Fixing Healthcare Podcast Transcript

Interview with Rick Pollack

Jeremy Corr: Hello, and welcome to the Fixing Healthcare podcast. I'm 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's currently a Forbes contributor, a professor at both the Stanford University School of Medicine and Business and author of the best-selling book, Mistreated: Why We Think We're Getting Good Health Care and Why We're Usually Wrong. His new book, Uncaring: How the Culture of Medicine Kills Doctors and Patients, was published two months ago. All profits go to Doctors Without Borders. If you want more information on the book and a broad range of healthcare topics, you can go to his website, robertpearlmd.com. Together. We also host the hit bi-weekly podcast, Coronavirus: The Truth.

Jeremy Corr: This is the third episode of season six. In season one, we had a variety of experts like Don Berwick, Eric Topol, Ian Morrison, and Zubin Damania, AKA ZDoggMD, on the podcast. Each opined on how to create the perfect healthcare system. In the current season, our guests are leaders from each of healthcare's components and their solutions focus on their particular area of expertise. And I can't think of anyone better able to talk about hospitals than our guest today, Rick Pollack. Rick is the president and CEO of the American Hospital Association, the AHA. The AHA is the nation's largest hospital and healthcare system membership organization with nearly 5,000 members, including hospitals, healthcare systems, networks, and other providers of care. Throughout Rick's six-year tenure as CEO, he's been a powerful voice to expand medical coverage in the United States, improve quality and patient safety, eliminate disparities of care and promote diversity in the healthcare field.

Robert Pearl: Rick, what are the five or six key areas that are most important from the hospital and health system perspective to fixing healthcare?

Rick Pollack: Well, let me break it down into a couple of different ways to think about that question, when we talk about five or six. Let me put it in this context. Right now, as we all know we're going through the COVID pandemic and it seems like this is going to be managing a chronic condition for some time. And when it comes to fixing healthcare, there are three things that we're dealing with as it relates to COVID, one of which relates to the question you raised precisely. But I would be remiss if I didn't say that there are three big issues we're dealing with right now that we're consumed with. And one is obviously providing relief to hospitals that are experiencing distress around COVID. And that relief comes in the form of regulatory waivers to allow people to respond in a quick and decisive manner. It comes in the form of financial relief.

Rick Pollack: The second big issue is recovery. And I say that in the context of, we went through an experience in which non-emergent services will all shut down and non-emergent services don't mean elective services that can go unattended to. We already see the ramifications of that. So when I think about COVID, I think about the three Rs. Relief is the first, recovery is the balance between being COVID ready to respond to searches and to respond to emergencies, but also being able to take care of regular operations, to provide people with the lifesaving services that are necessary. Then the third are in COVID gets to your question, Dr. Pearl, and that's rebuilding. What have we learned from this COVID experience that will help fix the system for the future? None of them like after 9/11, things aren't going to be the same.

Rick Pollack: So what do we need to learn, take away to reevaluate, reboot, but what can we do to re-imagine, to create a better future? So those are the COVID three Rs of which rebuilding and learning from the experience gets to your question of, how do we create a better system. The other piece of creating a better system or fixing the existing system. I would say revolves around two other groups of three. The first group of three is three issues that existed before COVID hit that just became more exacerbated. And that is dealing with healthcare workforce issues and the issue of resiliency dealing with behavioral health issues and dealing with health equity.

Rick Pollack: Those three things were out there big time before, people were focused on them, but they just became more challenging. And then the last bucket of three, I call the classic three. And the classic three are coverage, quality and affordability. And those issues never go away. And how we extend coverage and in our view build on the Affordable Care Act, how we continue to keep a focus on improving quality and ensuring that we deliver superb outcomes that never goes away and the issue of affordability. So I would group them in the three Rs for COVID, the big three, workforce, behavioral health and health equity and the classic three, coverage, quality and affordability.

Robert Pearl: You mentioned COVID and I really appreciate you doing so. Can you talk a little bit about the hospital at home programs, how they've contributed to better care? And whether these types of programs you think will continue in the post-COVID era?

Rick Pollack: Well, the whole hospital at home notion is something that was beginning to develop prior to COVID and then giving the COVID experience, it was something that became more prevalent. There are that have been pioneering in that area for quite a number of years Presbyterian health services in Albuquerque, New Mexico in particular comes to mind. And I know that Mount Sinai health system in New York is another example that is in that regard. I think it has a lot of utility. Most people would prefer to be in the home for a lot of types of services. I think that hospital at home has a lot of potential when we went through COVID and we saw the overload and we continued to see it today. Hospital at home has a lot of advantages. Of course, it's not the answer to all inpatient

hospitalizations, but where it's appropriate and the models do vary. I think it's something that we'll see a lot more of in the future.

Robert Pearl: I recognize that your responsibilities are national and therefore you have tremendous variation amongst how hospitals approach problems, but how do you see data being exchanged between the hospital at home and the hospital inside the bricks and mortar?

Rick Pollack: Well, if your part of a system and you have a hospital at home program, and of course in the case of Presbyterian and Mount Sinai, the two examples I mentioned, they are systems. I think that they're operating within a system, if you will, that is connected and clearly for hospital at home to be successful it involves the use of a variety of technologies that are necessary for monitoring and making sure that those connections are in place. I think it gets a little bit trickier where you're in relationships that are not system related and that obviously needs to be perfected. But most of the examples that we've seen really have been where the hospital is clearly tied into the technology with the setting at home.

Robert Pearl: And what are you seeing relative to telemedicine in that context?

Rick Pollack: Well, telemedicine again, really took off during COVID. It had hit unprecedented levels when people were reluctant to come to the hospitals and when non-emergent services were shut down, we've seen recently a little bit of a tailing off on it as people have felt more comfortable coming back to either physician offices or hospitals or other outpatient facilities for care. So the dramatic increase we saw has held off somewhat, but I think the cat's out of the bag now on telehealth. I think it's going to be used much more frequently. I think our millennial generation is very, very comfortable in doing things in that manner, but it's not the answer to everything. There are just so many services that are provided that involve either technologies or require person to person interaction.

Rick Pollack: I mean, as a physician you know better than anyone that there are certain things that you just can't do on the computer. And certainly we're going to see more of it, but it's not the answers to everything. There are certain applications for telehealth that are very effective and there are certain things that it can be very useful in to ensure access. You think about behavioral health as an example, where there are a lot of stigma issues associated with people seeking care. Telehealth has tremendous promise in that regard. When it comes to providing access to care in underserved areas and isolated, rural areas, there are a lot of opportunities there to provide care. So I think it's here to stay. I think it was definitely something that was proven to be very useful as a result of the COVID experience.

Robert Pearl: You're talking about the COVID time period. And one of the things that worries me a lot is the burnout that's happening, particularly for the critical care physicians and the nurses taking care of patients. And I spoke to one doctor who

had four patients die in one day and a resident who started the service with six patients in the ICU. And by the end of the month, all six were dead. What's your thinking and what are hospitals doing to address the fear about PTSD happening once this pandemic goes by and people re-experience the emotional trauma they've just been through?

Rick Pollack: I think that it's not even once we're done with it. It's as we go through it. The issue that is on the minds of most hospital CEOs that I talked to, and I talked to a lot of them all the time. You ask them what their priorities are and it's workforce, workforce, workforce, resiliency, resiliency, resiliency. Right now it's not an issue of having enough supplies. It's not an issue of having enough equipment. It's not even an issue sometimes of having enough beds. The issue is really having the staff available and there are so many different dimensions to the workforce resiliency issue that need to be addressed.

Rick Pollack: And unfortunately, a lot of them aren't going to be solved overnight, particularly as it relates to just the shortages that existed in certain professions prior to COVID. So ensuring that our teams are well taken care of in terms of their own health, their own wellness, that they are given all of the support that is necessary. It's just totally front and center. And there is no higher priority than ensuring that our workforce is taken care of. Without them, the system breaks down. Simple as that.

Robert Pearl: Shifting a little bit to the question of collaboration. During COVID we saw hospitals that were typically competitors come together to provide the best care. Can you tell listeners a little bit about some of that experience?

Rick Pollack: Yeah. There's no question that we saw a lot of collaboration among people that would normally be competitive in this situation. And I can give so many different examples from Florida and the Tampa Bay area in particular, where there were specific efforts among 51 hospitals that were put together. To Texas and the Dallas area where the Dallas-Fort Worth Hospital Council worked on with all of the hospitals in an effort to coordinate. To the New York city area where the Greater New York Hospital Association and some of the big systems work together. To an effort that we put together nationally in creating a dynamic ventilator reserve when ventilators were in a shortage situation, and we had systems donate. And it's still exists by the way, donate into a reserve where we can move them around as needed. And then there were informal arrangements where various systems had worked to provide staff to other systems in different parts of the country.

Rick Pollack: Because as you know, as we went through COVID, there were hotspots in different areas at different times, and we saw those systems come together. So there are a lot of examples where I'm very proud to say that people were very cooperative and collaborative. And in a lot of meetings that I've been in with association boards, that's one of the things that they talk about that they've been proud of is that as essential public services, hospitals really did come together. The other aspect of this is the value of healthcare systems and the fact

that we saw systems better able to respond to a variety of different issues. They were able to move staff around from one hotspot to another while things were acute in one area and less acute in another. Systems were able to do that, that were in multiple areas across the country. They had a lot more scale when it came to equipment when it came to dealing with PPE. So not only did we see the value of systems demonstrated, we also saw the value of the collaboration that you mentioned.

Robert Pearl: Do you see progressive consolidation being the direction of the future and the solution for the future?

Rick Pollack: I think, I don't know that it's a solution for the future. I think that there's great utility in it. Every community is different. Every market is different. And I think we'll see continued consolidation because it brings value, and the value comes in a variety of different ways. And I know we want to talk about how we fix the payment system and delivery system. I know that's an important issue to you, but just this one example, if we're really to move away from the fee-for-service system and move toward more integrated care, which is something we need to do, that means that you're taking risk, financial risk to manage care across the continuum. Well, in order to do that, you need to have the resources. And what we find is systems have the scale to manage risk in moving in that direction.

Rick Pollack: They also have the capital that's necessary for keeping facilities up to date and for purchasing necessary technology. And we do find that there are efficiencies that are achieved as a result of systems. So it's not the answer to everything, but they certainly provide value. And I think that that trend will continue. Now, again, consolidation can be defined in a variety of different ways. There are mergers, but there are also partnerships and alliances that are created that sometimes achieved similar objectives without outright merger. But I think partnerships are the future as we look toward improving the healthcare system, and there going to be a lot of different ones out there. If you've seen one, you've seen one.

Robert Pearl: What's your view on how we will move from fee-for-service service to capitation? Who's going to lead the process? How's it going to happen? How are hospitals and doctors going to join in the effort? What are your views on making that change happen for our nation?

Rick Pollack: Well, it's already happening. There's no question about it. The question really is how fast will it happen? When I see this question of moving from fee-for-service toward integrated delivery, I think it's really important that we move in that direction because the fee-for-service system, someone once said, by the way, it's in the clear dead, we just don't know when the funeral will be. And I think that there's validity to that because we're all headed in this direction. And it's a continuum when you think about it. As you go away from fee-for-service, the first stop on it is what you might refer to as value-based payment, which are often penalties or in some cases, incentives that are built into the fee-for-service chassis.

Rick Pollack: And if you're a Medicare provider, you're already doing value-based payment, because there are penalties for hospital-acquired conditions and readmissions, and there's value based purchasing. That's one part. Moving along that continuum away from fee-for-service perhaps is bundling. That's a next step along the process. A next step to that may be accountable care organizations. And next step to that may be having a partnership as part of a Medicare Advantage plan. Providers either on their own or with insurers. Or then you get to the point at which you have provider based health plans or partnerships with insurers. And we have over 128 healthcare systems, hospital-based healthcare systems that have their own health plans.

Rick Pollack: So I think that that's the direction we're moving in. Clearly the Affordable Care Act gave some juice to moving in that direction through some of the projects that were included in it. But unlike in the 1980s, when we moved to DRGs where we flipped the switch and yeah, there was a three-year transition period, but it happened pretty quickly. I think this is more of a dimmer switch, rather than a flipping of the switch. We're moving in that direction. It's just a question of how fast we can move and get there. Fee-for-service, we all know that the incentives under the fee-for-service system are not the right incentives, really, when you get down to it for providing good care, because there's no financial incentive to do prevention. There's no financial incentive to do care coordination. And those are the things that we really need to be focused on.

Robert Pearl: What are the challenges that I think about a lot, and I'm not sure I have a great solution. Hopefully you will, relative to the hospitals. Is that if we assume that all of the efforts are going to reduce disease and therefore the need for intense intervention, how will the hospitals make the leap between where they are today to a large extent with a fee-for-service type revenue base to a capitated one? Is there a transition that they can go through to allow them to not suffer financially? I'll say in the 10 years that it may take to be able to put in place all the efficiencies and make all the other adjustments.

Rick Pollack: Yeah. And that goes back to the continuum. Moving along that continuum, I think is the transitional point that we're at to do that. And the other part of this too, is that yeah, there is an infrastructure that needs to be maintained relative to the sophisticated diagnostics and the sophisticated surgeries and the sophisticated procedures that are going to always occur in the building. But that building that has all these essential public services that H that we all rely on that is a beacon that signifies to people that that is a place that is in many ways, society's ultimate safety net. We see it being demonstrated every day. We're in the process, let's face it, of redesigning that H. And that H is going to mean more than an inpatient hospital and an inpatient acute care facility. Already half the surgeries in the country that we do are on an outpatient basis.

Rick Pollack: So I think that this is a transition. The hospital is more than just a building. We already see us doing things in outpatient settings and home care settings and ambulatory clinics. And this is all part of making that transition. As we look to the future, so much service, so much healthcare is going to be necessary for

managing chronic conditions. I mean, you just think about the fact that there are 10,000 people that turn 65 every day and that Baby Boom population that's going to require the management of chronic conditions. I think redefining the H to address the fact that service and need and consumption of healthcare is going to occur in these different settings. And hospitals need to play a role in capturing that, will be driving us in that direction.

Jeremy Corr: One major concern for patients right now is the amount of COVID patients in hospitals. There are major, major concerns about people not being able to be treated at a hospital or being treated as well as they should be for a non-COVID issue. For example, if someone's dad has a heart attack, is his quality of care going to be worse right now, due to the overcrowding and burned out doctors, or even is he at risk of getting COVID in the hospital? Not to mention if there is a major surge, if the hospital hits capacity, then what? And also you have to factor in the numerous reports we heard from early on in the pandemic of people just not going to get treated for things they should be for fear of either A, getting COVID at the hospital or B, adding to the overcrowding at the hospital. What is currently being done across America to address this? And do you feel like we're in a good position right now, or what could we be doing better?

Rick Pollack: Well, first of all, in general, if you're not in a situation where there is an enormous spike or a surge going on and services are available and have not been shut down for just COVID, it's perfectly safe to seek care in a hospital. I mentioned earlier the three Rs around COVID and recovery being one of them. And we had a whole task force of clinicians and CEOs that talked about, how do you strike that balance of always being ready for an emergency spike or a surge, but also being safe for regular care? And I think we have found that balance. Now, of course, back in April and March and April of 2020, there was a shutdown for two months of all non-emergent services. And we now see a lot of pent up demand, and we've even seen mortality increase as a result of people not getting the care that was necessary.

Rick Pollack: I think we're way beyond doing that, except under certain emergencies that was a blanket shut down in the whole country. Now we see that occur in certain circumstances on a voluntary basis where we feel as if we have to do that, to deal with an emergency. And hopefully those situations are of limited duration. And that's where systems and the cooperation among hospitals to balance the load, if you will, becomes very critical. But I got to tell you, as someone that has been in and out of hospitals over the past 18 months as a patient for all sorts of testing, and everything's fine, but you have to do what you have to do for a variety of reasons. And as someone that has a 98 year old mother that has had some health issues, not to mention other members of our family, I have never had any concern about seeking care in our hospitals. In fact, I have a much higher level of confidence walking into a hospital with all of the precautions that have been put in place then I do going to the grocery store.

Robert Pearl: The state of Maryland regulates hospital pricing, and everyone seems sort of happy. The hospitals seem relatively happy. The purchasers seem relatively

happy. And yet the model doesn't expand. What's your observations from talking to the hospital CEOs in Maryland?

Rick Pollack: Well, I don't know if it's the grandfather or the godfather of the Maryland system was one of my mentors, my most influential mentor and my predecessor or predecessor before my predecessor, Dick Davidson. And he ran the Maryland Hospital Association and helped create that system and I'm well acquainted with it. And I served as his executive vice president for over 14 years here on the advocacy side. And Dick was very proud of that system, as you suggest people still are. And that system has evolved significantly over time from just focusing on inpatient hospital rates, to looking at more of a global system that is now very, very sophisticated and complex. But the one thing Dick always said, because when he came to be president of AHA, everybody said, well, the Maryland model is coming to the nation. Dick always suggested that we're dealing with 52 hospitals in Maryland at the time.

Rick Pollack: At least that was the number he always referred to. And they had a commission that was able to look at 52 situations, if you will, and coming up with the appropriate rates because they weren't all the same for everybody. And they had adjustments. And the notion that you can ever apply that to 5,000 hospitals was something that he was very dubious about. And that's where Maryland is a very interesting experiment. It has changed over the last quarter century. And while it has solved certain problems, I think that the people in Maryland, while they certainly operate within that system, they're still trying to manage through it. And the changes that they've made more recently to make it more global is something that is still an experiment.

Robert Pearl: The rural hospitals are struggling through their small size and high costs. What do you see as their future?

Rick Pollack: Well, from a policy perspective, there have been a lot of levers that have been put in place to help rural hospitals. The creation of critical access hospital designation of which there are 1,400. So community provider designation, rural referral designation, those things are in place. Now that doesn't solve all the problems of rural hospitals. We still have real problems out there in terms of ensuring that they stay viable. One of the issues that we see is rural hospitals becoming part of larger systems. And roughly half of the rural hospitals in the country now aren't in fact part of a larger system. And in that case that provides a strategy. And we put together a task force actually to think about the future of rural hospitals. And they came up with about eight different pathways. One of which is to be a part of a system, another is to adopt global payment system, if you will.

Rick Pollack: And there are a lot of different strategies that they have to employ. I think for a lot of rural hospitals, one of the things goes back to what I said before about redefining the H. We need to think about the rural hospital more as a network of caring there as a building. And again, you go back to this issue of chronic care management and the fact that so much of our healthcare expense and need in

the future is going to be managing chronic conditions. Fact of the matter is, most people want to have those situations or conditions managed at home. They don't want to have to leave their community for care. So for rural hospitals, they also need to be thinking about different pathways for the future. They need to be thinking about how they redefine who they are, what they are and what they do.

Rick Pollack: And in some cases it may be that a rural hospital is a network of which they may have a freestanding, urgent care or emergency room. They may have an ambulatory care clinic. They may have a SNF that's connected to it, or some sort of assisted living component or a home healthcare service, but it may not revolve around the building per se. And I think that those are the kinds of things that need to be thought through. And again, every community is different. What I've come to appreciate is that even when we talk about rural. Rural in new England is very different from frontier in the west. And a lot of different approaches based upon the nature of the community that one serves.

Robert Pearl: The residency programs in our nation are overseen by hospitals. What do you see needs to change going forward about resident education?

Rick Pollack: Well, we've already seen when it comes to resident education, a lot more focus in the outpatient settings. In addition, they may be based out of the hospital, but a lot of the training and practices occurring in a lot of different settings. And that's going to be really important because it goes back to the fact that hospitals are going to be more than the inpatient setting. And again, certainly there's a training component that involves the inpatient acute care setting. But we see a lot of training going on in outpatient settings as well. And I think that that is going to continue to be the trend in the future. And a lot of the training obviously is going to have to focus on teamwork, because when you get into providing care in the future, if not for today, and involves a team.

Rick Pollack: And one of the things that medical education for physicians at least, certainly is beginning to recognize is that interdisciplinary teams of which the physician is a key leader, if not the leader, is important but they cannot do it all alone. And in fact a lot of other allied health professionals need to be able to practice to the full potential of their license so that physicians can concentrate on the areas in which they are really most qualified to spend their precious time. So I think all of this is in transition as well. And I think there's a lot of opportunities here to improve residency training. The area that we're concerned about is just the number of additional doctors that are going to be necessary, given the retirements associated with the Baby Boom, and given the fact that we are going to have increased demand out there for service.

Robert Pearl: The American Hospital Association has both for-profit and not-for-profit hospitals and hospital systems. Do you see a difference in how well they operate or the role they play in their community?

Rick Pollack: Well, there are three different forms of ownership when it comes to hospitals. Of course, you have the investor rounds, as you suggested the for-profit players. You have the private nonprofit entities, which people normally think of as being a hospital. And then you also have government owned hospitals. So there are really three forms of ownership and all of them serve the needs of the communities that they're in. All of them are under pressure in the same way to deliver on superb outcomes, to lower costs as much as they possibly can and to make care more convenient to patients.

Rick Pollack: So I think that when you look at hospitals, all of them, regardless of the form of ownership that they may be experiencing, they really are all very similar in terms of the challenges that they face and the most important things that are on their to do list. Listen, in addition to the ones that I just mentioned, making sure that they're all working to experiment with, or engage in new payment models. Regardless of ownership, they're all doing that. Working to achieve solid hospital physician clinical alignment, all three forms of ownership are doing that. So I think that when it comes to the ownership question, I think, everyone is focused on really the same issues.

Robert Pearl: When I look for the opportunities for every hospital, as you say, with three different models sitting in play to lower costs, I'm always struck by the fact that the data says, at least nationally, if you're hospitalized on a Friday night, you're likely to spend a full extra day in the hospital recovering that if you're hospitalized with exactly the same problem on a Monday or Tuesday night. Do you see some solutions or ways that we can basically get people better, faster, which will lead to higher satisfaction and lower costs?

Rick Pollack: Interesting question. And certainly one that relates to operational issues in terms of the matter that you just raised. That's something that certainly needs to be explored and as a patient, I've experienced that. And that's certainly something that deserves a lot more attention and a lot more consideration. No question about it.

Robert Pearl: Let me ask you then another opportunity. The quality we know varies hospital to hospital across the United States. Is there a best way to measure quality and then help everyone to match the performance of the best?

Rick Pollack: Well, when it comes to quality, I think we've made a lot of improvements over the years relative to quality. And there are a lot of metrics that are out there. The government itself through hospital compare has its set of metrics that are out there that people use. Let's face it, quality is job one to coin a phrase, and nothing is more important than ensuring that we have the best outcomes possible and that we work to standardize things and eliminate variation. I think we've seen is that that's where a lot of healthcare systems bring scale to this whole question of standardization and eliminating variation. And that's where we've seen some real improvements. So the whole issue of measurement, quality improvement, that is an ongoing process that we continue to work to perfect. I think we've made great improvements, but as you can, well

appreciate, it is a lifetime's work. And we have to continue to keep a focus on that. And I know that that's something that is always top of mind for our members.

Robert Pearl: So the hospitals have done a really good job at trying to eliminate medical errors and improve patient safety. What's next? How are we going to continue to get better as you say, with a goal that can never be reached? We have to continually get closer to it.

Rick Pollack: I think it's just continuing to look at what the better metrics are as we move forward. When we get into the issue of metrics, there are things that over time get absorbed into the DNA of an organization, and they time out or tap out in terms of that measure, because we've pretty well adopted it. It's part of the DNA of the organization. And I think that as we move forward, we need to continue to perfect the metrics and look at ones that are the most relevant. Find the ones that have the most opportunity for improvement. And again, the folks that are experts in this area are continuing to keep an eye on it.

Robert Pearl: One of the areas that I know you're addressing almost every day right now is the desire people have for hospital data transparency on cost, particularly. And some of the challenges of providing it. Where do you see that going in the near future?

Rick Pollack: The real issue on transparency when it comes to prices is, what is it that an individual is going to have to pay out of pocket based upon their insurance plan? That's what I want to know as a consumer and as a patient. And that's the part that we need to focus on in being really transparent about. We've had admittedly concerns about the notion of having to post privately negotiated rates, because that leads to certain anti-competitive practices. And we don't think that that's useful to the consumer because that's not the rate that the consumer is really paying. They want to know what their out of pocket obligation ought to be. And I think that that's where the focus needs to be. The other thing to keep in mind of course, is that from a hospital perspective over half, and then sometimes way over half of our prices are not prices at all.

Rick Pollack: They're rates that's set by the government on the Medicare and Medicaid. We're not negotiating anything. We're given a rate and all of that stuff is totally transparent. And then when it comes to our negotiations with insurance companies, those negotiations, we're dealing with billion dollar entities that are in many cases dictating prices to us as opposed to negotiated rates. So I think the real question here is we have to do everything we can to provide the information to the consumer. We need to do everything we can to make sure that they know what their out of pocket liability is based upon the health coverage that they have.

Jeremy Corr: One thing that frustrates patients is when they get their bill and they found out they were charged, say, for example, $15 for a Tylenol. People understand that there will be a market for these line items on their bill when they get it at their

hospital versus when they go buy it at target. But the amount they're overpaying on these line items is something that often immediately angers patients when they open their bills. This, in addition to how confusing medical bills are for patients such as separate provider and facility charges, or even multiple provider bills drives patients crazy. I think it's safe to say the majority of Americans don't even know how to read a medical bill or understand the billing process. What should hospitals be doing to make this process easier to understand for patients? And what are your thoughts on how to fix outrageous line items such as a $15 Tylenol?

Rick Pollack: Well, we probably couldn't have created a more complicated system if we tried, when it comes to the billing system. And we have been engaged in various what we call patient friendly billing initiatives with the health care financing management association, the CFOs, to try to make things more comprehensible and that is ongoing. But at the end of the day, the real way to get at this problem is through prepaid care or capitation or some form of prepayment, which really doesn't involve focusing on line items. And doesn't involve the kinds of issues that you are talking about, where you prepay, you get the care that you need, and there are all of the mechanisms in place to ensure that you get the appropriate care. That's the ultimate solution for the puzzle that we've got going on right now.

Rick Pollack: The line item issue that you mentioned, that's a tough one because under the old or an existing system, it's not unlike the analogy of if you go into a supermarket and you buy chopped meat for a hamburger cost you X. But if you go into a restaurant and you have it cooked and you have it served to you, it's going to cost Y. And when you think about costing out what some of those items that you suggested may be, when you get in an inpatient facility or a hospital, you do have it delivered to you. There is some times regulations associated with the recording and the accounting for that particular item. So it's an artifact and in some sense of the fee-for-service system that we're dealing with, but the ultimate answer I believe is through prepayment, whether it's in the form of bundling, whether it's in the form of prepaid care on a capitation basis.

Jeremy Corr: Healthcare is always one of the top issues for voters when it comes to selecting which candidates to vote for in American elections. Yet Americans, regardless of political party, feel like not enough is being done in Washington. As an organization that does a lot of work in Washington and has a good understanding of American politics, if a potential presidential candidate for say, 2024, regardless of political party came to you and asked you for advice on what would be the best healthcare platform to run on that would have the most impact and most buy-in from voters while still being changes that could realistically happen. What would your advice to that candidate be?

Rick Pollack: My advice would be, listen, we worked hard on the Affordable Care Act. We supported it. We defended it in the courts. We still continue to believe that that is a platform on which to build, both in terms of expanding coverage, building on the delivery system, reforms that were inherent in it. And certainly the

quality improvements that were a part of it. Medicare and Medicaid, we forget those were created over 50 years ago in the '60s. How many times have we amended Medicare and Medicaid over the years? And we continue to do that every single year.

Rick Pollack: I think that the Affordable Care Act is still the basis for the future. It needs to continue to be improved and refined along those classic three elements that we've discussed. And while it may not sound like it's new and flashy, I think that a lot of it is a foundation on which we continue to build. I'm pleased that that is where president Biden has put his focus, and that's where we continue to focus. Even right now, in terms of what's going on on Capitol Hill in the infrastructure bills, building on the ACA, by extending the subsidies that were expanded in some of the rescue packages for the uninsured. That's still out there, that's a big issue. We still need to focus on that.

Robert Pearl: One last question, Rick. It's 10 years from now, what does the American healthcare system look like? What do the American hospitals look like? How different will it be than it is today?

Rick Pollack: Well, I hope that in 10 years we certainly have more of a focus on prevention. We have more integrated delivery systems that are providing the care to people where they're not bounced around from one unconnected facility to the next. I would hope that 10 years from now, we're in a position where there is a real focus on ensuring that people get the care in a very convenient way. Again, that they're able to access the care. I hope in 10 years, we can have built on the Affordable Care Act to get to almost universal coverage. We're not there yet by any stretch. So it goes back to those classic three. We need to make sure that we have coverage, that care is affordable, that it's delivered in a way in which it is focused on prevention and wellness and coordination. And that, again, quality is always top of mind.

Robert Pearl: Right now we know that the current vaccines are very effective at diminishing the need for hospitalization and preventing death. And yet even amongst hospital employees, we see a moderate amount of vaccine hesitancy. Is there a strategy that you recommend nationally to be able to address this and have us be able to reach a high enough level to achieve herd immunity?

Rick Pollack: Yeah. Well, first of all, we support hospitals that mandate vaccines for their employees, and we've worked really closely with the American Medical Association and the American Nurses Association and encouraging the public to get vaccinated. We've been involved in all sorts of public service announcement campaigns, and we've been working with the Black physicians against COVID. We've been working with a lot of different coalitions to encourage people, to get vaccinated, to make the case of why it's important and why it's safe. We've been working to ensure that clinical ambassadors, the best messengers are reaching out to the vulnerable populations.

Rick Pollack: In terms of hospitals, themselves, we find that high levels of vaccination, certainly very high among physicians, pretty high among nurses. And we also see that we're reflective of America when it comes to other segments of our employee population that just need more encouragement, but we support mandating it. There are certain states that prevent mandates. So we're not a regulator. We can only encourage people to go in that direction. And it's something that we need to continue to push in terms of getting to as high a level of vaccination as possible.

Robert Pearl: Thanks, Rick. I really appreciate your leadership. As I know, all the hospitals in America do, and I look forward to the success that you're going to have in the near future.

Rick Pollack: Thanks so much for having me. I really appreciate it.

Jeremy Corr: We hope you enjoyed this podcast and will tell your friends and colleagues about it. If you want more information on physician culture, you can find it at RobertPearlMD.com. Congratulations Robbie on the success of your recent book. I know it continues to stimulate discussion and debate and will improve healthcare for all Americans.

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