



SPECIAL PODCAST DEBATE

The Future of Hospice

Three Strategies, One Patient

A four-character performance script for Chris Comeaux

Prepared September 2026





Format: Four characters, all played by Chris Comeaux

CHARACTER AND PERFORMANCE GUIDE

CHRIS - Facilitator

Warm, curious, balanced, and occasionally provocative. Chris keeps returning the debate to the patient and family.

PAUL - Vertical Integration / Frail-Elder Practice

Practical clinician-operator. His favorite words are **continuum**, **relationship**, **home**, **caregiver**, and **longitudinal**.

CHRISTOPHER - Payvider Strategy

Strategist and economist. His favorite words are **alignment**, **attribution**, **risk**, **data**, **incentives**, and **total cost of care**.

COMEAX - World-Class Hospice and Palliative Care

Mission-centered craftsman. His favorite words are **excellence**, **trust**, **calling**, **discipline**, **quality**, and **human experience**.

OPEN

CHRIS:

What if the greatest threat to hospice is not that we fail?

What if it is that we succeed but at the wrong strategy?

What if we become world-class at hospice, but someone else controls whether the patient ever reaches us?

What if we build the perfect continuum of care, but the complexity and capital required pull us away from the very mission we were trying to protect?

And what if we become the payer as well as the provider, align every financial incentive, and then discover that the patient feels less free—not more cared for?



What if in our quest to innovate we open up the space to every flavor of healthcare including non-credentialed care modalities thus watering down the competencies that over these past 40 years have saved Medicare billions and has ensured millions passed from this earth having experienced love, dignity, and great care? What if we accidentally make that go away in our quest for innovation?

Today, I am going to debate those questions with three people who disagree with one another.

The complication is that all three of them are me.

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OPENING AND SETUP

CHRIS:

Hello and welcome again to TCNtalks and Anatomy of Leadership, where leadership, purpose, and care come together. I am your host, Chris Comeaux.

This may be the most unusual show we have ever recorded, but the subject could not be more serious. Around the country, some of the brightest leaders in hospice and palliative care see many of the same forces bearing down on our field. Yet they are arriving at very different answers about what organizations should become.

Before we debate those answers, let me set the table with eight challenges. Here at TCN, we used a great tool that is a future external environmental scan to scan the external environment and via that tool and via some of the brightest leaders in hospice and palliative care we have come to the conclusion that there are 8 challenges facing all of us. In fact, in April 2026, Cordt Kassner turned the tables on the podcast and interviewed me around these challenges. We will include a link to that show in the show notes. So here are those 8 challenges:

First, **hypercompetition**. We have more traditional competitors, more national platforms, more private capital, more substitute services, and more organizations trying to control the serious-illness patient before hospice ever enters the picture.



Second, **reimbursement and financial pressure**. Inflation, wage pressure, utilization patterns, payment limits, denials, and the inadequacy of fee-for-service payment for interdisciplinary care all collide with an expectation that we do more.

Third, **workforce and priority needs**. The people called to this work are scarce. We are asking exhausted leaders and clinicians to absorb more complexity, learn new competencies, and somehow preserve the humanity of care.

Fourth, **patient and family demographic shifts**. The baby boomers are moving into serious illness and end-of-life care. They are different customers. They have challenged institutions at every stage of life, and we should assume they will challenge healthcare too.

Fifth, **regulatory and political uncertainty**. Hospice is highly regulated, closely scrutinized, and increasingly shaped by policy decisions that can change the rules of the game.

Sixth, **technology**. AI, predictive analytics, remote monitoring, interoperability, and consumer technology may expand our reach—but they may also enable substitutes, intensify surveillance, or turn human care into transactions.

Seventh, **the speed of change and the need for resilience and re-culturing**. We are not managing one change initiative. We are asking organizations built around a defined Medicare benefit to rethink who they are and books have been written about how the change curve takes out many industry leaders. It's almost like trying to defy gravity. That's why authors even like Jim Collins have written about this "How the Mighty Fall." The risk is real this could be us, so this show is not advocating stagnancy or complacency.

And eighth, **the mental-health crisis affecting patients, families, and staff**. Loneliness, caregiver strain, grief, burnout, anxiety, and moral distress are not side issues. They are part of the care environment.

So those are the 8 challenges. Many of the best thought leaders in the space at state and national conferences lead off their presentations with very similar derivatives of these challenges. Let them sink in as they are fairly daunting.

Therefore, many leaders agree on that diagnosis. However, what I see emerging are three major worldviews—three macro strategies for responding..... almost the prescription if you will for navigating these challenges.

The first says: **move upstream**. Start with hospice, add world-class palliative care, then build home-based primary care designed specifically for frail older adults. Create one coordinated continuum. I refer to this one as vertical integration.

The second says: **do all of that, but do not stop at being the provider**. Become, partner with, or meaningfully participate in the financing and risk. Enter the payvider world through



accountable care, special-needs models, PACE, Medicare Advantage, or emerging CMMI models such as LEAD. I refer to this one as the payvider strategy.

The third says: **be careful and be smart**. Hospice and palliative care are profound specialties, not merely service lines in a larger machine. Become indisputably world-class at the work only we can do, and let excellence, trust, outcomes, and mission be the strategy.

To make the strongest version of each case, I have invited three guests.

MEET THE CHARACTERS

CHRIS:

First is Paul. Paul believes the answer is vertical integration through a frail-elder practice—hospice, palliative care, and home-based primary care working as one continuum. Paul, welcome.

PAUL:

Glad to be here, Chris. I would say you saved the most practical character for first.

CHRIS:

That confidence will become relevant later.

Next is Christopher. Christopher believes providers of serious-illness care must understand and increasingly participate in the financing of care. His worldview is the payvider strategy. Christopher, welcome.

CHRISTOPHER:

Thank you. I brought data, a risk model, and three spreadsheets Paul has not read.

PAUL:

And I brought an actual patient.

CHRIS:

Gentlemen, pace yourselves.

Finally, we have Comeaux, who argues that the best future strategy is to build a world-class hospice and a world-class palliative-care organization. Comeaux, good to have you.

COMEAX:

Thank you, Chris. I brought the mission—and somebody had better keep it in the room.

**CHRISTOPHER:**

Mission without margin is a memory.

COMEAX:

And margin without mission is just an insurance company.

CHRIS:

All right. We have officially started.

Here are the rules. I will ask each character to explain his worldview, his strategy and how it responds to the eight challenges. I will then affirm why the strategy makes sense and poke some holes in it. We will go in this order: Paul vertical integration, Christopher payvider, and Comeaux world class hospice and palliative care.

Nobody gets to pretend his strategy is risk-free. Nobody gets to win by caricaturing the other two. The question is not, "Which strategy sounds smartest?" The question is, "Which strategy best serves patients and families—and under what conditions?"

ROUND ONE: PAUL MAKES THE CASE FOR VERTICAL INTEGRATION

CHRIS:

Paul, take us inside your worldview. Why should a hospice move upstream into palliative care and then into a frail-elder practice i.e., vertical integration?

PAUL:

Because the patient does not experience life in benefit categories.

The patient does not wake up on Tuesday and say, "Yesterday I was a primary-care person, today I am a palliative-care person, and next month perhaps I will become a hospice person." That is how our payment architecture sees the person. It is not how the person experiences illness.

A frail-elder practice is not simply a primary-care clinic for people who happen to be older. It is a model designed for people whose health, function, cognition, and support systems have become fragile. These patients do not just need more office visits. They need a longitudinal relationship and a team capable of caring for them wherever they live.

Traditional primary care was not designed for that job. A fifteen-minute office visit cannot fully see the person with six chronic conditions, twelve medications, declining mobility, a frightened



spouse, a daughter trying to coordinate care from another state, food insecurity, and a home that may no longer be safe.

For this population, the home is not just a place of service. It is clinical information. The caregiver is not merely someone standing beside the patient. The caregiver is part of the care unit. Function, cognition, social isolation, spiritual distress, medication burden, and the capacity to remain safely at home all matter.

So, the vertical-integration strategy is simple to describe, although not simple to execute: begin with the strengths of hospice, extend those strengths upstream through palliative care, and extend them further through home-based primary care designed for frail elders.

The primary-care team must be able to deliver primary palliative care from the beginning—symptom management, serious-illness communication, advance-care planning, deprescribing, and care aligned with what matters most. Then specialty palliative care is layered in when needs become more complex. And when hospice becomes the right service and the patient's goals align, the transition should feel like the same trusted team adding support—not like falling off one healthcare island and swimming to another.

CHRIS:

Paul, how does that strategy answer the eight challenges?

PAUL:

Start with hypercompetition. If we remain only at the end of the continuum, we depend on other people to recognize the need, explain hospice accurately, and refer at the right time. Increasingly, those other people may be financially accountable for the patient, own competing services, or view hospice only as a cost center. Moving upstream allows us to earn the relationship earlier rather than waiting for a referral at the eleventh hour.

On reimbursement, I am not pretending the economics are easy. Fee-for-service alone usually will not fund the interdisciplinary model this population needs. You need expertise in the physician fee schedule and the disciplined use of appropriate care management services. You also need contracts with accountable-care organizations, Medicare Advantage plans, health systems, and other risk-bearing partners. And you must quantify the downstream value created for palliative care and hospice.

On workforce, this model can be attractive to physicians, advanced-practice clinicians, nurses, social workers, and other professionals who entered healthcare to know their patients—not to race through a schedule. Hospice organizations already understand teams, 24/7 responsiveness, family systems, goals of care, and caring in the home. Those are not small advantages.

On demographics, this model meets baby boomers where they are. It is home-based, personalized, relational, and easier to navigate. The customer does not need to understand



whether today's support is technically primary care or palliative care. They need to know whom to call and trust that the team knows them.

On regulation, an integrated continuum can reduce the artificial cliff created by eligibility rules. A person who is not ready or eligible for hospice does not have to be abandoned. The care intensity can change without the relationship disappearing.

On technology, remote monitoring, predictive analytics, and virtual check-ins become tools within a human relationship. Technology helps us identify decline, caregiver strain, medication problems, and emerging crises before the emergency department becomes the default.

On the speed of change, this strategy reframes the organization. We are no longer merely a hospice that added a clinic. We are a serious-illness organization responsible for a population over time.

And on mental health, an interdisciplinary, home-centered model can see loneliness, grief, caregiver exhaustion, anxiety, and spiritual distress much earlier than episodic medicine can.

Let me make it concrete. Imagine Mary, age eighty-three. She has heart failure, COPD, mild cognitive impairment, and a husband who is quietly becoming overwhelmed. Under the current system, she may see multiple specialists, visit the emergency department three times, and receive a hospice referral only after a final hospitalization.

In our model, the frail-elder team knows Mary before the crisis. It sees her at home. It simplifies medications, supports her husband, creates an escalation plan, answers after hours, brings in specialty palliative care as symptoms intensify, and introduces hospice honestly before the final emergency. When Mary elects hospice, she is not handed off to strangers. The circle of support expands.

That is not empire building. That is continuity.

CHRIS:

Paul, you have made a strong case. Here is what I affirm.

You are designing around the person's journey rather than around Medicare's boxes. You are addressing the greatest structural weakness of hospice: we often arrive too late and depend on systems outside our control for access. You are taking capabilities hospice already possesses—home-based care, interdisciplinary teamwork, 24/7 response, caregiver support, goals-of-care conversations—and extending them to a population that desperately needs them.

You are also correct that for the customer, the seams should disappear. The patient should feel one relationship and one plan of care, even if different disciplines, programs, and payment mechanisms sit behind it.

Now let me poke holes in it.



First, this is not a line extension. It is a new business. It needs upfront capital, physician leadership, billing expertise, different technology, different talent, data sophistication, contracting capability, and a tolerance for experimentation. A hospice cannot fund it through what Dr. Bethany Snider called “death by a thousand cuts”—quietly skimming a little resource from hospice each month and hoping a continuum appears.

Second, fee-for-service does not naturally support the team you just described. If the business model depends on future shared savings, downstream hospice value, or contracts that have not yet materialized, the organization may spend years carrying a mission-rich but cash-poor service.

Third, culture. Hospice teams operate inside a highly defined benefit with familiar rules. Population health is more ambiguous. Attribution, coding, quality measures, denials, network arrangements, and rapid iteration require different muscles. Some hospice organizations will underestimate that gap. Let me say that again as this might be the biggest one, many hospice organizations will underestimate that gap.

Fourth, workforce. You said this model can attract clinicians—and it can. But it also competes for the same scarce clinicians hospice already cannot find. If expansion weakens the core, the continuum becomes broad but mediocre. In fact, let me share an example I grew up with which is GM.....

Fifth, the transition to hospice is not automatically timely simply because we own both sides. An upstream team may become attached to its own care plan, preserve fee-for-service revenue, or believe it can manage one more crisis. Vertical integration can prevent fragmentation, but it can also create internal substitution. You must measure timely hospice transitions and guard against replacing hospice with a diluted version of palliative primary care.

Sixth, local scale. Twenty-four-seven access, home visits, interdisciplinary staffing, and technology are expensive when the patient population is geographically scattered. The model that works in a dense metro area may break in rural America.

And seventh, patient choice. You call it continuity. The patient may experience it as a closed ecosystem. If Mary prefers another hospice, does your continuum make that easy? Or has every relationship, data feed, and incentive been designed to keep her inside your system? Let’s not forget the talking point that worked against Obama Care you can keep your physician and how that was touted over and over again as a way to in many respects unravel PPCA.

Paul, your greatest strength—control of the continuum—could become your greatest blind spot.

PAUL:

Those are fair challenges. But fragmentation is not freedom. Sending Mary into a maze and giving her a list of phone numbers is not patient choice.



The answer is not to abandon integration. The answer is to build ethical integration: transparent options, warm handoffs, objective triggers for hospice assessment, open networks where possible, and measures that expose delayed transitions.

And yes, this requires investment. But doing nothing is also an investment decision. It invests our future in the hope that somebody else will keep referring patients to us.

CHRIS:

That is the strongest version of Paul's argument: continuity without captivity, and investment before irrelevance. Hmm let me say that again in defense of Vertical Integration, if the goal is continuity without captivity, and investment before irrelevance? Well, you may really be on to something with this strategy.

ROUND TWO: CHRISTOPHER MAKES THE CASE FOR THE PAYVIDER STRATEGY

CHRIS:

Christopher, you agree with much of Paul's continuum, but you think he stops too soon. Why?

CHRISTOPHER:

Because Paul wants to redesign care while leaving somebody else's incentives in charge.

He is right about the clinical model. But if another organization controls the premium dollar, the benchmark, the network, the attribution, and the rules by which value is measured, then Paul's beautiful continuum may remain a subcontractor.

The payvider thesis begins with an uncomfortable observation: the entity accountable for total cost of care increasingly determines what services are encouraged, delayed, substituted, or excluded. If hospice and palliative-care organizations remain downstream vendors, they may create enormous value while someone else captures the economics and controls access.

So yes—build hospice, palliative care, and frail-elder primary care. But also participate in the financing and risk of care.

That can take several forms, and they are not identical. An organization may participate in the Medicare Shared Savings Program (MSSP) through an ACO. It may enter the LEAD model, which succeeds ACO REACH beginning in 2027 and is designed as a ten-year accountable-care pathway with options for professional or global risk. It may own or partner with a Special Needs Plan focused on a defined high-need population. It may operate or align with PACE, where an interdisciplinary organization receives capitated Medicare and Medicaid payment to serve



eligible older adults in the community. At the far end of the spectrum, it may sponsor or acquire a Medicare Advantage plan.

I am not saying every hospice should become an insurance company. I am saying every serious-illness organization must decide where it will sit in the flow of risk, capital, data, and decision rights.

CHRIS:

Christopher, how does that answer the challenges?

CHRISTOPHER:

Hypercompetition first. In a referral economy, competitors fight for episodes. In a population-health economy, the organization with attributed lives can design the care model before the episode occurs. Attribution becomes strategic access.

On reimbursement, the payvider model attacks the central mismatch in our field. We know interdisciplinary, proactive, home-based care can prevent crises, but fee-for-service primarily pays for billable encounters. Under accountable payment, the organization can invest in a nurse call, a social-work intervention, transportation, remote monitoring, or caregiver support because avoiding the hospitalization has economic value.

On workforce, aligned payment can fund teams differently. Instead of forcing every professional activity through a billing code, we can deploy the right team member at the right time. We can use technology and centralized resources to extend scarce clinicians.

On demographics, baby boomers will demand convenience, coordination, transparency, and digital access. A payvider can create one front door and one navigation experience across settings.

On regulation and politics, participating directly gives the organization a seat at the table. We become a model participant with data and experience, not merely a provider reacting to decisions made upstream.

On technology, payer and provider data together are far more powerful than either alone. Claims tell us where the patient has been. Clinical data tell us what is happening now. Predictive models can identify rising risk, trigger outreach, and match resources to need.

On change and resilience, a diversified organization is not dependent on a single benefit. It can move resources as policy and patient needs evolve.

And on mental health, financial flexibility permits us to address caregiver strain, loneliness, and behavioral-health needs when they drive utilization, suffering, or both—even when there is not a neat fee-for-service code.



Let us return to Mary. Paul's team may care for Mary beautifully. But if Mary's Medicare Advantage plan denies or underfunds key services, directs her into a narrow network, or evaluates the team only through short-term utilization, Paul's model remains constrained.

In the payvider model, we hold responsibility for Mary's outcomes and total cost. We can invest earlier because we receive the benefit of avoided crises. We can create incentives for prevention, home-based care, medication simplification, and caregiver support. We can make hospice part of the care architecture rather than a last-minute referral.

The core principle is alignment. The same organization that benefits when Mary stays safely at home is responsible for funding the care that keeps her there.

CHRIS:

Christopher, here is what I affirm.

You are exposing the power structure. Clinical excellence does not automatically translate into strategic influence. The organization that controls payment, attribution, data, and the network can shape the patient's path long before hospice receives a referral. You know that old adage often holds true in healthcare he who has the gold makes the rules.

You also recognize that fee-for-service often rewards activity while underfunding prevention, coordination, caregiver support, and the interdisciplinary work that frail elders need. Risk-based payment can create freedom to use resources more intelligently.

And there is a defensive logic here. If health plans, health systems, primary-care platforms, and national aggregators are moving into serious illness, hospice organizations cannot assume they will always be invited into the model on favorable terms.

Now the holes.

First, risk is not just upside with a fashionable name. Depending on the model, it includes downside losses, benchmark risk, coding and risk-adjustment complexity, utilization volatility, reserve needs, actuarial uncertainty, compliance exposure, and years in which excellent care may not produce financial success. In fact, recently many hospitals who also thought this was a good idea are now exiting the insurance service line. Are we sure we are smarter and better equipped for this than they were?

Second and this is a key one; insurance and care delivery are different businesses. A world-class hospice does not automatically possess actuarial talent, network management, member services, claims operations, quality infrastructure, sales capability, capital reserves, or regulatory expertise. The leap from provider to payer may be larger than the leap from hospice to frail-elder practice.



Third, scale matters. A small or mid-sized nonprofit may not have enough attributed lives to manage statistical variation, spread infrastructure, or negotiate effectively. A partnership can solve part of that problem, but partnerships can also move control back to the larger payer.

Fourth, your greatest promise—aligned incentives—contains a conflict. When the same enterprise both authorizes care and bears its cost, every care decision has a financial shadow. Let that settle upon you for a second. Hospice could be introduced earlier because it is appropriate, or because it is cheaper. It could be delayed because the organization wants to retain revenue elsewhere. Palliative care could become a meaningful specialty, or a utilization-management strategy wearing a compassionate name. It was less than a year ago in this country that the head of United Healthcare was assassinated and on the bullet was engraved deny, depose, defend and half the country cheered. It's easy to demonize insurance companies but what ensures we don't become what we demonize?

Fifth, the language of population health can depersonalize. Mary becomes an attributed life, a risk score, a benchmark opportunity, or a high-cost claimant. Data can help us see her earlier, but it can also persuade us that the model knows what she needs before anyone asks her. And that is very anti thetical to what has always defined hospice, everyone matters at an individual level....

Sixth, consumer choice. A "one front door" sounds convenient until it becomes the only door. Beneficiary alignment, incentives, preferred networks, and seamless internal referrals can all be defensible. Together, they can create a mousetrap—a system designed on the assumption that once Mary enters, she will stay.

And seventh, hospice may still become a cost center inside the payvider. Ownership does not guarantee respect. A finance-led enterprise may pressure length of stay, eligibility decisions, staffing, or service intensity in ways that erode the very model it claims to integrate. Again, my comments about United Healthcare.

Christopher, you want to align the financing with the care. How do you keep the financing from swallowing the care?

CHRISTOPHER:

By treating guardrails as part of the operating model, not as public-relations language.

We need independent clinical governance. We need transparent measures of access, disenrollment, complaints, hospice length of stay, live discharge, caregiver experience, equity, and out-of-network choice. We need clear conflict-of-interest policies and board-level mission oversight. We need to publish whether we are improving quality of life—not merely lowering medical expense.



And I agree that not every hospice should become a payer. Some should partner. Some should take limited professional risk. Some should build capabilities first. But every hospice should understand who bears risk for its patients and how that entity's incentives affect access to care.

If you do not understand the financing model around your patient, you do not fully understand your patient's care environment.

CHRIS:

That may be Christopher's strongest point. The premium dollar may be invisible to the patient, but its incentives are present in the room. Let me say that again, the premium dollar may be invisible to the patient, but its incentives are present in the room. My first mentor in healthcare had a very crass way of making that point, he would say figure out how any provider or business in healthcare is paid and it will tell you why they do what they do? Why do hospital try to get people out quickly? Well, it is how the financing incentives of DRG work. Why do skilled facilities skill patients because that is where their margin is. I know so many incredible people doing great work but the guard rails built for them to operate within are often based on the financial model.

ROUND THREE: COMEAUX MAKES THE CASE FOR WORLD-CLASS HOSPICE AND PALLIATIVE CARE

CHRIS:

Comeaux, both Paul and Christopher say that remaining focused on hospice and palliative care leaves the organization downstream and vulnerable. Why do you still defend that strategy?

COMEAUX:

Because focus is not the same as passivity.

There is an assumption creeping into this conversation that bigger scope equals better strategy. It does not. Sometimes expansion is vision. Sometimes it is fear wearing a strategy badge.

Hospice is one of the most extraordinary care models ever created. When practiced at its best, it treats the patient and family as the unit of care. It brings an interdisciplinary team into the home. It addresses physical, emotional, social, and spiritual suffering. It supports caregivers, provides medications and equipment related to the terminal illness, responds around the clock, and continues through grief and bereavement. Hospice is a true medical specialty that's why having board certified physicians, CHPN nurses, LCSW's all make a true specialty care model.



Palliative care, practiced also as a true specialty, brings expert symptom management, communication, decision support, and whole-person care alongside disease-directed treatment. It can serve patients much earlier without requiring them to surrender every curative option.

My strategy is to dissect what makes each of those models special, define the components of world-class performance, measure honestly where we are, and build organizations that become unmistakably excellent.

World-class is not a marketing adjective. It means reliable and consistent access. It means clinicians with mastery. It means symptom response measured in hours, not days. It means care plans that reflect the patient's goals. It means the family knows whom to call at two in the morning. It means excellent transitions, low unwanted hospitalization, meaningful spiritual and psychosocial care, disciplined compliance, superb caregiver experience, and a culture in which people can do the best work of their lives.

It also means being clear about the difference between primary palliative skills that every clinician should possess and specialty palliative care for complex needs. If everything is called palliative care, eventually nothing is. Let me say that again for emphasis: it means being clear about the difference between primary palliative skills that every clinician should possess and specialty palliative care for complex needs. If everything is called palliative care, eventually nothing is.

CHRIS:

Comeaux, how does excellence alone answer the eight challenges?

COMEAX:

It is not excellence alone. It is strategic excellence.

On hypercompetition, mediocre organizations compete on relationships, geography, or price. World-class organizations compete on trust and demonstrable outcomes including decreases in total costs of care. Hospitals, physicians, payers, and consumers should know exactly what becomes better when we are involved.

On reimbursement, focus protects discipline. We know our unit economics, our staffing model, our cost per patient day, our quality drivers, and the services that create genuine value. We advocate for payment that recognizes quality rather than launching business lines we do not know how to operate.

On workforce, people want to belong to something excellent. A clear calling, superb leadership, manageable systems, professional development, and the chance to master meaningful work are competitive advantages. We should repair the work rather than continuously ask our best people to absorb new ventures.



On demographics, baby boomers will not accept a generic commodity. They will research, compare, ask questions, demand responsiveness, and expect care tailored to their values. A world-class provider earns active consumer preference rather than relying only on referral sources or on a mouse trap someone else built expecting them to passively go along with the care flow pre mapped out for them.

On regulation, the strongest defense is operational integrity. We should be the field's standard-bearers for eligibility, documentation, quality, stewardship, transparency, and zero tolerance for fraud, waste, and abuse.

On technology, we use it as an accelerator of excellence—not as the strategy itself. AI can remove clerical burden, detect symptoms sooner, personalize education, and make meaningful data available. But technology must give time back to the bedside.

On the speed of change, a strong identity creates resilience. If an organization does not know what it must preserve, every new trend becomes a strategic identity crisis.

And on mental health, hospice and palliative care already possess the interdisciplinary DNA to address grief, isolation, distress, and caregiver burden. Let us become exceptional at deploying it.

Return to Mary. She does not need us to own every part of her life. She needs us to be extraordinary when she needs palliative care and extraordinary when she chooses hospice. She needs a specialist she can trust—not a corporation trying to turn every stage of aging into a service line.

There is humility in saying, "This is what we do, and we do it as well as anyone in the world." We can build strong partnerships upstream without owning everything upstream. We can create preferred relationships with primary care, ACOs, hospitals, plans, and community organizations. We can make our value so measurable and our reputation so powerful that excluding us would be irrational.

The future does not only belong to the organization with the most boxes on its organizational chart. It may belong to the organization patients insist upon.

CHRIS:

Comeaux, here is what I affirm.

You are protecting something the other strategies could accidentally dilute. Hospice and specialty palliative care require deep competence. Expansion creates managerial complexity, and complexity can turn excellence into inconsistency. There is wisdom in mastery, a clear identity, and a refusal to chase every adjacent opportunity. As I shared earlier there are cautionary tales hospice leaders can learn from other industries who tried to become all things



to all people and they did none of it well. The GM example is the one I alluded to earlier. How did Toyota compete and ultimately win? They did it on world class quality.

You are also placing a bet on brand and consumer preference. If baby boomers become more active choosers of serious-illness care, a trusted, world-class organization could have power that traditional referral models underestimate.

And you remind us that integration is not synonymous with ownership. Partnerships, open networks, shared protocols, data exchange, and warm handoffs can create continuity without requiring one enterprise to employ every clinician and bear every risk.

Now the holes.

First, the patient cannot choose a hospice she never hears about. Excellence at the end of the funnel does not guarantee access to the funnel. If payers, ACOs, health systems, and primary-care platforms control the relationship upstream, your world-class program may receive Mary with three days left—or not at all.

Second, palliative-care economics remain difficult. Calling the service world-class does not fund the interdisciplinary team. Without risk contracts, philanthropy, health-system support, new codes with payment attached, or downstream value, a superb community palliative-care program may be financially fragile.

Third, referral partners do not always act on value. They act on convenience, contracts, network design, habit, ownership, and incentives. You may be objectively better and still be outside the preferred pathway.

Fourth, hypercompetition includes substitutes. Hospital-at-home, advanced illness management, home-based primary care, Medicare Advantage care management, and technology-enabled platforms may perform pieces of what hospice and palliative care do. If consumers cannot distinguish the difference, excellence that is invisible loses.

Fifth, focus can become a dignified word for strategic inertia. “We are protecting the mission” can conceal fear of investment, unwillingness to build new capabilities, or nostalgia for a referral environment that is disappearing.

Sixth, demographic change cuts both ways. Baby boomers may seek a world-class specialist, but they may also prefer one seamless platform that already knows them. You are betting they will interrupt an established relationship to choose you at the hardest moment of their lives.

And seventh, you depend on others to create continuity. Partnerships are often celebrated at the signing ceremony and fail in the daily work—different records, different incentives, no shared accountability, and nobody answering after hours.

Comeaux, how do you keep focus from becoming.... well irrelevance?

**COMEAX:**

By refusing to define focus as waiting.

A world-class strategy must include market intelligence, consumer education, data interoperability, measurable outcomes, preferred partnerships, rapid access, and a deliberate upstream presence. We should teach primary-care teams, embed palliative expertise, support ACO partners, and create open doors for patients and families long before hospice eligibility.

But we do not have to own the patient's primary care or insurance product to matter. We need enough strategic reach to ensure access and enough discipline to preserve mastery.

And let me challenge both of my colleagues Christopher and Paul: ownership does not equal loyalty. Patients do not owe our enterprise their next episode of care. If the only way our continuum or risk model succeeds is by keeping the patient from choosing someone else, it is not truly succeeding.

CHRIS:

That is Comeaux's strongest case: mastery without passivity, partnership without captivity, and a brand the patient actively chooses. Let me say that again: mastery without passivity, partnership without captivity, and a brand the patient actively chooses.

CROSS EXAMINATION: WHERE EACH STRATEGY CAN FAIL

CHRIS:

I want one short cross-examination. Each of you gets one question for another character.

Paul, you first.

PAUL:

Christopher, if your financial model shows that a shorter hospice length of stay reduces total cost in a particular year, who protects the patient from your spreadsheet?

CHRISTOPHER:

Independent clinical governance, transparent outcomes, and a payment model that measures quality over a meaningful time horizon. But I will turn it back: if your frail-elder practice keeps managing crises and delays hospice because the team believes it can do everything, who protects the patient from your clinical pride?

**PAUL:**

Objective transition triggers, external review, and patient-goal measures. The danger is real. That is why timely hospice transition must be a key performance indicator.

CHRIS:

Christopher, your question.

CHRISTOPHER:

Comeaux, if a payer controls ten thousand high-need lives in your market and selects a lower-quality owned provider, what exactly does your world-class strategy do next?

COMEAX:

It produces evidence, activates consumer demand, makes exclusion reputationally and clinically costly, creates alternative partnerships, and advocates for choice. But I concede the central weakness: quality without access is not enough. That is why world-class must include a market-access strategy, not merely clinical operations.

CHRIS:

Comeaux, your question.

COMEAX:

Paul, when your organization is operating hospice, specialty palliative care, home-based primary care, after-hours response, care management, technology, contracting, and multiple billing models, what are you willing to stop doing so that all of it remains excellent?

PAUL:

That may be the most important implementation question. The continuum cannot become a collection of under-resourced mediocre programs. We would stage the build, establish readiness gates, centralize only what truly creates leverage, and refuse to launch the next layer until the previous one meets defined clinical, cultural, and financial standards.

CHRIS:

Good. Each strategy has now admitted its Achilles' heel.

For Paul, it is complexity and the possibility that continuity becomes internal substitution.

For Christopher, it is conflict of interest and the possibility that alignment becomes financial domination.

For Comeaux, it is access and the possibility that mastery becomes irrelevance.



FACILITATOR SYNTHESIS: THIS MAY NOT BE ONE CHOICE

CHRIS:

Gentlemen, thank you, there was so much wisdom in what you all shared. Here is where I land after hearing all three.

These strategies are distinct, but they are not always mutually exclusive. The wisest path may be a sequence rather than a single leap.

An organization might first establish world-class hospice and palliative care. That is the foundation. Without excellence at the core, expansion magnifies weakness. Let me say that again, without excellence at the core, expansion magnifies weakness.

It might then build or partner into a frail-elder continuum where market conditions, capital, talent, and mission support it. That creates an earlier relationship and a better journey.

And it might then choose an appropriate level of financial participation—contracted value-based payment, limited professional risk, ACO participation, a joint venture, or, for a small number of organizations with the scale and capabilities, ownership of a plan or other risk-bearing structure.

The strategic question is not simply, “Which box do we select?” It is:

- What problem are we solving for the patient?
- What capabilities do we genuinely possess?
- What capabilities can we build without weakening the core?
- Where do incentives help or harm the patient?
- How will the patient exercise meaningful choice?
- And what evidence will tell us that the model is making life better—not merely making the organization larger?

CLOSING: THREE POINTS TO LAND THE PLANE

CHRIS:

Let me land the plane with three points:

One: the patient and family must remain at the center

Every strategy says that. The test is whether the operating model proves it.



Does the patient experience fewer handoffs, or merely more services carrying the same logo?

Does the caregiver receive real support, or appear as a data field in an assessment?

Do we measure quality of life, goal concordance, trust, and the ability to remain safely at home—or only utilization and margin?

Do we introduce hospice when it becomes the right choice, even when another part of our organization could keep billing?

And do we help a patient choose another provider when that provider is the better fit?

Patient-centeredness is not a sentence in the strategic plan. It is the willingness to design incentives, measures, governance, and daily behavior around the interests of the patient and family—even when those interests do not maximize our own enterprise.

Two: the customer is changing

We are entering the age of the baby-boomer serious-illness customer, and too many strategies treat that as a volume forecast rather than a transformation in expectations.

Baby boomers have advocated for themselves and created disruption as they moved through education, work, finance, travel, media, retail, and retirement. Why would healthcare be the one industry they quietly accept as it is?

They will ask why care is fragmented. They will research quality. They will expect technology to make access easier. They will challenge paternalism. They will want honest conversations earlier. They will expect services to adapt to their lives rather than forcing their lives into our programs.

The winners will not merely manage a larger elderly population. They will understand a different customer.

Three: the patient wants choice—not a mousetrap

This may be the point our field is most at risk of missing.

Many strategies are built on the assumption that once a patient enters our clinic, our continuum, our ACO, our network, or our health plan, that patient will remain inside the system we designed.

But the patient is not a captured life. The patient is a person with agency.



Continuity is valuable. Simplicity is valuable. Trusted relationships are valuable. But none of those should become an excuse to limit meaningful choice or quietly steer someone toward the option most profitable to us.

The best model will not be the stickiest mousetrap. It will be the model patients and families choose to remain in because it has earned their trust—and the model confident enough to help them leave when another choice serves them better.

So, should the future belong to world-class hospice and palliative care?

Yes, because no strategy can compensate for mediocre care.

Should hospice organizations vertically integrate into palliative care and frail-elder primary care?

For many, yes, because patients need continuity before the final chapter, and hospice cannot assume access will take care of itself.

Should some organizations become payviders or participate meaningfully in risk?

Yes—because incentives shape care, and the field cannot afford to be financially illiterate or permanently downstream.

But each yes comes with a warning.

Do not let excellence become isolation.

Do not let integration become captivity.

Do not let financial alignment become financial domination.

Keep the patient and family at the center. Build for the baby-boomer customer who is arriving. Preserve real choice.

If we do those three things, the debate will have served its purpose—because the ultimate goal is not for Chris, Paul, Christopher, or Comeaux to win which if you have not figured it out by now my name is Christopher Paul Comeaux and I go by Chris.

The goal is for Mary and her family to win.

Thank you for joining me for this special edition of TCNtalks and Anatomy of Leadership.

At the end of each episode, we will share a quote and a visual that possibly might create a brain bookmark and a thought prodder about our podcast subject so you further your learning and growth and thereby your leadership and hopefully it sticks.

Be sure to subscribe to our channel so you don't miss an episode and be sure to check out the book on Amazon and tell your friends and family and co-workers about it, the Anatomy of



Leadership. It's easy for us to rail against the world and be frustrated by things. Let's be the change we wish to see in the world.

Thank you for joining me for this special edition of TCNtalks and Anatomy of Leadership, where leadership, purpose, and care come together. Until next time, lead with courage, design with humility, and remember: care should be as it should be.

PRINCIPAL SOURCES

1. **Why Traditional Primary Care Fails Frail Elders and the Future Need for Specialized Models, Part One** - interview transcript supplied by Chris Comeaux.
2. **Why Traditional Primary Care Fails Frail Elders and the Future Need for Specialized Models, Part Two** - interview transcript supplied by Chris Comeaux.
3. Centers for Medicare & Medicaid Services, **LEAD (Long-term Enhanced ACO Design) Model**.
4. Centers for Medicare & Medicaid Services, **Medicare Shared Savings Program** materials.

CONTACT

If you would like to discuss this product, please contact Chris Comeaux (ccomeaux@teleioscn.org).