

TRANSCRIPT: Part Two - Dr. Joan Teno Exposes the Hidden Problems with Hospice Ratings and Quality Scores

Jeff Haffner: 00:01

Welcome to TCNTalks, and Anatomy of Leadership. We continue our conversation in part two. Dr. Joan Teno Exposes the Hidden Problems with Hospice Ratings and Quality Scores. And now, here's Chris Comeaux and Cordt Kassner.

Cordt Kassner: 00:22

You know, I find myself very uh excited about the direction that you're taking the conversation, which is if somebody calls you, or me, or Chris, or Ira, or whoever, right? And they say, you know, I'm in Houston and I need a really good hospice. Well, isn't it tremendous if somebody knows one of the four or five of us, right? But most people don't. And and so uh I developed, and Joan, you and I have talked about this in the past and more recently, the National Hospice Locator, kind of along that same line. Like you were talking about star ratings, hospice visits in the last days of life, gaming and an IPU. Uh and maybe gaming is a penalty, maybe burdensome transitions is another penalty. So in in the National Hospice Locator, I have like seven quality measures, you know, trying to add points to a hospice score. And I have one penalty, which is if they have if a hospice has been indicted or convicted by the OIG, it's a minus, you know, it's a penalty score. And as we're talking, I'm thinking, well, maybe I need to add another penalty score for the burdensome transitions and and what that might look like. Because this is a tool for everybody in the country to use to find a high-quality hospice provider. And so I would love to talk with you more. As I do with people around the country, are the measures I'm using the right measures? Are they weighted the right way? How can this be strengthened to help the public? Because that is the sole purpose of it.

Cordt Kassner: 02:00

And right now, like today, the locator is assigning, it is calculating a quality score for every hospice. But one of the thoughts that that I've had recently around integrating AI into the National Hospice Locator is for the user to input some, you know, five questions. I don't know what the five questions are. Answer five questions of what's most important to the patient. And therefore, if the three of us are looking for a hospice in North Carolina, we might get different answers for what's the best hospice for me, for you, which is kind of an interesting. I'm talking with 1520 AI, which recently acquired hospice analytics. I'm talking with them about how we could develop such a tool, which could be fun. Um, but all of that in reaction to the criteria that you use or other people use to determine a high-quality hospice. I want to get back and poke on this issue of small hospices not having to report data or Medicare not reporting the data they receive from those smaller programs. If that's a star rating, where only 30% or so of hospices have a calculated publicly reported star score or other measures in my assessment and in the National Hospice Locator that dings small programs that don't have data to report. And and I say, you know, in the fine print, that doesn't mean this is a poor hospice. It just means we don't have their data to report. How would you address this issue? How how could we fine-tune this for rural or you know even urban providers who are smaller?

Dr. Joan Teno: 03:59

Yeah, I think first of all, there's a lot to unpack here. So one of the first things to unpack is how do you weight all these measures coming together? Okay. I have now a 9,000-word chat with Claude AI where I'm sort of poking it to understand how it would derive weights. Okay. And I think the best starting point is to rely on experts. Okay. But I think future research needs to decide, you know, just like some of the questions. Um, well, if a hospice is convicted of fraud, does that fall on them for two years? Does it fall on them for three years? Okay. Um, I think there's going to be some measures that are going to need to be a flag. Um so like I think gaming should be a flag. Um what to do with rural locations? I wish I had a good solution. But on the other hand, I think some of these rural locations are actually probably some of the best hospices. Um in, you know, and really they're not my problem child to look at. Um you know, uh, so I wish I don't know, I have to think about it. But I think it's gonna be exciting. And I share your vision. I really want a consumer to be able to run write a prompt that says, tell me the hospices that are, you know, four or five stars, um, you know, good visits measure, has an IPU, um, or you know, maybe eventually we can get um, you know, that has uh Portuguese staff or something, you know, that's really important to them. I'm I'm sure there are small hospices that serve very boutique or very um private things that we don't want to penalize them. Um, but I don't know if I have a good answer for you uh on that. I do want to point one thing out, okay, and I'm gonna push back on a little bit. Um I think as I said before, there is not 6,970 hospices, okay? And that has implications for the statement that um, you know, 30% of them have star ratings. I actually think we're gonna be more towards the 5,000 to 4,500 hospices. Um, I've done sort of just a flow diagram looking at hospices that had an ADC over 15, you know, and I there was like a really old article from 10 or 12 years ago that's on the internet where you were at a conference where you talked about what's the viability of an ADC after two years. And, you know, I think they were using a 15 or 20 range. I actually, for this just thought thought piece, um, I used five. And, you know, when you get down to five and say, okay, someone who has an ADC of five or is not reporting an ADC, it's really suspect. Um, you know, we we're starting to get the caps reporting up to 42 or 43 percent of star ratings. Um I'm always struck by the paradox that 88% of the hospices have uh 88% of the people who die on a medica uh the Medicare hospice center that is in a CAPS hospice star rating uh institution. So, and then you know, there is this percentage of people who don't meet the reliability, the interunit reliability for star ratings. Is there something that we could do where we we could say looking at the geography, here's how these small hospices perform in this region? I don't know. It's I think it's gonna be a political decision, and it's probably way above my pay grade. But uh I really think uh more information is better. And one other thing I'll say is maybe what we really need to do is let people decide what information you want now. And then they can say, I want this level of information with this degree of certainty. Okay. And let them just filter the data. I think the friend who I talked to on a Friday, you know, trying to go through compare data and looking at 90 hospices is not a really viable way of choosing a hospice program. Um and you know, uh we just need to fix that. And I think part of it is um you get reported on compare. If you have one patient in that zip code, you get reported. So maybe we need to have a different threshold. But I think it's important to really ask the fundamental question. Why aren't people using the Medicare Compare website? Okay. And, you know, I think and part of it is just think about, you know, there's a there's a trajectory of people who

have an acute on chronic, and then the family is like dealing with someone in the hospital, and they're, you know, days away from dying and they have to go to this website. So we I think we need to do a better job of getting the information out to consumers to facilitate their choice. And I think I would side on giving them more information than less information. And then, you know, I think we need to really clean up the compare website. And, you know, right now they're flagging them for not reporting data, but maybe we should flag them for what is viewed as a sentinel event, or maybe we should flag them for what is evidence of gaming. You know, there's a hospice with 90% of the patients with dementia. That's a little suspicious, if you ask me.

Cordt Kassner: 09:52

I, Joan, I could talk to you all day. I love this.

Dr. Joan Teno: 09:54

I I'm gonna be really fascinated to hopefully you share your journey with me where you go with the analytics. Um, I know I'm going to push for thinking about a proof of concept with Cloud AI and say, can I create a composite measure and can I improve the interunit reliability? Um, yesterday I got as far uh with Cloud AI based on the published data with three or four measures where I could combine them to get you know an interunit reliability of 0.85. And then, you know, I said, well, what if you add BT1? And they said, well, it's really only, you know, Claude said it was only a minor improvement, and it would probably be more better to think of it as a flag. So, but I think there's gonna be a lot of political decisions, but I think the time is we have this wonderful set of data.

Dr. Joan Teno: 10:45

Let's use it, let's put it together, but let's make sure we do it in a way that's fair to the hospice providers. But I also want to make sure we do it in such a way that we maximize consumers' ability to make choices.

Chris Comeaux: 10:58

Well, one thing that I thought of, um, Joan, when you were talking about the rural hospices, we work with a lot of rural at Teleios. And one time I had a board member and he he taught me the Willie Sutton rule. And he I'm like, the Willie Sutton rule? What the heck is that? And he goes, Yeah, Willie Sutton was a bank robber and asked him why he robbed the bank. And he said, well, that's where the money is. And I think the ones who have done the the not good are playing the Willie Sutton rule. They're going to the metropolitan areas where all the people are, and the vast majority of people in the rural area are doing the best they can with the scarce amount of resources to serve. So then the law of numbers is not exactly in their favor, and they're not fighting off a bunch of competition because the Willie Sutton rule is not in their favor. So, you wrote about your interaction with ChatGPT. So, you've had some great examples of great AI interactions. That's one in your sub stack where you were trying to select a Rhode Island hospice, and it was fascinating because the AI sounded confident, but it was relying upon unvalidated, even some imputed, made-up, hallucinating measures. So, what

does that experience teach you on maybe the opposite side of the promise, but also the danger of AI decision making?

Dr. Joan Teno: 12:09

I think the danger is just the fact that it's hallucinating. Um, and not hallucinating in terms of sort of being on drugs and hallucinating, but it's it's creating information and you have to, I think what I've learned from it is you always have to probe what the data sources is. And so, like I just sort of in that interaction push back and said, listen, you can't do that. And you know, maybe what we need to do is have live discharges be an available um information. I mean, right now, the the tension of the HCI is it's a topped-out measure, but some of its components don't achieve sufficient interunit reliability to be publicly reported. Is there a way of putting it together and giving it less of a weight because it it you know needs a bigger end to, you know, you know, to get that interunit reliability, that you could combine it and use it in information? And I think that's gonna be the question for people who think about this in terms of psychometrics and uh see if there's a way of combining this to make it all work.

Cordt Kassner: 13:17

Kind of a similar question that that Chris is asking. Instead of the you know, like what's working, what's not working. Uh I also talk with consumers, uh usually once a week through the National Hospice Locator, but also friends and colleagues who who call or or have questions about hospice. And I and I'll tell you one, I spoke with a I mean one of our people, right? A trained hospice valid medicine, certified nurse practitioner, like in our circle, who called me up and said, hey, you know, my my dad needed a hospice in such and such state. And and so I looked, and I recommended this one, and boy, was it lousy. And like, what do I do? Like, dad died, what do I do now? And and so you like I started thinking to myself, are they accredited? You could talk to the AO, are they, you know, uh licensed by the state? You could talk to the Department of Health, you could talk to Medicare. You know, I started going down the complaint road. But actually, what surprised me was in less than five minutes of my looking into this hospice, my thought was, why did you pick that hospice? Like it was so clear that the hospice that she picked would be right near the bottom of my list. But that was but but she's in the field and she's, so she selected this one. And I thought that was so curious. And that's the question that I want to pose to you, which is when you're talking with the public, not the policymakers, not the academics, when you're talking with the general public, what misunderstandings about hospice do you run into that that you'd like to correct? Like, well, they think this, but actually it's that?

Dr. Joan Teno: 15:06

Um, there's two things. I think that's a really good question. Um, so first of all, all these things that we public report are based on averages, and there's always variation around those averages. So, for example, you could have a large hospice that has three different teams, and it could be the one team that's based on ALS is not functioning well just because of the that shared collaboration is not working. Um, yet you will not be able to sort that out in any of the compared data. Okay. Um, so that is always a problem. You only can go so far with that. I'm always kind of surprised when people have difficulty trying to select a hospice program that

they really don't look at the data. And I think, first of all, one of the experiences I had was where they actually just referred one of my friend's father to a hospice without asking her. Um, and you know, I said, no, no, no, no. You, you know, you're the durable power of attorney, you have a right to have a choice made, and you need to let's go through. And I just sort of walked her through the compare website and we came up with a hospice that was in the area of Massachusetts that eventually got the referral and things went well. Um, but I think we need to make things a little more actionable and you know, and I think it's the sophisticated consumer that's gonna need to draw on multiple sources of data and think it through. I don't know. It's just it's a good question. Um yeah, it's the future of where we should be going, hopefully.

Chris Comeaux: 16:47

So let's maybe step back from some of the technical data, kind of get you out of it for a second. What concerns you the most about the current state of hospice in America? And, you know, you you're at an interesting part in your career, Joan. Where do you still hope that the field can preserve its mission, but still address fraud, profiteering, and these measurement challenges? And, you know, many respects, this Dr. Byock shared, you know, he wrote his strategic framework. He said, I couldn't sleep at night. So you kind of had to get that thing out of him. And my guess is you probably have a similar affection, but also concern for our future.

Dr. Joan Teno: 17:26

So my concern is we're gonna lose public trust. And I and I think some of that is already uh occurring right now. And that, you know, and the reason I started the Substack was I just, you know, Rhode Island is a certificate of need state. And they kept on approving the health, the health council kept on approving another for-profit or private equity-backed provider uh for the state. And they weren't looking at their data. And, you know, I've written several letters to various people to the governor, to uh the uh person

Dr. Joan Teno: 18:00

who's charged the health department and making the argument that listen, hospice is really what I call a constrained market. Okay. Two things. One, short of a pandemic, uh, the death rate is relatively stable. It's slightly increasing. But the second of all is the way we've structured the Medicare hospice benefit is it is still viewed by a lot of consumers as a terrible choice. And, you know, while people are, yes, I want to get my hip pain fixed, they're not knocking on the door to try to get into Medicare hospice. So I think that limits the number of people that you can have. And when you have an oversupply of providers, I think you end up with reduced staffing, lower quality of care, unethical enrollment practices, and you end up with hospices that are going from focusing on patient needs to patient recruitment. So I think it's really important that we again look at certificate of need laws and think about certificate of need very separately when there is a constrained or saturated market like hospice. I think the evidence is there. Um one thing that's really interesting to maybe circle back to um the CAPS uh reporting. Uh California reports only about 8%. Um CON states are much more higher in the 50% range. And, you know, I think, you know, we want competition because I want everybody to be striving for excellent, but we don't want an oversupply that leads to really this

sort of abariant behavior where I think uh they call uh Tom Konsumpkis and crew call it profiteering behavior, which I think is a a really problematic. And I think that's the thing that if I think really saddens me, is there are persons who are running hospices who think it's great to make a profit over not providing services. And that is really disheartening for me to see. So, you know, I'm hoping that in this sort of data-driven uh look and hospice moratorium that we can start fixing some of those problems where hospices are just selectively enrolling only nursing home and AOF patients. They're not providing all four levels of care or at least three levels of care. Um, and you know, I want to return some of the integrity back to it. But on the other hand, I don't want to lose short of the message that um staff in hospice are amazing people. Each week I see this. And um, you know, one of the things I we published a paper on the difference between for-profit and not-for-profit patients. And I was surprised it wasn't bigger. And I think the reason why there's not a bigger effect size on the CAPS uh scores is the staff. Um, I have routinely hear about nurses who don't turn their beeper or their cell phone off at night. They take calls, they go the extra mile. Um, and I think sometimes we don't cherish how hard these staff are working and how good their hearts are to provide care for this population. Um, you know, they're not the problem child here. They're the ones that we should be really commending because they're doing a a great job. I uh I have no regrets uh about being a hospice medical director and and really working with a wonderful group of uh healthcare professionals. And I really there's few things in medicine where you can work with the team, and hospice is one of those few th places where you can work with an entire team. And that in itself is just such a joy to be part of.

Chris Comeaux: 21:52

Yeah, I love what you just said. I agree with you, and it's obviously why we do the show is for those people, is to be a resource to them. But they're doing amazing work, and then the other part. I feel like you've alluded to it. The model that they exist in is a brilliantly designed model, the holistic care, the IDG approach, the fact that we create a care plan to keep what's most important in front of them and keeps them focused. Um, it's a brilliant model. And and and you were part of the group that created this thing.

Dr. Joan Teno: 22:19

Actually not. Well, I I I'm sort of more of a second way person, but hats off, you know, the core group of people who did this was just an amazing group of people. Um for the hospice that I spent a lot of my time and I currently volunteer, it was a guy named Reverend Charlie Baldwin, who created um what was Homin Hospice Care of Royal Island, became Hope Hospice. He used to like uh reach into his wallet and pay people out of his wallet in those first days. Um and, you know, those are the people that we really need to celebrate. Um they they they're the ones who took it, this really wonderful idea and translated it into something, you know, just think about it. Sometimes I can get down and say, oh my God, we haven't made enough progress. But in my lifetime, we have made a lot of progress. We have like 53% of persons dying who receive some level of hospice care and their family receives some level of bereavement support. Um, so that's pretty amazing. Growth of palliative care has been fairly amazing. Um, I wish we could have done more.

Dr. Joan Teno: 23:30

Absolutely. Um, you know, not being satisfied and always striving for excellence is something we should be doing.

Chris Comeaux: 23:36

Absolutely. Um, I want to make sure, Joan, I may have misunderstood you earlier, but you you quoted 80 something percent of people still complete a survey. Is that what you said? Like actual patient served or patients that died.

Dr. Joan Teno: 23:50

So ,88% of the decedents have CAPS data. Okay. Excuse me, 88% have star ratings, and it's 94% have CAPS data. So, there's a group of people who just don't achieve that uh hospices that don't achieve that end. So, we have this paradox of, you know, a a denominator, which I don't think, you know, here's the sad thing is we don't know what the denominator is. Um, you know, right now the denominator is set at the threshold of one bill and uh for CCN to say someone's a hospice. It's pretty easy to say something is a hospital because it's a physical unit. It's not that easy with a CCN. So I think we really need to clean up the diameter. And uh, as much as I love MedPAC, I would point out to MedPAC that the number of hospices, and they actually say this in the report, is not really equivalent to access because I I really believe that, you know, I I'm gonna stake my bet. I think we're gonna be around 45 to 4,600 hospices by the time that uh CMS gets through with looking at all these and and sort of doing their work on suspending some of these uh hospices that are really ghost hospices. I think already in LA the figure is climbing towards a thousand. So I think the denominator is gonna go down. Now, the problem is these hospices are submitting fake data. Um and so that affects utilization-based measures. What's interesting to me is it doesn't impact CAPS data. Okay. Unless they are totally uh not sending the surveys out, but or not giving the vendors the right depths, but that can be checked. So, I think CAPS data still has integrity. I have concerns about utilization data such as visit data, um, can be faked, you know. Um the BT1, the Burdensome Transition Measure one probably can't be faked because it involves the hospitalization.

Chris Comeaux: 26:00

So, it's gonna be interesting to unravel all this. Well, two more, and then I'm gonna hand it to Court. And so, I think I've asked you this before, but the CAP survey itself, we can rely upon the questions. You've spent a lot of your career crafting that survey. I've always had just a niggling concern. Do we have the right questions in there that we really do know what drives satisfaction?

Dr. Joan Teno: 26:24

I, you know, first of all, it's not me. Um it's a wonderful team that ran, uh, a really good group of um folks who I get enjoy being on conference calls with, uh, Rebecca Anheim Price, Melissa Bradley, uh, you know, just to name a really wonderful group of people who have crafted it. These are survey methodologists. Um I get to listen in and uh occasionally be a pain in the ass. Um, but uh, you know, I do think it is. I think my one concern is as we change, make changes to hospice. So let's say, for example, there's several laws right now that are focusing on high cost

palliative procedures, okay? Um, does that mean we need new survey items? Okay. Um, you know, for it you know, what happens when if you implement a policy, and this is just hypothetical, but you can have 10 dialysis sessions um and that's it. Well, do people, you know, do we really need a question around coercion and decision making? Right now, we probably wouldn't that question would not have the signal to differentiate that. But if we change the policy to around how we deal with high-cost palliative treatments, do we need a whole new set of items around decision making?

Chris Comeaux: 27:44

Well, and this leads to my last question, which unfortunately it's a big one. I don't know how you want to answer it, but you alluded to we've kind of hit this ceiling of sorts of percentage of patients served. There, I'm starting to see multiple schools of thought. I've kind of crafted them into three, that there's kind of a school of thought of high-quality hospice and powder care chassis together, maybe powdered care reimbursement. We've been working on that for years. Another school of thought I would call more of a vertical integration strategy where you create a narrow network, home-based primary care, palliative care, and hospice. And then the third strategy, I would say, is kind of vertical integration, but those lines get erased. And some kind of way through multiple iterations of advancement and payment, maybe you get like a pace without walls reimbursement where you get the capitated rate. You manage the clinical care pathways for right care, right place, right time. And maybe that whole that word hospice goes away and it's referred to as advanced illness management or serious illness. I feel like you kind of alluded to maybe tipping your hand of um, but I don't want to read into it.

Dr. Joan Teno: 28:51

So you know, I think you're raising a really good question. And I'm gonna I'm gonna give you some data back. Okay. So, we have this sort of notion of um to elect into the Medicare hospice benefit, you have to basically state um, my focus is now solely on comfort, okay? And you lose access to some palliative treatments, okay, which could be beneficial like blood transfusions, um, you know, weeding off of dialysis. Um and that part of it, you know, I'm really impressed. I've looked at maybe 15 years worth of data and the meeting length of the stay is a flat line. Okay. And I think a lot of it is a flat line because of the way we structure the benefit. But interesting enough, in countries where they have not this sort of what I refer to as a terrible choice, it's only four or five days more. Um you know it, you know, I just think we have to remember that there is a group of people who um are gonna be in this category which I affectionately call hell no, I won't go. Um and you know, we saw that in the Medicare choice model. Um, we saw there's a group of people who stayed on Medicare choice, who basically died on MCCM, or they transferred to hospice in the last three days of life because they were no longer making the decision. So, I think there's a sizable part of the population that's never gonna enroll in hospice. I'll give you one more data and I can actually give you the reference. We we inter from eight hospices across the country, we interviewed 100 family members um about the choice of hospice when they had a seven-day stay. And there's a good portion of them that said basically it's was about the right time. And of those people who said there was about the right time, several of them refused an earlier mission. And then the second thing, which I think is an important finding, is acute on chronic events. Okay. Um, you know, I can tell

you I've taken care of cancer patients who are doing well, have a massive PE and die a day later. I don't know if we would have predicted the massive PE. So, you know, we're always going to have to deal with this disease trajectory. So, I'm gonna circle back one more time and say, you know, what is the denominator people who we can get onto hospice services? It's not gonna be 100%. I think it's it's like I think Rhode Island,

Dr. Joan Teno: 31:30

which is our last 2024 data is 63%. I think we're getting pretty much topped out. Um, I, you know, maybe we'll get it up to 70%, but I really don't see us, you know, getting much higher. So I think that's, you know, one of those things I see as a warning sign is you already have a fairly saturated market. You already have a lot of people on the Medicare hospital benefit. And you know what? People have choices, you know. Um the medical director St. Christopher was someone who I uh was a friend with and did a research project with, Bob Dunlop. And um, you know, early on when I was still very young, um back before all the gray hair, you know, Bob taught me something that's really relevant. You know, if the patient chooses to be in an ICU and die in the ICU, that's good. That's what they wanted. As long as they had understanding of what their options were and they made a decision based on their own values and goals, that's the way we should support them. So I don't think we're gonna get 100% in Medicare. In terms of payment model, God, we need to do some work on that. I I am hopeful that we can get further down the line of concurrent care. Um, I think concurrent care could work, but it's gotta be the right payment. Uh and I think unfortunately it's gotta be a big enough hospice to do it. Um, I think it really is hard for hospices with an ADC of 20 to do concurrent care. You know, and how to do that from a policy standpoint, I'm not an attorney. Thank God I'm not an attorney. My sister is a judge. You don't want me to be an attorney. I don't know what the rules of authority are. And I'm sure, you know, I'm the person who basically raised why can't we count spiritual persons as part of the services we provide the hospice? And an attorney in the room said, You don't understand there is a separation of church and state. Um, but I said, like I argued back, well, they're really providing counseling, you know, most of them are masters prepared people. But no, I I got I got schooled on the separation of church and state by an attorney.

Cordt Kassner: 33:36

So you know, I I as I said earlier, I could continue this conversation all day. I I you're one of the most intriguing, fascinating, knowledgeable people in this area of anybody on the planet. And and I think rather than t taking 60 seconds and asking you six more questions, I'd rather take it and just thank you for for what you have done, what you've done through your career professionally, personally, how you have shaped end-of-life care. I uh very few things are immeasurable, but that might be one of them that is immeasurable. I just really, really appreciate uh you and your perspectives. And uh I just want to thank you for that. I I don't know that we acknowledge and thank and highlight our our heroes enough, but you're one of mine, and thank you.

Dr. Joan Teno: 34:29

Well, that it's unbelievably nice to say, but I want to say um I grew up with this unbelievable cohort. Okay. Um, first of all, one of my best friends, Irene Higginson. Every year I have the privilege of going to King's College and I have lunch with Irene, and we just talk policy, and it's like one of the best conversations I have. Ira, amazing person. Diane, Sean, David Casseret. What a cohort to be part of. So, you know, you know, I I think as I I wrote in a previous thing, it really is a village of people that uh I've had the privilege of working with. And, you know, and hopefully, you know, I I think I may have told you, but but I have planned out my retirement and volunteering and giving back and mentoring is key to my plans, in addition to traveling and buying more camera equipment and keeping my dog's bet bills paid, are are key as I uh sit here with a puppy at my knee bugging me.

Chris Comeaux: 35:32

And Substack is part of that uh plan, right?

Dr. Joan Teno: 35:35

Substack, Substack's my new hobby.

Chris Comeaux: 35:37

Okay, very cool. Because I've I'm a huge fan of your Substack, and I just want to echo what Cordt said again. You're one of my heroes as well. And just to get the opportunity to talk to you and share you with all of our listener base is just an incredible honor and privilege. And so thank you, and we're glad that you're gonna keep giving back in all those ways, including the Substack. Thank you very much. All right, War. To our listeners, we want to thank you. At the end of each episode, we share a quote, a visual. The idea is to create a brain bookmark. This one's gonna be fun, a thought prodger about our podcast subject the further your learning and growth, and thereby your leadership. We want it to stick like a brain tattoo. Please be sure to subscribe to our channel, TCN Talks and Anatomy of Leadership. We don't want you to miss an episode. We're gonna include a link to Joan's Substack and anything else she wants us

Chris Comeaux: 36:20

to include. You know, it's easy for us to reel against the world and be frustrated by things. Let's be the change we wish to see in the world. So thanks for listening to today's podcast. And here's our Brain Bookmark to close today's show.

Jeff Haffner: 36:33

"We have the data now. Let's use it" by Dr. Joan Teno.