwide reinsurance fund that would compensate for unusual things occurring for these at risk providers and insurance companies, or whomever, or some local outbreak of an epidemic, who knows where, that would be compensated or reimbursed for these very unusual events, but yet they can wipe you out. So that can create a country wide healthcare reinsurance fund.

Jeremy Corr: I'm glad you mentioned the economic impact of COVID-19, and not only in the rural areas it's had an effect, but it's had quite an effect on nearly everybody, not just farmers in rural areas, but people in cities, small cities, big cities, everything. As a public health expert, what are your thoughts on the lock downs and economic restrictions? Have they done too much damage to the economy with regards to like I said the shutdowns and restrictions, and have they had so much of an effect on the social determinants of health, like drugs, drinking, suicides increasing, I even think a lot of the civil unrest we're seeing is probably exacerbated by a lot of people being out of work and things like that. Kind of what are your thoughts on that?

Stephen Shortell: I agree with that, and I think we won't see the full impact of the COVID-19 and our response to it, probably it'll play out over several years. This coming year in terms of the mental health that you mentioned, physical health issues as well, potential increase unfortunately in suicides, etc., increase in homelessness among some populations also. So I think we're just seeing the tip of the iceberg of the impact of COVID-19.

Stephen Shortell: In terms of the response, I err on the side of caution, with a public health background. I think Tony Fauci has got it mostly right. Clearly there are trade-offs, there's no question about that. I think we've learned to become more nuanced and sophisticated in some states, not all, in terms of how you open up, and what criteria you use to open up. It's kind of like an accordion, right, in a way. We have a problem in America in disciplining ourselves with the distancing, the face masks, avoiding the large crowds, etc. etc. that's been so highly variable and pretty much directly traced to outbreaks where that hasn't occurred, the Sturgis motorcycle event, for example, of a week or two ago.

Stephen Shortell: One way to think about it is in terms of Girl Scouts, or Boy Scouts, out in the forest on a camp out trip, you get lost and you're trying to come out of it. And that's what we're doing now, at times we see clearings and then we go for it, we open up. And then we find out well, gee, we're back in the forest, that was just a temporary kind of clearing. And you know, the point is there's a rescue team out there and that rescue team are the vaccine developers. And until the rescue team gets to us, we are still going to be wandering in the forest. And we may come to clearings now and then, but we're still going to have some members of our troop getting sick, some unfortunately dying, maybe a few escape here or there. But until the rescue team comes to us, and even then there's going to be hiccups, as we know, in the distribution system, and how much protection is it going to be, etc. etc. Until that rescue team gets to us, we are not going to be in a position where we can say we've kind of controlled this virus, we've got the vaccine, and we can more fully open up our economy and get back to some kind of new normal. Not the old normal.

Robert Pearl: Thanks, Steve, for being on the show today and for your thoughts on the public policy and public health aspects of COVID-19.

Jeremy Corr: Robbie, what are your thoughts on what Steve said?

Robert Pearl:

Jeremy Corr: Please subscribe to Fixing Healthcare on iTunes or other podcast software. If you liked the show, please rate it five stars and leave a review. Visit our website at fixinghealthcarepodcast.com. Follow us on LinkedIn, Facebook, and Twitter @FixingHCPodcast.

Robert Pearl: We hope you enjoyed this podcast and will tell your friends and colleagues about it. If you want more information on these topics you can visit my website: RobertPearlMD.com. Together, we can make American healthcare, once again, the best in the world.

Jeremy Corr: Thank you for listening to Fixing Healthcare with Dr. Robert Pearl and Jeremy Corr. Have a great day.