TRANSCRIPT: Why Traditional Primary Care Fails Frail Elders and the Future Need for Specialized Models | Part One

Leadership And Purpose Opening

Melody King 0:00
Everything rises and falls on leadership. The ability to lead well is fueled by living your cause and purpose. This podcast will equip you with the tools to do just that. Live and lead with cause and purpose. And now, author of the book, The Anatomy of Leadership, and our host, Chris Comeaux.

Meet Dr. Bethany Snyder

Chris Comeaux 0:22
Hello and welcome. I'm so excited today. Our guest is Dr. Bethany Snider, who's the CMO of Everent Health. Welcome, Dr. Snider. Good to have you.

Dr. Bethany Snider 0:32
Yeah, thanks for having me, Chris. It's great to be here.

Chris Comeaux 0:35
Absolutely. Well, let me go ahead and read from your bio. So, Dr. Bethany Snider is a senior vice president and chief medical officer of Everent Health. She provides executive physician leadership for care delivery and medical strategy across the enterprise, leading system-wide innovation and best practices in hospice, palliative care, and primary care. Previously, she served as the Chief Medical Officer of Hospital's Health, where she helped advance clinical programs and quality across the organization. She's board certified in internal medicine and hospice and palliative care medicine, and Dr. Snider trained at the University of Kentucky, Go Wildcats, and completed a Hospice and Palliative Care Medicine Fellowship with Hospice of the Bluegrass, which is now Bluegrass Navigators. She partners closely with affiliates to accelerate the growth of sustainable programs, strengthen clinical quality, and expand access to high-quality care for people living with serious illness. She serves on the board of directors of AHPM and in her second term on the Kentucky Inter Interdisciplinary Palliative Care Advisory Council, which was where she was appointed by the governor. She lives with her husband John and her two children in

Taylorsville, Kentucky. So, Bethany, I told you I was going to ask you this question. So, what's your superpower?

Dr. Bethany Snider 1:47
Well, I think my leadership superpower is galvanizing people behind a shared vision. I have a unique opportunity. I think it's in my DNA. So when I believe in something, there's such strong conviction, it kind of pushes me forward. And I've been blessed to really galvanize and get people to rally behind that to help us move missions forward.

Chris Comeaux 2:14
That is a superpower because usually leadership skills and physician don't always come in the same packaging. And so the fact that I do believe that is a superpower. Well, I've been really thank you for agreeing to do this. I've really been wanting to talk to someone who I just have great respect for, and you're definitely tops of that list to talk about this emerging concept of frail elderly practices.

Defining A Frail Elder Practice

Chris Comeaux 2:36
So many hospice leaders, I think it was probably two years ago at a national uh conference. And I remember a CEO called me after and she goes, This term frail elderly practice has been thrown about. What is that exactly? And so, how do you define a frail elderly practice? And I don't know if this is true, but do you believe it is emerging and becoming an important service line as we go forward for serious illness care, health care as a whole?

Dr. Bethany Snider 3:03
Yeah, I think these are two critical foundational elements to what we believe and what I believe is the future for our space specifically. So when I think about a frail elder practice, what I'm really speaking to is not just primary care for older adults, but this is really a model that is designed for people whose health, function, and support systems are really fragile as they are progressing through the last few years of their life. And so these are people that don't just need visits, right? When we think about primary care a lot of that is still very volume driven. These are people that need a different, comprehensive model of care that wraps around them that really ensures they have access to the high-quality services that we all believe in, right? When you think about palliative and hospice, but it needs to be more longitudinal. So it's not about acute visits or dealing with crises. This is really around enhancing quality of life, changing behaviors, and providing them access to the supports they need wherever they are. And so to me, that that's really a frail elder

practice and what we're trying to build at Everent Health to meet the needs of our community. But secondarily, I'd say a secondary benefit is it's going to help ensure that hospices have access to patients that deserve our services. And so when you ask the question, do I think this is where we're heading? Is this what we need? I think this is a requirement for organizations like ours that have been legacy hospice organizations to ensure that specifically frail elder adults will have access to palliative and hospice care when they need it, as the landscape and the payment models in our country are shifting dramatically.

Chris Comeaux 4:47
So,

Why Primary Care Falls Short

Chris Comeaux 4:48
what's changing about the aging population that maybe makes traditional primary care creating gaps where they're not maybe increasingly it's insufficient for those that are aging, especially as you know, we have this huge demographic of the baby boomer. So we're gonna have the largest amount of older adults ever in the history of at least our country that's occurring.

Dr. Bethany Snider 5:09
Yeah, so I always uh tell people this story. I trained in primary care, right? So I did internal medicine, but I actually did the primary care track. And through those three years of training in Kentucky, which is my home and where I care about people most, I saw two things. Number one, primary care in its current state is insufficient for people with serious illness, particularly for elder adults. And number two, we're already in a primary care crisis. And so this is really why traditional primary care is not enough and it's not working for that population. Uh, my brother-in-law is a primary care doctor in our town, and he is constrained by 15-minute visits where people have to come to him, right? And in the course of that time, you know, he wants to spend more time, and then you just get backed up because we're still mostly in a volume-driven medical practice model. You can't identify those nuances that really keep frail elders from being successful and thriving in their home environment, specifically isolation, caregiving strain, functional decline, um, obviously management of multiple comorbid conditions. And so, in my humble opinion, real primary care and medical care for this population has to include the home, it has to include the caregiver, it needs to be longitudinal and not episodic. And while we say primary care is a longitudinal relationship, when you think about the connection points that you have with these people, it's very episodic and it's very short episodes of care. And

I think what we've seen, right, in this population with healthcare spin, but also just crises that occur and advanced illness, that's not enough for them. Frankly, it probably never was, but we did the best we could with the models that we were given initially. And I think we need to challenge ourselves to design models and systems that actually serve the patient and their family the best. And in my humble opinion, frail elders need comprehensive interdisciplinary primary care that extends into the home and helps identify environmental, social, psychosocial, spiritual issues that actually keep them from living their best life for however much long time they have.

What Frailty Looks Like Clinically

Chris Comeaux 7:33

That's awesome. I you may have answered this, but I think this inventory would be helpful. When you think about frailty, what are the key characteristics that distinguish a frail elder person from maybe typical Medicare beneficiary? And again, why does that distinction even matter?

Dr. Bethany Snider 7:49

Yeah, I think it's a really important thing, and there's a lot of nuance to frailty, right? So there is a lot of evidence that is developing in the literature over the last decade, really around frailty as a marker for poor outcomes or for um disease progression. It also is a marker for catastrophic healthcare events. And so these are really individuals that have functional limitations. Maybe they already have complications related to their illness, and they have this kind of longer-term functional decline. So frailty is a distinct, right, medical condition characterized by multi-system depletion over time, but also physiologic vulnerability. There are a portion of Medicare beneficiaries that may have a chronic illness, but functionally they're doing well. They can get out, they can manage their ADLs, they have good support systems. Those aren't the people I'm talking about. So we're really looking for people that have this kind of progressive decline, functional limitations, social constraints, things that are really impacting them, both physically, but obviously mentally, that causes these distinct pieces of distress. When you get down really to kind of the medical side of frailty, we're thinking about people with have polypharmacy, right? So tons of medication use, which comes with a burden of adverse effects and drug interactions. They also are often dealing with complex symptom needs. So think about fatigue, muscle wasting, some subtle cognitive deficits. So we're not talking about necessarily dementia specifically, but as we all age, right, our brain atrophies over time. And so there's some cognitive impairment that develops. And then, of course, functional

limitations that are really causing them to be dependent on others to help support their needs.

Chris Comeaux 9:46
So well said. You've you just made we we were always tape podcasts back to back. So the podcast actually taped this morning, right before yours, was with the IHI. And we were talking about the Four M's. We're talking about what matters most, mentation, medication, and mobility. And if do you guys talk about that out of curiosity within the work that you do?

Dr. Bethany Snider 10:07
We do. So that's a framework, right? Most palliative providers are familiar with. But as you heard me just articulate them with different letters, like those are critical factors that if we don't evaluate and address initially, we're gonna fail in our goals to maximize their quality of life and support them with the services that they need.

Chris Comeaux 10:27
Many

Why Hospice Must Move Upstream

Chris Comeaux 10:28
hospice organizations should be looking beyond the Medicare hospice benefit. So why, as they kind of think about, you know, we got all these interesting substitution competitions, challenges, multiple hypercompetition in multiple ways, why should hospice leaders be paying attention to frail elderly practices right now? And maybe even especially over these next several years?

Dr. Bethany Snider 10:51
Yeah, you know, Chris, you and I could spend hours talking about this, but I would say for anybody that listens, if there's one thing I would hone in on, it's what we're about to talk about around how do hospices stay relevant. So Everent Health, right, brought together Bluegrass and Hospice a couple of years ago. And this is part of the reason. What we see is the financial incentives and the way healthcare is shifting, frankly, does not align with the traditional hospice model. So when we think about protecting the mission of our affiliates and organizations that we care about, the way we do that is to look for connection points with the population that we seek to serve, maybe not today, right? This might be years later, but to get access to those patients and to those populations to ensure access to our services when they need them, particularly at the end of life. The

example I use most often now, which I think a lot of people are not paying attention to, frankly, in hospice, is accountable care. So we are part of an ACO through the MSSP program. And what I've learned over that time, as well as experienced when trying to contract with other ACOs for our services, is hospice is being seen as a cost center to manage. So as we move more providers or health systems plans into these total cost of care models, the unfortunate consequence of that move, which I don't think is necessarily the wrong thing, but it's an unintended consequence, is hospice is being seen as a cost center to manage instead of a value add to their patient population. If we as hospice organizations and entities do not move upstream, other people will have access and control of these patients and these relationships, and it will make us irrelevant. So the traditional hospice patient base is going to be affected as these upstream models manage serious illness. Frankly, they have to get more sophisticated to manage the cost of care of these individuals. And they potentially delay access to hospice, redirect, as you said, with substitute competition models, or reshape the types of hospice referrals that we're going to receive. We already see this in our market with a couple of partners where they are pushing our length of stay way down for hospice because they're accountable to the cost of care. And whether that's an indirect or a direct strategy for them, we're living it. So, you know, I remember 10 years ago, we all sat in rooms and talked about how do we get longer lengths of stay, right? Like we want to take our median length of stay back then from 14 to 20. Like, how can we go in a more positive direction? We've actually gone the wrong direction for the last five years. Where for us, we've seen median length of stay continue to shrink and it's being driven a lot by these value-based providers and trying to find, well, what is the right time for hospice? What really makes that complex when we talk about primary care and access, right? A lot of times patients find that transition to hospice through their providers. Well, as acute care systems are trying to push more care out into the community, we do not have the volume of providers needed to manage those populations. So what happens, right? Let's say I'm a frail elder, I have a primary care physician in my community, I start having changes in my condition, I can't see them for two or three months. Well, then think about that juxtaposition of maybe I'm hospice eligible, but I'm not going to see my provider for three months, and I don't really have awareness to what hospice is and how it can benefit me. You've just delayed access to that benefit. And so I think it's a twofold issue. I think we don't have enough providers in our country to help manage these types of patients that really have advanced illness and end-of-life needs. So getting access to providers who we trust to help have those conversations with us isn't readily accessible. And the financial incentives in these value-based models are not aligned with the traditional hospice benefit and the expense that is seen. We in this field, right, we know the value of our model. There was a great study put out a few years ago by Nork talking about the savings that comes through hospice. But what I see in the boardrooms and in these negotiations is they don't want to appreciate the indirect savings, right? They want to know what are you going to do for me right

now? And when they see the expense that comes with that, it's easy to forget the indirect savings that will come when you wrap the patient with the right model of care at the right time. And so I think hospice leaders must pay attention to frail elder practices or really thinking about how do I get access to models of care that get me in the door with the population that we want to serve. Everyone would say patients with advanced illness, right? That we can walk with longitudinally over years so that we can ensure they get access to palliative and hospice care when it's the right time for them. I worry if our colleagues across the country don't start to pay attention, we will see the benefit that we love erode to even shorter lengths of stay. And access will become really challenging for some across the country because they will be substituted with much smaller options. Or frankly, hospice may cease to exist in its current form. I hope that's not the case and we're fighting to really adjust that. But I think hospice leaders need to challenge themselves to think more about population health. The population we need to serve because we have the skill set is the seriously ill. And that really moves us upstream in the last few years of life as opposed to thinking about the last six months of life.

Length Of Stay And Missing Benefits

Chris Comeaux 16:44
Is there in these boardrooms and negotiations? You may not be able to answer this, but is there an optimal length of stay? And I'll actually kind of help you with it. So we we were part of this TMMI when I was still at Four Seasons. And we did find that at that 60-day length of stay, there were still significant savings. Once you get longer than a hospice length of stay about 60, it starts to get questionable. I know that doesn't square with what Nort came up with, et cetera, but at least led us to believe that that may be the sweet spot. Interestingly, Dr. Snider, you I think you would affirm this. I've asked nurse after nurse optimally. We all agree the fifth, the 14, that sucks. That brink of death is so hard to do good care. And I've asked them, I'm like, hey, if you could wage, we wave a magic wand, what would be that length of stay? And invariably they say 60. So we have the quantitative saying we still save money at 60. And then nurses saying, look, you give me 60 days, we could do magic with the patient and family. Does any of that kind of come out of those negotiations? Or you don't even get to that point. They just look at you as a cost period.

Dr. Bethany Snider 17:46
No, they there's definitely a magic number that most value-based providers are seeking for hospice. So they don't say hospice is bad, right? They say we only want it for a certain period of time. I've had various ranges, nothing up to 180 days like the benefit was designed. I would say generally it's half of that or less. So it's kind of, you know, there's a

range of that. The other thing that I think really complicates it, and we may talk about this a little bit later. That's okay if you have an alternative solution for these patients outside of the hospice benefit. But as you know, in our country today, we don't have that, like a palliative care benefit or a serious illness benefit. So what really makes me nervous is if we have people start stripping away what they believe is the value of hospice, the problem is we're leaving people in crisis for months, if not years, because we don't have a solution for them prior to this end-of-life benefit.

Embedding Palliative Care Into The Model

Chris Comeaux 18:43
Well, maybe this kind of leads to the again. I I thought of many of my questions when you and I were at a national conference together and was so stoked that we got to spend this time together. So, where does palliative care fit within this for elderly practice model? Is palliative care still a separate service line? Is it a consultative layer? Um, you know, is it embedded into the design of the practice? Mm-hmm.

Dr. Bethany Snider 19:08
Yeah. So it might be the bias that you're talking to a palliative physician. But from our perspective, palliative principles are embedded into the design of care from the beginning. So I think it's really a both and, right? So when you build teams that are going to manage frail elders, they have to be capable of doing primary palliative care, right? So they know how to have complex decision-making discussions and doing advanced care planning. They know how to walk patients through prognosis and how that will change over time and impact decisions they may need to make. They need to have basic symptom management understanding, as well as continually trying to elicit goals for a patient and family of what matters most to them. What are they most concerned about? How do we align the goals that you have with the care that we're providing? So I think palliative care should be a foundational element of any frail elder practice. And at least for Everent, we then are also layering on specialty palliative care because there are patients that really need a true specialist palliative care model. And so we've built the design where that gets layered on to patients either based on time as their disease progresses, or when there are acute things that really would benefit from a palliative specialist to step in. So, from my perspective, it's foundational across the practice model. And it's really thinking about where does primary palliative care fit in for the team that's managing these individuals longitudinally? And then when does specialty palliative care really intersect within that team for certain patients as their disease changes or their needs escalate?

Recruiting And Retaining The Right Team

Chris Comeaux 20:50
You know, you've kind of alluded to the workforce issue throughout all of healthcare. I mean, you're probably navigating that even as you're trying to start a for elderly practice as well, right? Or are you finding because the mission-oriented nature of this, that's kind of a competitive advantage where, you know, primary care, maybe that feels like, yeah, you know, primary care has been around forever. This sounds sexy and new. Is that true or is that not true?

Dr. Bethany Snider 21:17
I think hospice organizations that go down this path are really uniquely positioned to recruit the right kind of providers and team members to their practice for a couple of reasons. Number one, if you've talked to any primary care provider in a health system today, that is an extremely challenging job. Uh, it's 24-7, frankly. The messages never stopped. There's a huge volume of patients that you struggle to manage just because primary care in general, we have poor access in our country. And so that is a really taxing job. And often when I talk to some of my colleagues in primary care, they feel like they could do more, but they're constrained by the system. That doesn't allow them to do what they need to do for patients. And so I think what's beautiful about a frail elder practice model for physicians and advanced practice providers is we offer them something better. Two things, I would say. One, the mission alignment, it's really easy to recruit providers to our mission, right? They believe in the value of the care we provide. And a lot of people feel called to that type of work. But secondly, when I talk to most primary care docs that I've trained with or even colleagues, they go into primary care because they want to have an impact on these patients and families and really know these people and build relationships over time. And the beauty of the practices that we design is you get time with people. Going to people's homes, assisted livings, or facilities, wherever it is, isn't the right thing for every provider. But when you find the people that are open to it or interested in it, it's a transformative career. I often tell the story of when I was in training as an internist. I had no idea what palliative care was. I had very little exposure to hospice personally. And so when I got to go out and make home visits in a shadow opportunity, as I was trying to decide, I thought I was going to be an oncologist, but then somebody said, Hey, you should try out this palliative care thing. I think you'd really enjoy it. Walking into people's homes is such a humbling experience being invited in. But it teaches you so much about these people and what they value and what's hard and what's easy. And it really changed my whole perspective of healthcare and how we take care of people because traditionally I would look at a patient with all these meds and these issues. And when they were struggling with that, right, they're non-compliant. Like we would label them, well, you're just not doing what I tell you to do. When you walk into their home and

you see what they struggle with or the resources that they may not have access to, it gives you a whole different perspective on how to best care for them and actually what optimal care looks like. It might not be all the things that we do for the healthy 50-year-old with cardiac disease. You can layer that alongside their goals and their value system. It is such a rewarding career. When we find people that want to give it a chance and step into this space, they never turn back. It's not really volume-driven, it's value-driven, it's relationship-driven. And thankfully, we don't have the same pressures that a traditional, you know, primary care practice may have. You can give them more flexibility, more time with patients and families. And I think it really gets back to the heart of medicine and why so many people get drawn to that career and helps kind of shine a light on what it can be as opposed to what many have experienced over the last decade.

The Interdisciplinary Model In Practice

Chris Comeaux 24:50
I love that. So walk us through what does it actually look like to care for a frail elderly patient? I mean kind of put us inside the model from the first encounter through ongoing management. What does the care team look like? I feel like you kind of alluded to that. How does coordination happen?

Dr. Bethany Snider 25:06
Yeah. So from our perspective, a frail elder practice has an interdisciplinary foundation, just like a palliative and a hospice team. So when we think about successful population health management for this group of individuals, you have to be able to address all the needs we previously talked about. So the team is comprised of a physician. They don't have to be geriatric trained, but they need to be geriatric minded, right? To really think about risk-benefits evaluations and that maybe the evidence to support these drugs and a healthy individual isn't the same for a frail elder. They're supported with case management, right? So we need to know what's going on with patients and families, and we're not in the home. It is a more high-touch service. We've got social workers involved to help address psychosocial needs. Behavioral health is a critical component of a successful frail elder model. And so having capabilities to address depression, anxiety, social isolation, caregiver strain, we need those supports but expertise at the table with our team. And then, of course, pharmacy support and a pharmacist on the team to ensure that we're evaluating medications appropriately, looking for how they might be driving some of the symptom burden that patients are experiencing. And we wrap these patients and their families and their caregivers, frankly, if they're in a facility, with 24-7 access. And so I would say the first encounter starts with an optimal patient experience where we get in swiftly, right? We need to be responsive when they ask us to come and take care of

these patients. Illnesses, but their function, their cognition, their caregiver capacity. I think that's a huge thing that often gets overlooked. Like maybe you have family or individuals that seemingly look like caregivers, but can they actually provide care? How is your home built for safety? Do you have social supports that we can draw in to help manage isolation and some of the issues we've talked about? What does their nutrition look like, right? Nutritional decline is one of those early markers of frailty. And so where are we on that trajectory? And then most importantly, what's most important to them and what are their goals? Once we have that initial visit, and you can imagine that's a lengthy visit to start to build rapport and to really do a comprehensive assessment of this individual patient's needs and what their goals are, then we have to make sure we are responsive to them when they need us. And so that's where the care management team comes in to really check in with these individuals, right? Some of that check-in might be via technology, other time it's through audio or visual check-ins with these patients. And layering on that what I call disease-specific care plans. So, right, those of us in hospice, we know this idea of care plans outside of hospice, particularly for providers. Most of us have no idea what a care plan is, but we really have to take those core tenets of if you have heart failure as your primary issue, we've got to have a crisis plan for you. We've got to educate and train you on what that disease looks like as it progresses over time. And then have the needed resources in the home. So as we start to see that change, we can intervene immediately. I think where some programs really struggle as they're building these, it's an investment, right? So to do this well, the hospice organization has to invest to build these capabilities and to scale them as your program grows. And what I've often heard in conversations is, well, how are you going to do that 24-7 access piece, right? Like we have limited resources, we have limited margin. It's non-negotiable because as you know, Chris, crises don't happen between eight and five Monday through Friday, right? They happen after hours and on weekends. And there are so many patients that have said to me, I would call, you know, so and so, and they'd say, we'll just go to the emergency room. That can't be our answer if we want to do this well, particularly as we build these models for value programs and accountable care programs. So that's kind of, I think, at the highest level, what this model looks and feels like that. The other piece of it that we've been really intentional around is the handoffs. So when you think about other service lines, right, whether it's palliative care getting involved, or even the handoff to hospice, or if you need to bring in home health to intersect with these patients, we have to have excellent communication and coordination so that it feels like one team, one service, one model that supports these individuals. I think at its basic core, a frail elder practice is taking palliative and hospice principles and applying it for a longitudinal population. And so when we think about all the things that make us successful in palliative and hospice care, frail elders, people with advanced illness should have access to those same things. And so it's really how can we build a flexible model that's agile? I will say when we build teams, right, we stand these up as independent business lines separate from the hospice because

you have to be very flexible and nimble. We have to be agile as we grow and we scale and processes change, because you have to know what patient needs you, when they need you, and to be able to respond to them. And that's where a lot of times we'll talk to our teams is we're all kind of generalists, right? Like if the director of business operations hears the phone recon, he's gonna pick up the phone and help the patient. And so I do think that's something that you've got to be flexible and agile as you're building these types of programs because the reimbursement is so different that you need good teammates that are bought into the mission and that are gonna do what's necessary to make patients' lives better. And that doesn't always mean just sitting in my little box of what my role is. It really means being able to adapt and adjust to what the needs of our patients and families are.

Right Care Right Place Right Time

Chris Comeaux 31:18
You know, what occurs to me listening to Dr. Snyder, there's an adage I think many of us have used. I'm not sure if any of us are really putting meat on the bone, but right care, right place, right time. It feels like you really are living into that and innovating a new model.

Jeff Haffner 31:33
Don't miss Part Two of this episode, coming this Friday.