TRANSCRIPT: The Critical Competencies Hospice Leaders Must Build for Value-Based Care Success | Part One

Leadership Framing And Welcome

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.

Chris Comeaux 0:22
Hello and welcome. I'm so excited today. We have a guest with us. We have Dr. Jessica Hubbs, who's an Internist and the Chief Clinical Officer at Advanced Care Innovations. Welcome, Dr. Hubbs. It's so good to have you.

Dr. Jessica Hubbs 0:35
Thank you so much for having me.

Chris Comeaux 0:37
Yeah, let me introduce you to our audience. So, Dr. Jessica Hubbs is an Internist and she's the Chief Clinical Officer at Advanced Care Innovations, where she supports independent, home-based primary care practices across the country within high needs ACO Reach model. She has spent her career working in home-based primary care, supporting high needs patients both in the field and developing operating care models to better serve the high needs population. Dr. Hubbs brings experience in ACO Reach and Medicare Advantage, where she is focused on shaping care delivery to improve quality and value-based performance outcomes. Her special area of Interest lies in shaping care models that foster the integration of clinical and non-clinical services to improve access, quality of care, and quality of life for patients and providers who care for them. So,

Asking Why Changes Everything

Chris Comeaux 1:24

Dr. Hubbs, I told you I was going to ask you this question. So, what is your superpower?

Dr. Jessica Hubbs 1:30

Oh, you did. You warned me. And I I still, I, you know, we'll call it a superpower, at least something that I strive and hope is a superpower of mine. But I um, you know, I was reflecting on this, and I think that um there's a lot of power in general of always being driven to understand the why. And um, you know, an example of this is um I can tell a quick story. Please go ahead. Um, you know, when I was a resident, actually, I was uh had a rotation in the emergency room. And I remember getting a call from the ER doc at like three in the morning, three thirty in the morning. And it was to see a patient for really a primary care need. They needed a blood pressure medication refill. And um, you know, so I went down to the emergency room. But I remember in this conversation with the patient at the time, I, I asked him, you know, why did you come to the emergency room at 3 :30 in the morning for, you know, we can take care of you in the outpatient setting? And he said, I work three jobs. I don't have a day off. And the office is closed when I try to get an appointment. So this is the only place I can really access my care. This is the only way I can take care of myself and the only time I can do it. And, you know, that in and of itself, if we don't ask the why, if we don't strive to understand, you know, we will label a patient with noncompliance or not really get to the solution itself. And so that for me, I, I hope is a superpower, but also something I think is deeply important in in medicine and care delivery is to always ask the why of why is something happening so that we can work towards the solution, really the most important thing. So, if we don't ask the why, we miss the solution.

Chris Comeaux 3:23

So beautifully stated. And I've been navigating some interesting health challenges, and I'm a busy healthcare professional, which were the worst, right? Their schedule never complies with mine. And um, there's been a couple of frustrations why I didn't have to go to the ER at three o'clock in the morning. I really wished a few more people would have asked me, well, why are you trying to access it this way? Um, and I find that quite often healthcare, I have a good friend who kind of said this, and it's like it's almost like a conveyor belt, and you know, everyone's a nail and it's a hammer, and it just does what it does. And very few people would do something like what you've just said stated, um, just to step off the hamster wheel and just ask good questions, what matters most to that person? Which those are things very near and dear to my heart because those are things that have differentiated hospice over the years. Um, I don't know if you had a chance to listen, Dr. Hubbs, but we actually had Dr. Don Berwick on our podcast, which was such an honor. I mean, he's the father of the triple aim. We now use the quintuple aim, which was birth out of the triple aim. And he talked about just the fact that some of the beautiful things within hospice, like the rest of healthcare, could learn from that, which I think will

set the table well for some of the questions that I want to go into with you. Uh, before we do, though, um, I did want to ask you, because I think a lot of our listeners are hospice powered care leaders all over the U.S., they don't know about advanced care innovations. Can you just say a little bit about that?

Inside Advanced Care Innovations

Dr. Jessica Hubbs 4:48
Of course. Yeah. Advanced care innovations is the largest high needs ACL reach in the country today. Um, and really within that, uh, we support largely independent home-based primary care practices all over the country in 33 states and really supporting those providers and practices to be successful in value-based care, in particular, the high needs ACL reach model as it stands today, lead in 2027 and beyond for the next 10 years. But, you know, I get the incredible uh experience of getting to partner with our providers, our practices, learning their care delivery models, what their experiences are for patient care, and then really taking the operational components of these models with CMMI, in addition to some of the data and analytics, and making all of this actionable and relevant to support providers and supporting high needs patients and really ultimately being successful in uh ACO and these value-based models of care.

Chris Comeaux 5:54
Good deal. Well, let's jump in because I have a lot of great questions I want to ask you. So,

LEAD Model And Value-Based Future

Chris Comeaux 5:59
healthcare seems to be moving at a pretty rapidly rate, paying from going from paying for episodes of care to trying to pay for outcomes. What are the most important serious illness alternative payment models that are emerging today? And why should hospice empowered care executives leaders be paying attention?

Dr. Jessica Hubbs 6:17
This is a great question. Um, you know, and there's so many models emerging through CMMI right now, and it's a very exciting time. And I think all of that really is starting to signal this um shift and push and really reinforcing what CMS has communicated, that they want all Medicare, traditional Medicare beneficiaries to be in some form of a value-based care model or payment arrangement by 2030. Um, for me in particular, I may be biased, but I think LEED is one of the um, you know, most important models that we're

seeing coming out or emerging that will lead long-term enhanced ACO design. And that really starts, it's the revised version of ACO Reach, the model that we're in today, um, starts in 2027 and runs for 10 years, which is the longest value-based model that CMMI has really, really put out there. Um, and they've shaped it in a way that we're starting to see it be, you know, I'll use the word competitive, um, with programs like Medicare Advantage and with programs like MSSP, and ultimately really creating some uh legislative things that are starting to get providers into these value-based models and also expanding the services that can be offered to patients. So that is, you know, one of the biggest models coming down the pipeline that I think is relevant for hospice and palliative care as much as it is for any home-based primary care provider out there, um, or primary care provider for that matter. And, you know, if I one of the things I would say of why that is, if we look at the models today and the implications of shifting all traditional Medicare beneficiaries into a fee for serve uh into a value-based model of care, you know, um, what we're already seeing in ACO is in high needs in particular, just because of the makeup of our patient population. We're really seeing that um bringing traditional fee-for-service patients into value-based care arrangements is starting to innovate in the way that we, you know, do care delivery directly through the provider. And I'll use the example of a high needs ACO that aligns as far as patient population with the cohorts you have and take care of and serve under hospice and palliative. When we looked at high needs ACO historically and even today, hospice is about 12% of that total cost of care. And the downstream implication of that could really go two ways. One way, and we see this happening a little bit today, is that enablers and um practices are starting to bring that care upstream and expanding their services under home-based primary care and primary care and palliative to be able to serve the patient with those expanded set of services earlier, which has downward implications for hospice. And I think that we would continue to see that as you know, CMS really doubles down on the push to bring all traditional fee-for-service patients into value-based care.

Defining The High Needs Population

Chris Comeaux 9:45

No, it was gonna I want to, we're gonna unpack that just a little bit further, but I do think it'd probably be helpful, Dr. Hubbs, because you use the term high needs. And so it feels like you're painting the picture of that patient population. Can you just talk about that a little bit more like what is exactly a high needs population?

Dr. Jessica Hubbs 10:00

Uh a high needs patient population is really what I would consider to be a patient who is often homebound or home limited. This is the patient who can really no longer access

their care truly in a meaningful way outside of the home. They um oftentimes, when you look at eligibility criteria, they have an extremely high risk score of, you know, two or greater, oftentimes three or greater. Um, they've experienced home health for 90 plus days. They've been in a skilled nursing facility for 45 or more days. So it really starts to paint this picture of an extremely clinically and oftentimes socially complex patient.

Chris Comeaux 10:44
Thank you for that. And um, I feel like you're kind of going here, but let me kind of cue it up and because I think it'll continue where you were.

Hospice Upstream And The Six-Month Myth

Chris Comeaux 10:51
So I do think there are a lot of hospice leaders that are wondering whether these models are competitors to hospice or natural extensions of hospice expertise. So, where do you see hospice and power care organizations fitting into this future serious illness ecosystem?

Dr. Jessica Hubbs 11:08
I um, you know, I my honest answer is I think it could be a headwind. I also think it is an extraordinary opportunity. Um, I lean towards the opportunity side because I think we're in this really beautiful moment right now where hospice and palliative leaders have the opportunity to start bringing those services, those really rich services under the hospice benefit that are so important. I think we're in a time right now where we can really start to bring those services upstream and actually expanding access and allowing patients and their families to experience those rich benefits sooner. And I, I know you and I um had briefly kind of chatted on the six-month eligibility period uh um for hospice was really a financial and a legislative decision. It wasn't a clinical decision. And and not to its day, I don't think even providers were not necessarily taught that. We're taught the eligibility criteria for hospice. And when you really think about that, you have to ask yourself, you know, why? And what are the services patients need? When do they need them? Who needs them the most? And how can we start to shape payment models and care delivery models that expand that access, not limit it? And therein lies, I think, the opportunity for hospice and palliative organizations across the country.

Chris Comeaux 12:38
Yeah, I love that you brought that up. I almost kind of forgot we had talked about that in their first call. That um I have this article, and it was Tom Hoyer, who is the administrator. It wasn't called CMS back in the day when hospice became a benefit. The acronym was

HICFA, the Healthcare Financing Administration, which now is CMS. And um, the gist of the article was is that there was like the 11th hour, and they're like, wait a minute, we can't leave this hospice benefit open-ended. We must have some kind of determinative timeline. And so six months was kind of pulled out of the air. And I think I was reading a history book during that time, and I kind of confluenced these two things. Like the DMZ, which is between North and South Korea, was very similarly. Like you think there's like this major like river or just something geographic. And no, it was like literally two guys late at night, and they had to figure out kind of like this list look where they're gonna put the line between North and South Korea. It feels like an applicable analogy that you think all this, you know, research and this is why the six-month prognosis, but actually it's not. And then we know those of us that have kind of grown up in this work is that physicians are really not so skilled at that prognostication. Um, you know, the median length of stay for many hospices is still 14 days or less, which means 50% of people are getting that very short length of stay of two weeks. Invariably, I've asked hospice clinician after hospice clinician if you were king for the day and you had the perfect length of stay where you did just knock it out of the park, patient family, beautiful life closure. We have all these beautiful mission moments where sometimes like families reconcile after years. That answer has been invariably about 60 to 90 days, which gets to kind of one of the questions, because I love how you're saying that good hospice providers should think about how do they take some of these competencies and go further upstream. I do believe a lot of the powdered care movement of our country, and I was part of the kind of pioneer organization that was doing that, it was born out of hospice. And now you're seeing that kind of morph somewhat into home-based primary care, although there are a lot of people kind of coming into the space that aren't necessarily coming from hospice, morphing to powder care to home-based primary care. I'm very biased, I will admit, because I've kind of grown up on that side of the house. But there's some core, beautiful competencies in hospice that I do think inform great podcare, that I do think potentially can inform great home-based primary care going forward into the future. But I do think there's this interesting thing about like, well, are these emerging things like what you're a part of at Advanced Care Innovations? Um, you know, it are are we like you probably have heard the term coopetition. Are we competitors or are they competition? And I feel like you're kind of poking on, like, I would fully agree that long length of stay are very susceptible. Like hospice at $5,000 a month. Um, but I guess it has the question is that um, because we actually learned this, I don't know if I share with you, we were part of the CMMI grant for to prove powder care for the country back in about 2016, somewhere in that ballpark, maybe 2015. And we found that at that 60-day length of stay of hospice, chassis to great powder care, great bending of the cost curve. You start getting beyond that 90-day length of stay. There's some good questionable things there. Now, I know there's the Nork study and a lot of other studies out there that say, well, hospice even at two years may save money. I would think going forward, two-year length of stay of hospice,

probably not gonna happen. But do you think even that 60 to 90 days, Dr. Hubbs, is at risk, or or do we just not know yet?

Dr. Jessica Hubbs 16:22
You know, I think that's the um, I don't know if we know yet. I think we've seen that in the data. And I see clinically, you know, huge opportunity. And I think one of the things we're even looking at right now with partners and and uh, you know, um opting not for competition, but cooperation and partnership to collaborate and build these amazing models and bringing this upstream is really our goal. Um I think that we're looking right now, we're looking retrospectively. Um, we're looking at, you know, not just the length of stay, but the diagnosis attached to it. We're looking at the services the patients received over the entire life, you know, their their time in care of hospice. And at what point did those services change? And and that will inform more objectively, I think, some of what we're hoping to see. But, you know, what I can say is I really does the physician want to be a prognosticator, and you said it, we're not very good at it. Um, you know, and and by really bringing a a clinician and a patient to me, you know, we're really looking for what's the right plan of care? What service do do we need to help support and really take care of and wrap around you? And, you know, it's not about six months or or even three months. It's we need this now to do right by you and being able to provide that. And so, um, you know, we'll see what the data says. I'm not a hundred percent sure how that will shake out. I do believe that those services change and that, you know, there's a point in time when we need, you know, really true hospice, you need the nurse, you need the spiritual care, you need bereavement services, you need all of all of those really wrapped around you with a frequency of those supports too. And so we'll see what that time frame is. I think the studies are out there and um hopefully we'll inform some of these models moving forward in the future to bring them sooner too.

How ACI Partners With Providers

Chris Comeaux 18:34
So I didn't tell you I was gonna ask you this. I did ask you to kind of give a quick thumbnail on advanced care innovations. But do you, are you more of that convener trying to shape how this goes so that way you provide good care and you're more partnering with people providing the care, or do are you a bit of both? You also own some providers on your own.

Dr. Jessica Hubbs 18:53
We're really partnering today. And honestly, it's one of the things I love about what we do at Advanced Care Innovation. You know, there's a lot of models out there that um, you

know, and I I come from the payer side. Um, that's honestly, and I'm grateful for it. That's how I got into home-based primary care in the first place, was through a payer and doing home-based primary care as a wraparound support from the payer. And the challenge with that was it was a little bit redundant to the primary care provider that already existed, but it was also filling that really important gap of home-based primary care where it didn't always exist in the network. And so, really, what I love about what Advanced Care Innovations is doing is that we have taken, you know, not being duplicatist to care that already exists in the landscape through home-based primary care, primary care, palliative hospice, but partnering with, you know, and really empowering the models and the supports as opposed to directly doing. And it's allowed us to really have extraordinary partnerships and really to wrap around the folks already doing the work and helping them to be successful in these models as opposed to, you know, duplicating it.

Chris Comeaux 20:13
Well, well, then I think this probably segues well to the next question.

Building End-To-End Clinical Capability

Chris Comeaux 20:17
So if you're able to walk into 10 hospice organizations next week, what would be the biggest capability gaps that are preventing them from succeeding under these new payment models? Um, and so that almost like you're able to coach them, like, okay, there's the gaps, and this is where you guys need to do better going forward.

Dr. Jessica Hubbs 20:37
Yeah, I think that's a great question. Depending on where a hospice palliative organization is at today, I think the biggest gap if if if they're looking to participate directly in home-based primary care and to participate directly in models like LEED, which I absolutely think is the opportunity um, you know, uh to participate and to expand the way you can care for patients the way you already do, but earlier on in the cycle. I I think the primary gap to solve for, solvable by the way, is um being able to start providing clinical care that's truly end-to-end. It's it's not um it's it's symptom management. It's symptom management plus all of the other complex coordinated care. And so it's really a clinical gap, potentially, uh, of solving for and bringing in providers who are are certainly symptom managing and strong in hospice and palliative, but also strong in really complex primary care. Um, you know, I think that that strength in the primary care itself lends itself nicely to being able to manage total cost of care and taking on financial risk if that's the direction an

organization is headed. Um, and so. Filling that gap or really expanding and strengthening on that clinical piece is important.

Chris Comeaux 22:07
I didn't tell you I was going to ask you this, but it's it's so fascinating to sit down and talk to you. And um, I've got now 30 years in hospice and powder care being part of Four Seasons Hospice was where we had done the CMMI grant. Dr. John Morris, Dr. Janet Bull, they were very influential. I kind of joke, they were kind of the grandfather, grandmother in some respects of definitely community-based palliative care. Diane Meier and others, CAP C incredible on the acute care side. We were one of the early innovators on the in the community. So I kind of look back, and uh we've even had Dr. Ira Byock on the podcast, and he talked about like one of the early hospice meetings they said around the campfire, and they envisioned a day that there would be textbooks about, you know, basically being a hospice medical director and just all the competencies. So fast forward, here we are about 40 years into this whole movement that started as hospice, Kubla Ross, you know, Dr. Sisley Saunders in England, and you've got hospice defined, you've got Palliative Care, you've got AHPM, the American Academy of Hospice Palliative Care Medicine, you've got CAP C. And you being a physician, I like, I don't know how much you interact with those entities, but is there like this new competency on the home-based primary care side? Because, you know, I was part of the senior leadership team of us growing up, these powder care providers, um creating a powder care immersion course, because even some of the fellowship programs, those providers were not ready to really be plug and play. And now you go further upstream with these high needs patients. And so is here's the gist of my question. Is there a skills gap? And and where is that skills gap being filled today for the providers that are kind of serving these high needs populations?

Dr. Jessica Hubbs 23:50
So great. I um I think it goes both ways, right? And and actually MPHI, this kind of conversation of where hospice and palliative fit and bringing services upstream into home-based primary care. And to me, you know, as much as it's adding in uh complex primary care management, it's also bringing upstream to home-based primary care providers and primary care period, the incredible strengths that hospice and palliative do so well, which is end of life, advanced care planning, having these really complex discussions, understanding a patient's why and what their wishes and values are. And I think a merriment of those skill sets really starts to build an extremely powerful, you know, care management, care delivery of wrapping around a patient and their family holistically. And so it is as much, you know, we absolutely need to expand our knowledge and experience with what home-based and prime uh palliative and hospice providers do so extraordinarily well. Um, it's a merriment of those two in my mind.

Chris Comeaux 25:03
Again, you're reminding me of Dr. Berwick's comment in the podcast. I forget exactly how I asked him the question, but something along the lines of, because he's obviously a great thought leader about where the future of healthcare needs to go for healthcare in our country as a whole. Great student of studying healthcare systems all over the world. Of course, he was in charge of CMS. And he, the gist of his answer was hospice is an amazing model. And there's wisdom in that model that needs to inform the rest of healthcare, was the gist of his answer. Feels like you're saying it just in a much more eloquent, very thoughtful, knowledgeable way because you're sitting in the catbird's heat of helping people kind of do that. Um, which maybe leads to another interesting question. So health

What Payers And ACOs Want

Chris Comeaux 25:46
plans, Medicare Advantage organizations, ACOs, risk-bearing entities, as they evaluate serious illness partners, what capabilities separate those organizations that get the contracts from those who do not?

Dr. Jessica Hubbs 26:00
You know, that's interesting. I, I think for us on the ACO side, I'll I'll start there. We're really looking for um collaborative care partners. You know, um and and and maybe because of I don't know if it's solely because of this, but on the Medicare Advantage side, it's a little counterintuitive. Um hospice is carved out of the MA benefit, it is um right or wrong for patient care. It isn't necessarily the natural progression to have that primary care provider concurrently alongside the hospice provider, you know, in really partnered management of that patient through end of life. And when we are seeking partners with hospice and palliative providers, it's truly that coordinated partnership to wrap around a patient. And it's critical in ACL. Um, and so when we're thinking about partnerships, we're really thinking about providers who are going to be true partners with us, collaborate on a care plan as a part as opposed to doing it in silo and starting to marry and bring together the care between the home-based primary care provider and the hospice uh providers or the palliative providers, as opposed to separating them the way we maybe traditionally approached it. And so and on the MA side approached it. Um, for payers and and you know, I'll speak to Medicare Advantage just because that's where my my past experience was. And we look for these things too on the ACO side, don't get me wrong, but it's that hopefully as clinicians we get better at identifying and making referrals to hospice and to palliative more timely, and or have all of those services under one umbrella, and it becomes less of an issue. But the time to, you know, from time to referral to time of bringing that patient into hospice care was really critical for us. And then, and then um,

you know, revocation rates and all of these pieces were things we tracked on the payer side that were helpful to have visibility to. But I think even that is starting to change and ACO is driving some of that change. Where if you ask me today, the number one thing I would seek in a partnership with hospice and palliative organizations, it's that they would partner with us and it would be concurrent for managed care as opposed to siloed care.

How Attribution And Preferred Networks Work

Chris Comeaux 28:31
Well, at the when we get towards the end, we'll definitely want any contact information that people do want to partner. Um, I didn't tell you I was gonna ask you this, but like what are the total number of participants that you guys have via advanced care innovations and then how many organizations are representative in terms of those total covered lives?

Dr. Jessica Hubbs 28:48
We um have about 20,000 patients this year in 2026. We expect that to grow in part because of um growth, natural growth, and also the way the model is shaping into lead, where now um, you know, practices really their entire panel uh can be under lead as opposed to today in in a high needs ACO. It's the high needs eligible patients within their fee for service panel. So that change in and of itself drives growth under a lead. Uh, but today we're about 20,000 patients over 33 states. Uh we partner with almost 70 unique tax IDs um and unique provider groups really taking care of patients directly.

Chris Comeaux 29:35
So um this feels like a good kind of lead-in question. So so let's say I had an organization, a great hospice and paradigm care program, and we're we're expanding our capability in home-based primary care. If and I come to you, is it my attribution of those patients that get you that patient population? Or do you bring the patients to them? Hopefully that question makes sense.

Dr. Jessica Hubbs 30:00
Yeah, absolutely. It goes, it could, it could be either, honestly, which is some of the beauty of it too. I I think there's a pathway for hospice and palliative organizations who want to directly participate in lead or, you know, other value-based models where they are the home-based primary care provider, they carry the patient attribution through their direct care and billing to have what we call plurality of care or services with those patients. There's also the other pathway where maybe an organization isn't wanting to take on full scope a new line of business effectively and participating directly or is in a different place

as far as taking on risks. Um they can be a preferred partner to organizations like ours. Uh absolutely a pathway in reach today and in laid tomorrow, where, you know, comparing networks of overlap, partnering as preferred providers, and really looking at these coordinated, you know, partnerships uh where we are in sync with a hospice provider. Um, and maybe even you know, bringing some of those services upstream in a partnership. There's a lot of opportunity for creativity there. Um, but uh but honestly, both pathways, preferred provider, participant provider, both are options. Don't

Don’t Miss Part Two

Jeff Haffner 31:26

Don't miss part two of this episode, coming this Friday.