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

Leadership Excellence Program Invitation

Chris Comeaux 0:00

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Sona Benefits Ad 1:35

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Jeff Haffner 1:55

Welcome

Show Intro And What's Ahead

Jeff Haffner 1:56
to TCN Talks, and Anatomy of Leadership. We continue the conversation with Dr. Jessica Hubbs. In part two, The Critical Competencies Hospice Leaders Must Build for Value-Based Care success. And now, here's our host, Chris Comeaux.

Chris Comeaux 2:18
As

Partnerships For Advanced Payment Models

Chris Comeaux 2:19
we go to this next segment, um, I think a lot of our listeners are probably thinking about this. So no organization can really build every capability internally. Like, you know, you're you're based in California. You see a lot of the icky stuff in the news, which by the way, is not that is like that is like the most horrible press because um I think it was with Kim Brandt, the director of CMS, chief hybrid officer of CMS. I think she or I had just heard this analogy. Like, there's this guy that was part of the NBA that apparently was throwing the basketball games, like he was betting and like like intentionally doing stuff to lose the game. And we drew the analogy of like some of these horrible situations in California. It like be like LeBron James compared to the guy who's throwing the bat. They're not even playing the same game. One of them is trying to become world-class, the other is like, you know, trying to screw everybody up. And it was an interesting analogy that I thought. So anyway, I hope that doesn't kind of taint your perception of hospice because you're in California. But the reality is hospices have so much today they're trying to navigate. And then if they're kind of behind and they're like, we need to start a pilot care program. And now these guys are talking about like serving high needs with home-based primary care. So there's some people, they just can't develop every capability internally. What strategic partnerships do you think become essential over the next five years for organizations wanting to participate successfully in some of these more advanced serious illness payment models?

Dr. Jessica Hubbs 3:48
I um I'm an advocate for hospice and palliative and think that, you know, I too agree that what we're seeing in the news is so unfortunate. Um, you know, and and hope that more comes out to really empower and support the incredible care that really is provided by so many organizations, especially not-for-profit hospice. You know, um, sometimes a small

subset can really shape the view of the entire um landscape. And and so um, you know, I I think that there's more to come there. But the services, as somebody who, you know, I have patients on hospice and I've had family on hospice, and it is an extraordinary way to really take care of a person. So I, I hope that that is the message for for people and communities, even with all of this other out in the press. But um, as far as you know, being prepared, getting into the value-based models, thinking about what helps to be successful, what capabilities you you really need, I think that it's first, you know, thinking about what you are or are not willing to do as an organization, your readiness. Do you want to be a home-based primary care provider and really integrate some of your services upstream? Do you want to test the waters maybe through a preferred partnership first as you're really building some of those strengths or thinking about how you can shape some of your care delivery to bring services upstream upstream, either directly in home-based primary care or indirectly as a preferred partner. So number one is just, you know, knowing maybe your landscape and what your preparedness is, and knowing that there's a pathway for both. And then two, I think it's, you know, maybe having conversations with folks like us and uh getting a sense of what services, what's the need, what are the challenges on the ACO side, um, you know, and and how do we solve for those together? Um, you know, through preferred partnerships or even jumping in uh full circle into um value-based care directly.

Chris Comeaux 6:03
Good deal.

Blending Primary Care Palliative Hospice

Chris Comeaux 6:04
If you look five years into the future, what does the ideal serious illness care model look like? Which might be a hard question. If we got everything right, patients, families, providers, and payers experience care in a much better way compared to today, what might it look like?

Dr. Jessica Hubbs 6:20
You know, I um I I'll take a stab at it with the caveat that maybe I'm wrong. Or maybe it's a version of this um uh reiterated multiple times over. I really think that it's going to be uh the amalgamation of today home-based primary care, palliative, hospice, three different payment models, care that really belongs together. And the more cohesive it is, the better the direct patient care is. Um, and the sooner we can really access those supports upstream. Today there's a six-month limitation and often eligibility limitations to receiving some of the services on hospice, unless you have that terminal diagnosis and the

prognostication that of us are very good at of six months of life loss to access perhaps it's a home health aid and um some easier access to DME. And then, you know, when you do need additional services and resources or the cadence of your needs change, you're really starting to use that full benefit. And so to me, what that looks like five years from now is blending that together, being able to have a patient still with their home-based primary care provider, strong palliative as a part of that, and some of the hospice services integrated into that care, irregardless of six months, and then referring into hospice, you know, for that full scope of care um based on the complexity and need when that when they need. Um or maybe it's altogether. I, I don't know. Um but that to me, it's it's the blending, the merriment of of those three pieces and getting really strong at that. Um, and and not having to worry so much about access to services based on time, but access to services based on need.

Will Concurrent Hospice Care Return

Chris Comeaux 8:21
So these feels like questions. I love your answer, by the way. And so um, this might feel like a curveball, and you could ask me a question in return, but the carvin feels a bit like a potential curveball. Do you think that the carve-in might come back around? We know the V BID was not successful. Um, we've all got maybe a little bit different intel, but one piece of knowledge that I kind of gathered through some of these conversations is that one of the key reasons why the VBID was sunseted is that the devil in the details of some of the payers getting it actually paid. Like, isn't it kind of crazy sometimes? Like the way systems and processes work are like the ultimate divide demise of something that might be a great idea. And so again, I don't know how truthful that was, but it was kind of an insider, hey, I'll let you know this is kind of why it wasn't successful. The systems and processes really didn't allow a lot of the payers to pay for a hospice um further upstream concurrently Carved -in. And so, do you think the Carve-in might come back around? I don't know if you have an opinion about that.

Dr. Jessica Hubbs 9:24
I don't know. Um it's possible. Um, but I, I genuinely don't know. Um, it's something I'm watching too, um, you know, especially as they start to make the programs ACO, lead, Medicare Advantage, MSSP, you know, I won't say equal playing fields, but more competitive with one another. Um, you know, and and trying to align some of the design, you know, and and down to the the financial modeling. Trying to make them a little bit more apples to apples than perhaps they are today. I could see that happening, you know. I d will it? I don't know. Um, you know, but could it, sure, you know, and and could we be prepared and ahead of it irregardless of what they do or don't do? Absolutely. You

know, to me, leads the opportunity to learn that now and and maybe offering those wraparound services, you know, it fits the need for payers too, um, to be able to access those services for, you know, maybe their top 20% of the population who's falling into this high needs cohort, you know, that need is there today. They might view it a little differently, but um, I think now's the opportunity, and and leads really created a pathway to to start to build these models and these engines for more integrated care.

Medicare Advantage Incentives And Complex Care

Chris Comeaux 10:47

You don't have to make any comments to this, but one of the reasons why I loved having Dr. Berwick on the podcast, he was one of the first ones. I think it was a health affairs article. Start being critical of MA plans, that the original hypothesis of MA is that it was going to bend the actual cost curve, but yet through coding, et cetera, they actually cost more than traditional Medicare. But this is the part that I know there's a lot of great people. I know in MA plans, wonderful human beings doing great work. So I fully own that. But yet, about 20% of MA expenditures and are in the crazy administration. But yet, traditional Medicare is only 3% of every dollar. So three cents on every dollar goes through administration. But yet in MA plans is somewhere between 16 and 20%. And one of the um, we had T.R. Reed on our podcast, he went and researched every healthcare system in the world. He wrote a fascinating book called The Healing of America. And he was on the board of this uh large healthcare system, he left it a name, but he's like at the ribbon cutting, standing next to the CEO, and he goes, Mr. CEO, this beautiful building that we're doing the ribbon cutting on, what healthcare will be provided in there? And he goes, What are you talking about? That's like the billings and collections. And it's it's a really interesting commentary of that's you know, that's not the best place for us to expend resources on the future of healthcare, especially the baby boomers, the complex needs, a number of people, multiple comorbidities, chronic diseases, et cetera. So again, I told you you totally could take a pass. I don't know if you want to make any comments on all that. Um, not disparaging, there are great people working in MA plans. There are some great MA plans out there, but there's something wrong kind of in the general system.

Dr. Jessica Hubbs 12:26

You know, the one comment I will make is, you know, there's been headwinds and downward pressure across the board in healthcare. Um the risk adjustment hit a lot of the MA plans hard. And actually, within that, not that that was the only reason, but we actually, you know, saw some plans perhaps shy away from taking care of really complex high needs patients. And that to me is the exact opposite of of what we need and uh what we can really support and and ultimately be successful as a payer, uh, as an ACO, if you

double down on serving the patients who need you the most and and do it well. But by do it well, it you have to be really strong at good clinical management, which is really integrated care across the three pieces we've been talking about today: home-based primary care, strong primary care, strong palliative, advanced care planning, and strong hospice services. And the better you get at that, the better you get at integrating those, the better you get at really supporting the patients who need that level of care. And and also identifying who those folks folks are at the right time. So the plans who have doubled down on complex care management and not shied away from it in MA and ACL across the board, I, I am hopeful and excited. I think they're gonna do well. And this is my, you know, two cents on the matter. But I, I think the the stronger you get at that, at true quality patient care, the better off you're gonna be down the line and not shying away from those patients, but really serving the people who need us um the most at the right time.

Chris Comeaux 14:16
Well

Dementia Length Of Stay Reality

Chris Comeaux 14:17
said. And you took us back to the mission, which is exactly where most of our solutions should come back to is what's best for the patient and family. Let me ask you this question. I didn't tell you I was gonna ask you this, but I was thinking when you were alluding to earlier, um, looking at multiple disease diagnoses. And I would imagine Alzheimer's is so difficult. We had Dr. Joan Tino on this podcast. I'd never heard it phrased this way, but to me, it's such a great sticky way. She said it's a death by inches. And so that makes it so difficult. And some of the profiteering in this space has been on some of those very long length of stay patients. Um if you look at the typical distribution of a hospice of the length of stay of their patients, it's a backwards J. So if you got 14 days or less, you got a peak, then it goes down, and then you got how long that tail is, might depend upon some of your non-cancer diagnosis, especially like Alzheimer's and that those long, long, long lengths of stay. And um, one of the physicians who I was kind of raised by, which is kind of a joke, I'm the CEO, but I was raised by great physicians. And so it was a great student, they were brilliant, and it was all about the care model, which is why I love this work that we're doing in Teleios. And so she would say out loud, I'm not sure the best model for some of those dementia Alzheimer's patients, because again, now I would phrase it by a death by inches. Have is that kind of what you were alluding to

earlier about disease diagnoses? I mean, we don't have to go too far into it, but I love some of your thoughts around that.

Dr. Jessica Hubbs 15:46
It it is, you know, and it's interesting. What what we see in the data aligns perfectly with um, you know, death by inches is a really um profound way to state that. Um our data aligns with everything you would expect to see clinically related to dementia, dementia-related diagnosis. And I, I think that is the perfect example and application of you know, really blending these services together. We have patients who, you know, let's out outside of the profiteering and and negative applications, which I, I don't believe are the majority, you know, let's let's learn from that, you know, because we're saying six months arbitrarily, because we need to, and there has to be a financial model that's sustainable, but we have patients and we have a diagnosis where we know the duration and need for those services is longer because of the disease process itself. How do we look at that and learn from it? Understand what the supports that were needed across those couple of years, more often than not, that we see on hospice. And then how do we start to shape a model that makes that more financially sustainable, but doesn't impact the quality of care and the level of services that we can support a patient and their family with. So that's the perfect application in my mind. Let's look at that, let's learn from it, and let's figure out how to develop a model that allows those patients and families to access the support they're getting on hospice sooner, perhaps in a different payment structure.

Chris Comeaux 17:30
Yeah,

Preserving Hospice While Expanding Upstream

Chris Comeaux 17:31
well said, which now where I want to go to this one. Almost like, let's take Alzheimer's aside for what I'm about ready to say. And why I love doing this podcast, Dr. Hubbs, is I learn from amazing people like you. So this is my thought today. And the beautiful thing is I may think differently 60 days from now. But because that backwards J is the typical distribution of hospice, if could we go into a future where it's much more like a bell-shaped curve, but it's a very steep, steep bell? And the median is pretty close to the 60, and the average is pretty close to 60, with not much on either side. Like that's the ideal length of state. Remember, I said I've asked many clinicians. And that hospice at 60 days, maybe no more than 90 days, is a beautiful model. And then you take those competencies and go further upstream, palliative care, home-based primary care, but they're not that full model that is hospice. You have you have aspects of it that are further

upstream, but that Cadillac, if you will, or you know, hospice model, because it's it is costly, so you can't go too far upstream with it, but you have aspects that that is the future where we end up, as opposed to, well, let's erase all of those lines and you've got these clinical competencies, and you allow the people driving the care to weave the clinical competencies. My concern today is we still may lose something in that process. And this is one of one aspect I've debated with clinicians. I would love to hear your viewpoint. There is something about the election of the benefit. As human beings, we are death adverse. One of the kind of ways I say it is kind of a joke is everybody wants to go to heaven, nobody wants to die. Um, and you know, why do we have that 14-day lent this day? Dr. Tino has said there's always about a third of the population. She calls them the hell no, they won't go kind of people. And so that's why, you know, we see like death service ratios kind of peaking out at about 55% or so. And so, could we create such a beautiful continuum that you're able to get the vast majority of people in that 60 days, but you've got palliative care and home-based primary care further upstream? And because if you eliminate the election of the benefit, there's so many beautiful stories I could tell you, families reconciled after many years being in therapy and just not communicating with one another, but dad is now dying. And they could put aside some of those things, and then great hospice creates beautiful death, and the family is changed on the back end of it. One of the stories I tell in one of my leadership talks is this guy talked about how he was transformed as a CEO of an organization of 10,000 people. He said I was an SOB to work for. I happened to go up to the guy at the end of the presentation and he asked me what I did, and I told him I work in the hospice. Well, the guy starts crying, like right in front of me, and I thought, oh my God, this is gonna be a fascinating story. And it was, it was a hospice experience with his mom that was that transformative experience. And he became a different CEO to 10,000 employees. And think of the impact on those 10,000 employees and their families, because we've all probably worked for a bad boss before. We take that home with us. So I just threw a lot at you. Kind of today, my belief is if we can preserve it to be about 60, 90 day window, as opposed to erase the lines and it's just called serious illness. But I am debating that myself. So I'd love any wisdom that you have.

Dr. Jessica Hubbs 20:57

You know, from the clinical perspective, I I want my patient to be able to have the services that are gonna support them most. And so if that's 30 or 60 or 90 days or two years, I want to have access to the services so that I can include that as part of my care plan. Um, and so that my patient has what they need. And, you know, uh I'll I'll use this as a measure. It's one of actually my favorite quality measures uh uh that we have today is days at home. You know, rarely some people want to pass away in the hospital, and that's okay. Um, but most people don't. You know, so how do we increase their days at home? We talk about um mortality, you know, maybe a little bit less about morbidity. You know,

what is um the days at home? What is the not just the duration of life, but also the quality of life with which we live uh in end of life? Um I'll quote my Amazing colleague Dr. Tom Cornwell. You know, he says, Hope for the best. And I do too. He's I'm uh so grateful and lucky to have him as a colleague and on our team. Um hope for the best and plan for the rest. And you know, I, I don't know what that bell curve will end up looking like, or even how the benefits benefits will shape over time. I do think that, you know, policy is slow. Policy is smart, but policy is a little slow. And I don't know that even I, you know, I don't necessarily want to see all of those lines erase either. You know, I I would agree with you that philosophically there maybe is a shift, you know, when somebody is really enrolling into hospice care and everything that comes with that. Um, but that's also for us to learn, you know, clinically what that looks like and what that right way to approach it is that is cohesion for the patient, because they're not looking at us as a hospice provider and a home-based primary care provider and a palliative provider, they're looking at their care team. We're all the same. And so, you know, how do how do we allow it to be all the same for them with the right care and support?

Chris Comeaux 23:19
That's so well said. So well said. You need to tell Tom that I said hi, by the way. So fun fact um, every year, I don't know if you ever heard the term go to gimba, but Toyota teaches their leaders that you got to go see for yourself. So traditionally, until COVID, every year I would go out on patient visits, even though I'm a CPA by trade. And I've started that when I was 25 years old and I continued it. Well, my go to gimba that year is I went because I want to learn home-based primary care. So I went and shadowed with Tom. This was February 2020. So we did not know what we were seeing front lines was the beginning of COVID. And so I was with Tom for a couple of days doing home visits with them. And it was a such an amazing learning opportunity, literally to go out in the field with him, watch him do the work. And then 30 days later, I realized, my God, all those respiratory infections we saw were like the early part of COVID. Yeah. So anyway, you need to tell them that I said hi and I told you that story.

Dr. Jessica Hubbs 24:15
I will. I absolutely will.

Three Investments For The Next Year

Chris Comeaux 24:18
So a couple, a couple of final questions, and we'll kind of land the plane here. So if you're speaking directly to hospice and path care CEOs listening, what are three strategic investments that they should think about making over the next 12 to 24 months to

position their organizations for success in this rapidly environment that changing environment you and I have been alluding to?

Dr. Jessica Hubbs 24:39
I think um, you know, as far as investments, invest in the clinical arm, especially if you want to directly participate and lead, invest in that clinical chassis that's gonna allow you to take care of patients across the continuum and really integrating the care across, you know, three arms of the organization. Data, you know, I, I part of me loves to say it and part of me hates to say it, but data is powerful. You know, it helps us understand what we're doing well and where we have opportunity for change. And so to me, you know, knowing your outcomes today, knowing, you know, data around perhaps some of your longer length of stays. And, you know, if it is um dementia, dementia related diagnoses, which certainly is compatible with what we see, you know, uh, what's the opportunity there? You know, how do we kind of bring services upstream with partners like an ACL? Um, you know, and and really thrive in this kind of reimagined model. Um, so data, I would say. Um, and then, you know, partnerships, uh, building partnerships across your network. And um really um perhaps historically we've thought about partnerships in the form of um, or at least I have, um, I'll speak for myself there. I've thought about networks as far as a hospital network and a SNP network, but I think we're in a place right now where the network is was the provider, you know, and and a home-based primary care provider, perhaps. How do we build that network of partnership um and get really strong there? Um, but I think those are the three things.

Chris Comeaux 26:25
Perfect. Well said. Well, um,

Leadership That Stays Patient Centered

Chris Comeaux 26:27
I'm kind of passionate about leadership. The podcast is called TCN talks, the Anatomy of Leadership. So I have to ask you a leadership question. You know, healthcare is full of uncertainty. I mean, I, I love, I love your consistently, your answers take us back to the mission. I think that's so beautiful. Um, and ultimately I think that's how we're going to navigate this uncertainty. But leaders can easily become consumed by the regulatory changes, the payment reform. From your perspective, what distinguishes leaders who merely react to these changes from those that perhaps are catalyst to build better systems for serious illness, seriously ill patients going forward?

Dr. Jessica Hubbs 27:04

I um, you know, I, I love that question. And we we talked a little bit about bosses today. And I had the immense pleasure of having a really extraordinary boss when I was first um really getting into the payer side of the house, which I never envisioned myself doing as a clinician. And and he used to say that um healthcare is the one place where if we if we just do right by the patient, the rest will follow. And I, I truly believe that to be true. Um that you do right by people, the rest will follow. The the finances follow, um, the rest follows. And so for me, it's reminding ourselves of that. And then it's, you know, right now it's scary. It it's a change in models, it's a change in reimbursement structures, there's downward pressure on everybody in healthcare and trying to navigate these big structural changes. But I think it's um if we stay focused on doing right by the patient and being innovative and not shying away from it, you know, and and really more integrated care. If we stay focused on that um and and and lean into it, don't shy away from it. You know, there's immense opportunity right now.

Chris Comeaux 28:25
All said. Final thoughts. You have the year of hospice and palliative care leaders. What final thoughts, wisdom would you like to share with them?

Dr. Jessica Hubbs 28:32
I um am so grateful for the work and the presence of hospice and palliative to serve patients. Um, you know, our our care and certainly for our high needs patients wouldn't be what it is without that. And so thank you. And um I can't wait to see what is ahead for all of us because I think that it's it's more of getting to work together.

Chris Comeaux 28:58
So well said. Well, thank you to you and your team, the work that you're doing. I'm so glad. Thanks for agreeing to do this. When I heard you on stage at NPHI, I'm like, we need to meet Dr. Hubbs and we need to see if she'd be glad to be on the podcast. And so thank you. And you're doing some fascinating work. This is a fascinating time for us to be alive. Um, I've got about 30 years now, kind of growing up in this beautiful field that is hospice and palliative care. And it does feel like we're at an interesting crossroads. And how do we shape what the future looks like? Um, having Dr. Byock on the podcast was pretty fascinating. And for him to say, yeah, we sat around the campfire and we envisioned days that, you know, people would actually there'd be fellowship programs, there would be textbooks. And here we are living into that. And it made me wonder, well, what are we envisioning? What are we bringing about in that future? And I think a lot of the things that you've um kind of painted the picture with your amazing words today, I think starts to give us an idea of what that future is. My um, I'm kind of a detailed thinker, a process thinker. I get a little anxious going, oh my God, we have so much work to do then to kind of bring that future together and um change management. It's going to be

fascinating amongst all that. But back full circle, thank you for the work that you're doing and thank you for taking the time to have this conversation.

Dr. Jessica Hubbs 30:14
Oh my goodness, thank you so much for having me. It's such a pleasure and um love the conversation and I appreciate it so

Closing Thanks Quote And Subscribe

Dr. Jessica Hubbs 30:22
much.

Chris Comeaux 30:22
Yeah. And 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. It's to be a thought prodder, but our podcast subject to further your learning and growth and thereby your leadership. We're hoping it sticks like a brain tattoo. Be sure to subscribe to our channel, pay this episode forward to your friends, your coworkers, other leaders in the hospice and palliative care space. You know it's easy for us to rail against the world and be frustrated by things. Let's be the change that we wish to see in the world. So thanks for listening to T CNTalk's Anatomy of Leadership. And here's our Brain Bookmark to close today.

Jeff Haffner 30:57
If we don't ask the why, we miss the solution. — Dr. Jessica Hubbs