Transcript

Rebecca Ramsay on Home Based Primary Care

Melody King: 0:01
Welcome to TCN Talks. The goal of our podcast is to provide concise and relevant information for busy hospice and palliative care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host Chris Comeaux.

Chris Comeaux: 0:23
Hello and welcome to TCN Talks. I'm excited Our guest today is Rebecca Ramsay. She's the Chief Executive Officer of House Call Providers. Welcome, Rebecca.

Rebecca Ramsay: 0:33
Welcome. Yeah, it's great to see you, Chris, and I just want to thank you for inviting me to talk with you today about something that I spend a lot of my waking hours working on and something that's really near and dear to my heart, so I'm really excited about this conversation.

Chris Comeaux: 0:49
I'm excited too. Hopefully you didn't feel stalked because there's an NPHI meeting. I'm like across the room like I want to get Rebecca. I want to have her on this show. And I think we were actually both running to the bathroom between a break and I said, hey, I want to get you on the show. And that was the beginning of what finally, we're able to get you scheduled. So before we jump in, Rebecca, what do you want our audience, what do they need to know about you and your story? It's always a great way to connect with our listeners.

Rebecca Ramsay: 1:15
Yeah, well, personally, I live in Portland, Oregon, with my husband of 25 years and our labradoodle, Ava.

Rebecca Ramsay: 1:22
I have two young adult sons that I'm very close with, and they both live in the southwest, and I love the outdoors, cycling, gardening, and I'm a bit of a foodie, so I also love to cook Professionally. I think what would be helpful for the listeners to know is my background's, a little bit unique. Within the field of healthcare delivery, I, after earning a bachelor's in nursing and working as a nurse for about a decade, I went back to school and got a

master's in public health with a focus on policy and administration, and directly after graduate school I took a position with a community-based Medicaid nonprofit health plan by the name of Care high-quality actually still technically work for them, because House Call Providers was acquired by Care Oregon about eight years ago.

Rebecca Ramsay: 2:15
But before that happened, my position at Care Oregon for many years was to design, develop and expand the health plans, clinical case management and expand the health plan's clinical case management and population health programs. So, my approach to that work was to learn from our health plan members and from our network of primary care providers what gaps they were experiencing in the health care system so that our case management and population health staff could provide complementary rather than duplicative services that were also really meaningful to people. During my tenure at Care Oregon, I also had the opportunity to see firsthand what it takes to design a payment model that incentivizes the right things, things like, you know, innovative, high quality, holistic care that helps plan members achieve their goals. So that's the unique part of my background is that when I moved into the CEO role at Housecall Providers, I had those 12 years of experience working within a health plan and it really taught me how to be the best partner I could be to now the payers that we're contracting with across our three clinical programs. So I've been on both sides the payer side and the provider side.

Rebecca Ramsay: 3:44
Yeah, and I guess the one other thing I would say that has really significantly influenced my career and my values as a leader is that I have only worked for nonprofit healthcare organizations that were committed to serving patients first and foremost. So, while I do believe there's room for all kinds of organizations in healthcare, I just have a personal belief that there and I think there's ample data to support it that when we remove the need to return profits to investors, we usually see the results in higher quality care for patients most of the time. So you know, Chris, you know as well as anyone how difficult it's become for nonprofit hospices to stay viable. Given just the exponential growth of for-profit hospices and in our community like so many, the options for patients to choose nonprofit hospice are disappearing.

Chris Comeaux: 4:42
Well, that's exactly. You're definitely getting in my passion zone here. Before we. I didn't tell you I was going to ask you this, but I just have a sense that I mean you are again. That's why I wanted you on the show. You're one sharp cookie. But I also get there's a deep passion about why you do this work. But I've never asked you why do you do this work? Why did you become a nurse? Why do you do this work?

Rebecca Ramsay: 5:03
Why did you become a nurse? Is there a story there? Probably the story is exposure to my father, who was a physician, and my mother, who was a psychiatric nurse practitioner. And particularly, but I have you know, my whole career has been focused on working for nonprofits but also working in a vulnerable population space. And when I grew up we lived in a rural town in Oregon.

Rebecca Ramsay: 5:34
My father was a specialist. He was a urologist, but almost all of his patients, or the vast majority, were Medicare age patients, or the vast majority were Medicare age. And in that rural community and some of you who are working in rural communities probably know this dynamic the Medicare rates were just really really low. There were also at the time a lot of uninsured patients that he was seeing. So he regularly would receive payment for his services in the form of huge packages of salmon, homemade furniture that would end up on our deck and all kinds of things. That just kind of speak to that value that he had, which was everyone deserves healthcare, no matter, you know, their circumstance or their ability to pay, and I think that really kind of shaped my, my values as I went into the healthcare setting.

Chris Comeaux: 6:39
That's so cool. I'm so glad to ask you that question. I just it was just something that tweaked me. I've never told that about you, but I just get a sense that you have a deep passion for this work. It's not a job to you, it's something more than that and that's probably one reason why I've kind of reached out to you. The other reason is you're just in a very unique program because many other community-based nonprofit hospices that you and I NPHI of hang out with didn't grow up the way. How you got in the hospice, you started off on the home based primary care space and then later expanded in the hospice. That makes you a bit of a unicorn amongst the groups that you and I peer group you and I are part of. Can you talk about that journey, because I just think it gives you a very unique perspective.

Rebecca Ramsay: 7:24
Yeah, of course, and you are correct that House Call Providers has a really interesting history and, just professionally, for myself, hospice was something that I had to learn. I'm still learning. Thankfully, there are a lot of people at House Call Providers who grew up in the hospice space, but that definitely was not my background. Call providers who grew up in the hospice space but that definitely was not my background. So I have learned a tremendous amount from those colleagues at NPHI that have been in hospice longer than I have. So the organization was founded in 1995 by Dr Benneth Houston who, as a girl, went out on house calls with her physician father in Southern Oregon and, after

graduating from medical school herself and practicing for several years, dr Husted felt called to practice home-based primary care and opened house call providers in the Portland Oregon region at that time to primarily care for elderly and frail homebound patients. The practice was the only one of its kind at that time and it grew pretty steadily because she partnered with the adult care home community, which is really large in this Pacific Northwest region, and with what is now known as Aging, Disabilities and Veterans Services region, and with what is now known as Aging, disabilities and Veterans Services In 2009,. So 14 years after the House Call Primary Care Program was created, the House Call Providers Board of Directors made the decision to open a hospice program. So, to clarify, that decision was made before I joined the organization as its CEO and I am really grateful to my predecessors for creating our hospice, because we are now proud to be among the very few nonprofit hospices in the state consistently surpassing the statewide averages in both patient quality and experience wide averages in both patient quality and experience.

Rebecca Ramsay: 9:28

The reason that leadership decided to open a hospice 15 years ago is that they saw this opportunity to do an even better job serving our patients across a broader continuum of care. So our primary care practice takes care of patients of all ages above the age of 18. So 18 to you know. I think we have a patient now who's 107. But they're often in the last years of life at some point under our care and our providers were regularly referring these patients, who had developed deep trusting relationships with those providers and our organization, to an outside hospice when they became eligible and interested in end-of-life care. And, as I know your listeners will understand that transition to hospice is often a very emotional one for the patient and their family, and so house call providers recognized the profound benefit to our primary care patients and their families of offering a relatively seamless transition to hospice within that same organization that they knew and trusted. So, our hospice.

Rebecca Ramsay: 10:36

At that time in 2009, the plan was that we were going to just serve our own primary care patients, and so we figured it would be relatively small hospice but, you know, we would have those trusting relationships and that continuum of care. Quickly, our reputation in the community grew and they you know, these stakeholders and community partners that had been referring primary care patients to us began referring their own patients to our hospice. So, a few years later, we began accepting referrals into our hospice from external providers, and today our hospice census is driven by a mix of about 35-40% from our own primary care practice and about 65% from external referrals. And then one other thing I wanted to mention because some of your listeners might not know this there's actually another clinical development milestone in our history, and this one actually did occur

during my tenure as CEO. In 2017, we added a community-based palliative care program as a third clinical service line in our home-based practice, and I know a lot of the hospice organizations and leaders that are listening, have probably done that over the last decade or so.

Rebecca Ramsay: 12:00
This program that we created was uniquely designed to care for Medicaid and duly eligible beneficiaries, so it has some really unique care model design elements.

Rebecca Ramsay: 12:11
For instance, we have a housing specialist and a social determinants of health specialist on that team and it generally serves a younger population than some might expect. It generally serves a younger population than some might expect and I'm mentioning this because I actually listened to the last TCN Talks episode with Torrie Fields, who's actually a friend of mine and used to be a House Call Providers board member, and she spoke about the really exciting palliative care progress that we're seeing among state Medicaid programs. And I just wanted your listeners to know that Oregon is one of those bright spots because we recently passed a Senate bill 2981, which is Oregon's version of a mandated Medicaid palliative care benefit, which is different than, for instance, what's happening in Hawaii, where they did a full state plan amendment, and I think that is just absolutely the direction we need to go For now. We're happy with this Senate bill and leaders from our organization were instrumental in providing input into the design of that benefit, so it's just really exciting yeah.

Chris Comeaux: 13:17
Great stuff and again just shows you the unique, just the unique position that you're in. So obviously a lot of our listeners they get hospice, they get palliative care, but where I wanted to have you is just, you're such a great expert about home-based primary care. What would you want our listeners, those people that you walk around with an NPHI, what would you want them to know about home-based primary care?

Rebecca Ramsay: 13:41
Yeah. So that's a great question and it would be interesting to know what others in this field would say. But I think for me and for most leaders who are really deep into the home-based primary care space, the intent is to deliver primary medical care directly in the patient's home, just like you do in hospice. But this is comprehensive primary care services and so, rather than going to an office to see your primary care provider, your primary care provider comes to you and they might come to you in an adult care home, in a private home, in a assisted living or memory care facility. You know we see patients across a variety of settings. So when we say home, it's a broad definition and it typically

serves individuals with complex chronic conditions and functional or cognitive limitations that make it difficult for them to get out to a traditional brick-and-mortar healthcare setting. And it's a really effective way to deliver medical care to these patients because it cuts through a lot of the barriers that people experience, especially those with complex chronic conditions and serious illnesses, and it enables access to really responsive primary care for those patients that would otherwise struggle to engage in preventative care or chronic disease care. So the philosophy of home-based primary care is actually really similar to hospice in that it places as much emphasis on the holistic person, the social, emotional, spiritual aspects of a person's health care experience, as well as on the medical aspects, so it offers a more personalized care experience, and all of these things typically result and we have quite a bit of data now to show this typically result in much better clinical outcomes and reduction in acute care spending, acute care like unnecessary ER and hospital visits.

Rebecca Ramsay: 15:54
A couple of other things to know. you know, typically it's thought of as a service that's tailored toward a frail, elderly, homebound population, but this is changing and, for instance, we have developed strong partnerships with several Medicaid and duly eligible plans in our region. So, we actually care for a significant number of Medicaid patients that are younger and maybe wouldn't be considered homebound using a traditional definition, but they face significant barriers to accessing office-based care Dragonfly they just do much better with medical care that comes to them. Some of those younger individuals do actually have physical disabilities or maybe developmental disabilities that really do keep them in that sort of homebound criteria, but a lot of them don't. Yet they're still, you know, they're still experiencing these barriers and we're finding that we're delivering really good outcomes to these payers. So, we continue to have a lot of demand to care for this younger population and I think this just validates the uniqueness and effectiveness of this care model for a broader population than maybe we once imagined.

Jeff Haffner / Dragonfly Health / Ad: 17:13
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Rebecca Ramsay: 18:00

So there's so much I could say, Chris, and I'm trying to just in the interest of time. I'm trying to focus on what I really want your listeners to know. So, let me tell you about two other things, or do you have a question?

Chris Comeaux: 18:10
No, actually. Well, I think you probably were going to go here, but I have a sense that it is your model. Is it much more interdisciplinary than maybe folks might think?

Rebecca Ramsay: 18:21
It is yeah, and again, this is, I mean, just like hospice, really similar to hospice. Home-based primary care actually requires a multidisciplinary approach. You know, nearly all successful home-based primary care programs have an interdisciplinary team. Usually there are nurses and social workers that are also providing home visits, either in between the provider visits or sometimes alongside them. And in addition to social workers and nurses, our practice actually provides services from a clinical pharmacist who can visit patients or talk to them on the phone and also does a lot of consulting just directly with our primary care providers.

Rebecca Ramsay: 19:10
And what's interesting about her is that she actually has a specific training in palliative care pharmacy. So just a really good fit for our practice. And then we have a behavioral health counselor, which is really unique because, you know, particularly for those individuals who are homebound and really can't get out, if they have a behavioral health condition, they can't get out to see a specialty behavioral health provider, so our behavioral health counselor will go and visit them in their home. And then we also have a spiritual care counselor in our primary care program. So these other disciplines facilitate that holistic care approach and really give our patients the best chance of staying out of the hospital, out of the skilled nursing home and living as independently as possible in their homes.

Chris Comeaux: 20:01
Is there, like? I hate to call it an average and let this stay, but have you ever looked at like what's the amount of time that people stay in the home-based primary care program?

Rebecca Ramsay: 20:11
Yeah, you know we don't tend to measure that just because it's so.

Rebecca Ramsay: 20:15
It's a continuous program and so I mean, I've looked at the, I've looked at the variability and you know we have patients who have been on our service for the entire time, so we

still have patients that we've been in existence. So we still have patients that started as younger patients at the beginning of the practice almost 30 years ago who are with us. Not very many. The vast majority of patients are with us. I would say between three and probably five years, and the average age of the patient population in primary care that we serve when I started eight years ago in this role it was around 83. And it's dropped to about 78, 77, 78, because we're actually bringing on more Medicaid populations gotcha, yeah, yeah.

Chris Comeaux: 21:10
Really that Medicaid population really necessitate the behavioral health person on the team or did that precede that population?

Rebecca Ramsay: 21:19
really good insight it. I think that the providers who have been with us for a long time much longer than I've been here, we actually have a lot of longevity would say that they always wanted a behavioral health counselor, because obviously, behavioral health conditions don't discriminate based on age or payer model or any of that. I do think that that need became more acute as we started broadening the population that we were serving. So the other thing that we do in the behavioral health space is that Care Oregon, our parent company, has psychiatrists who are working at the health plan level and they actually provide training and didactic training sessions as well as consultation to some of our providers when they're really when they're struggling with a particular mental health or behavioral health condition.

Rebecca Ramsay: 22:28
And then Oregon has a telehealth consult line called I think it's called OPAL is the and of course I'm not going to remember the name of it or the name of the acronym, but it's a, it's a telehealth expertise around behavioral health that you can actually call into as a provider and get sort of almost immediate or pretty immediate consultation. So that's really a great resource as well.

Chris Comeaux: 22:57
I'd love for you to answer this question. So again, it's so unique that you started the home-based primary care side, or your program did, and expanded into hospice. Then you've got many of our peers who have hospices and are sitting there kind of twiddling their thumbs, debating paralysis of analysis. So why should they consider launching their own home-based primary care service line from your perspective?

Rebecca Ramsay: 23:21

Yeah, that's such a great question and there's just a lot of different levels that I could answer that question from, so let me answer it Chris from a couple of different perspectives. So, at the highest level, you know, our societal demographics are driving the need for different approaches. Things are so drastically different today than they were in the 1980s when the hospice benefit was created. The average lifespan is longer for an American, and that are living longer with complex chronic conditions and serious illness. What hasn't changed, though, is, I think, the relatively universal human desire and need to remain independent as long as we can and to be, you know, in our homes, engaged with our families and loved ones for as long as possible. You know, in our homes, engaged with our families and loved ones for as long as possible. So if you consider those two things together, I think what emerges is this realization that our healthcare system needs to evolve in order to meet the needs and the desires of a changing world, a changing society. We need care models that are more flexible and designed to help individuals access that comprehensive chronic disease care wherever they are, whenever they need it. So I believe that we have to shift our primary frame of reference from the patient always having to be the one that takes action to access primary health care to the health care team, being willing to bring that care and meet that care where the patient is. I think you know and Tori talked about this too in your last episode but we need to create a continuum of health care services that really meets patients where they are in that disease process and that honors their you know their goals of care. So back to your question.

Rebecca Ramsay: 25:26

I'm guessing that most of what I've talked about you know in regard to these care principles sound pretty familiar to your listeners and to you, chris, having dedicated so much of your career to working in hospice. And that's because I don't think there really is another type of organization that is better prepared to build this type of care than a hospice organization. Maybe the folks in hospice don't feel that way, but I want to really emphasize you know now that I'm actually, you know, leading an organization that does both. I'm actually leading an organization that does both. There are so many similarities the holistic philosophy of care, the interdisciplinary care model, the home as the place of service, the skill in navigating those complex medical decision making and providing goal aligned care. That is exactly what hospice providers do best. So in my mind, it's really a perfect match.

Rebecca Ramsay: 26:26

The other thing in terms of why more hospice organizations should think about opening home-based primary care programs. The other thing that I want to underscore is that there have been several recent papers published by colleagues of mine and I can get you these, chris, if you want to. You know, put them up as a resource that has demonstrated a huge gap between the number of Medicare beneficiaries who meet sort of Medicare's

traditional homebound criteria and those that are receiving home-based primary care. According to their research, at most only about 12% of Medicare beneficiaries who would actually benefit are receiving home-based primary care, and the reason is that there's a lot of people who need it, but there are not enough providers or organizations that are willing and able to specialize in this type of primary care. So the bottom line is that we need more organizations able and willing to provide home-based primary care.

Chris Comeaux: 27:34
That's so good. You're actually reminding me how I got the job at Four Seasons, where I was the longtime CEO which founded TCN. It was a brilliantly designed interview process. Well, they had us choose a scenario and we had 30 minutes to prepare as part of the interview process and then present to the full board of directors. I was 30, so I was young, didn't know what I was getting myself into. The scenario I picked was why they should launch a palliative care program and, quite frankly, I didn't know much about palliative care, and so it was a fascinating like quick presentation.

Chris Comeaux: 28:08
And then, of course, you might know you know, we were the pioneers of palliative care. Dr Janet Bull, Dr John Morris were my medical directors, two amazing physicians I got to work with. But just listening to a lot of things you're talking about, we saw a lot of the similarities in the business case and the need within the community for palliative care. And also then what I would go back and tell my young self is it's not going to be all rainbow and unicorns. There's a ton of challenges of running a palliative care program, and my guess is there are a ton of challenges of running a proud care program, and my guess is. There are a ton of challenges of running a home-based primary care program, so can you talk about some of those?

Rebecca Ramsay: 28:45
Yeah, I will, but first I just want to say one other thing that I forgot to mention in terms of the benefits to a hospice organization from a business perspective, of creating a home-based primary care program. You know, I mentioned earlier that our hospice began in 2009 by exclusively serving our own primary care patients and then we opened to external referrals. But even today, you know, 15 years after we founded our hospice, we still receive over a third of our hospice referrals from our own primary care program, and those referrals tend to be earlier in the end-of-life care journey, so the benefit of hospice ends up being more often fully realized for those patients that are referred by our primary care practice. It's really a very high-quality sort of referral path that creates a win-win for patients and for the hospice organization. So, I just I wanted to mention that.

Chris Comeaux: 29:52

Yeah, thank you for mentioning that, because that is huge and that was very similar to the business case that we made on the palliative care side. But that's a pretty good wow. A third, and do you know the upside of the length of stay? Do they have a 25% greater length of stay? I obviously made that statistic up.

Rebecca Ramsay: 30:12
I don't have that actually in front of me, but I know that it's longer than, actually we also receive a lot of referrals from our palliative care program and so, if you take those as well as from home-based primary care, they are the referrals that have the longer lengths of stay.

Chris Comeaux: 30:30
Yeah, it just creates a beautiful continuum. Well, what about the challenges? I'm sure it's performed perfectly. Every day, no challenges, right?

Rebecca Ramsay: 30:39
Oh my, yeah, no, I wish I could say that. Yeah, no, I'm going to be like fully transparent here and say that, just like hospice, home-based primary care is not an easy, straightforward business to run successfully. It is not for the faint of heart, but since your listeners are typically in the hospice and palliative care field, I know they understand this. So let me talk about three main challenges. The first is maintaining a stable primary care workforce, and I don't know that this is any more difficult than maintaining a stable hospice workforce. I mean, maybe on the primary care provider side it's a bit more difficult. But, you know, because it's one of our bigger challenges, I wanted to call it out, even though I know this whole. You know, creating a stable workforce is challenging for all of your listeners most likely as well. I mean, I'd love to meet somebody who doesn't have that as a challenge.

Rebecca Ramsay: 31:50
Most primary care provider programs across the country do not require, or even encourage necessarily rotations for their students in home-based medicine. So, there ends up being a lot of on-the-job training and mentoring that may be needed when you're hiring primary care providers for this unique care model In order to effectively address that. What we've learned over the years is that we needed to create a role that is called a clinical mentor. So this is a primary care provider who sees patients, but the majority of their FTE is dedicated to train and mentor all new primary care providers that we hire. And then we've also been pretty successful in partnering with, like the geriatric fellowship program up at our university hospital system and medical school, as well as partnering with nurse practitioner and physician associate training programs to provide these types of experiences for students in their rotations and I think that has helped. In fact, I know

that's helped us create a future clinician pipeline because we've actually hired several providers who used to be students experiencing our care as a student because we created those rotations. So I think that program that we've created and those partnerships are, I'm hoping that it's giving the educational programs more inspiration and motivation to put home-based medicine in their curriculum. That said, we are still facing significantly more demand at times than we can meet with the capacity that we have, and recruiting, you know, qualified mission-driven providers still can take us months, so it's just a reality that we have to manage. Take us months, so it's just a reality that we have to manage.

Rebecca Ramsay: 33:43

The second challenge I want to talk about is the payment structure of primary care. This is a really important one. The most common form of payment for primary care services, whether you're in an office setting or in a home setting, is Medicare's fee-for-service reimbursement model, which is based on the Medicare physician fee schedule, which I know a lot of palliative care programs are very familiar with, and it's you know it's adjusted and updated annually. I'm just going to go right out and say this Home-based primary care cannot be delivered sustainably in a fee-for-service environment. Many people and practices have tried, and almost everyone I know would agree with me and say you're not going to be able to create a really successful program on a fee-for-service chassis successful program on a fee-for-service chassis. There's just too many expenses that are associated with this model that don't have a reimbursement code in the fee schedule. I mean, just the travel expenses alone are significant, and the thing about the way that the primary care fee schedule is set up is that it kind of assumes that you're seeing 18 to 22 patients a day. Well, I can tell you that traveling between patient visits means your providers can't see nearly that many patients, and so in order to cover and I'll you know our our practice on average sees six patients a day. If they're, you know there may be days where they can see, you know, eight to 10 or 11 if they're seeing them all in one particular assisted living facility, for instance, but in general, across the practice it's six patients a day, and so to cover those labor costs for the providers, along with the other interdisciplinary team labor costs, becomes a whole lot more difficult if you're billing on that fee-for-service chassis. So successful programs have needed to negotiate value-based terms with payers to be more sustainable, and the good news is that more and more payers are interested in home-based care models and in value-based contracting, so there's an opening there in most communities.

Rebecca Ramsay: 36:05

The third challenge I want to talk about is how do you determine the right scale for your program in order to maintain, and how do you maintain a steady pace of referrals across your service area to create that efficient practice? And again, most of your listeners are going to understand this right, the importance of a steady referral stream. That's not

going to be new to them. But what's different about primary care is that there isn't the same culture and practice of flexing staff. When your census dips, it's going to be really hard, if not impossible, to hire a primary care team and a primary care provider who is going to agree to an understanding that they're going to, you know, be flexed if, for some reason, their patient panel isn't full. It's just not the culture, it's not the ethos. So you have to be much more attuned to keeping the provider panels full in order to ensure that you're covering your costs and your providers are efficient.

Rebecca Ramsay: 37:11
Sometimes this means things like changing provider territory boundaries when sort of patterns of population density and referral patterns change significantly. The other thing that sort of points to this challenge is that you know the death rate is obviously lower in home-based primary care than it is in hospice, but it's still high enough that you actually need a pool of patients to draw from. When patients on your provider panels are, you know, die. So we have an annual death rate in our primary care program of about 22%, and what that means is that for a census of 1,800 patients, which is what we have we can expect to need to replace about 14 patients each year sorry, not 14 400 patients each year, or sorry, not 14, 400 patients each year, just to maintain our census and keep everyone busy. So that's pretty different than a traditional primary care practice.

Rebecca Ramsay: 38:11
And then, finally, the scale question is really tricky and again, you know I know hospice leadership and your listeners understand this it's not going to be a new challenge to figure out, you know, especially if you're trying to expand how do we do this in a way that is going to be efficient and effective?

Rebecca Ramsay: 38:33
You know you have to think about what your service area looks like in square miles, what the travel and traffic patterns look like in those areas that you're thinking about serving and what the population density looks like on a map, because, of course, the most efficient way to use your primary care providers and field-based clinicians is to keep their territory as small as possible so that they're not driving a lot and they're spending most of their time seeing patients In hospice. We've found that this is a bit easier because more of our patients tend to be living in congregate settings. They're older, they're frailer, they've had to move into, you know, assisted living or other sort of congregate settings. In primary care, we have a larger proportion of our patients that are living in single homes or smaller, you know, adult care homes. So we just have to be more careful about how we draw our service line boundaries and how we assign territories to our providers.

Chris Comeaux: 39:32

Wow, yeah, easy peasy, right, and I guess, as you probably have a list of 10 more, but those were did those felt the most weighty and probably where you see you guys spending the most amount of time.

Rebecca Ramsay: 39:44
Yeah, wow, yeah, I think those are the most important.

Chris Comeaux: 39:47
Interesting thing I was thinking about was just the paradox of that challenge of the panel.

Chris Comeaux: 39:53
Sounds like a huge issue and yet you want them to be properly motivated or appropriately within the mission to get those patients the care that they need, especially whenever it's to move on to hospice. But yet then isn't it interesting that then the panel challenge and so keeping that pipeline funnel, making sure that people. Have you even gotten sophisticated enough, Rebecca, where you guys look at because your population has got to be a pretty important component of that. You're not in that case, but we work with hospices all over and we work in a, we'll just say, the Midwestern kind of the flyover territory and their population is shrinking, which is so then you've got to be very attuned. Now, luckily, they're just a hospice, so as it shrinks they are there's still hospices one of the thriving businesses when a lot of other businesses are not. But have you guys even got that sophisticated? I guess that's one of the reasons why, like the diversification in Medicaid, you mentioned the disabilities all of that increases the possibility of that pipeline. So, yeah, any comments there?

Rebecca Ramsay: 40:58
Yeah. So, yeah, any comments there? Yeah, you know, I think we're really lucky and somewhat unique even within the field of home-based primary care, because I do, I sit on the board the C6 board of the American Academy of Home Care Medicine, so I'm in contact with a lot of other leaders of home-based medicine across the country, so I get to kind of compare notes. We have always, all 30 years of our history, had more capacity than I mean sorry, more demand than capacity.

Rebecca Ramsay: 41:36
Yeah, in our home-based primary care program, and I honestly don't have a really clear answer to why that is, other than maybe the original partnerships that were set up and the fact that we've been around for a long time and our reputation has just been really strong. Most home-based primary care programs haven't been around as long as we have, so we really haven't struggled so much with creating the demand. We have struggled with having an optimal payer mix, because we do serve Medicare fee-for-service patients and

there's no negotiating with Medicare, so we are on that fee-for-service chassis. We lose money for every Medicare fee-for-service patient that we're caring for. So we have to have a robust census of and referral sources with payers who actually pay us a value-based payment structure to kind of offset.

Rebecca Ramsay: 42:43
We're also involved in ACO Reach. So this is a Medicare shared savings program that allows and the patient has to be sufficiently high risk and meet certain criteria. So as an example, we have about 300 Medicare fee-for-service patients that we serve in that 1,800 total panel. About 300 are Medicare fee-for-service. But about 40% of that 300 patients so 130. Actually, no, it's higher now it's about 180, are enrolled in our ACO, in our REACH ACO, and for those patients we actually receive a PMPM payment from Medicare on a monthly basis. It's not as high as what I would like it to be but it is a PMPM.

Rebecca Ramsay: 43:42
We still have to encounter the fee-for-service claims to CMS so they know what we're doing but they don't pay us on a fee-for-service basis. And then if we at the end of every performance year, if that population of patients that is enrolled in the ACO REACH program, if their total cost of care is lower than a comparison group in our region, because Medicare has so much data right so they can look at a comparison group of Medicare beneficiaries that look the same as ours, based on clinical conditions and something that's called an HCC hierarchical condition category HCC code if they can use that to match us to a similar cohort. If those patients that they match us to have higher costs, they basically give us a portion of the difference between the cost of that population and the cost of the ACO reach patients that we're caring for. So we earn shared savings on that population. So that also helps us to offset the money that we're losing on fee-for-service patients that are not quite high risk enough to be in the ACO.

Chris Comeaux: 44:58
That is awesome and that Chris is where the future is going. Obviously, and of course, we're not expecting anything less from you, you being a pioneer in even the payment area, which leads to I really wanted to ask you this question and especially framing it in this way If you knew you would not fail and you had the resources you would need at your disposal. So, it's kind of like you know, if Rebecca was dreaming and she could wave her magic wand, what would the continuum that you would design in the future to care for those with the chronic, serious illness, end of life illnesses basically the population that you're serving today?

Rebecca Ramsay: 45:34

I love this question, Chris, because I really like to dream. You know, it's interesting because I think House Call Providers has a very good start at creating this ideal continuum, just because we already have within our organization home-based primary care, palliative care and hospice services available for a good segment of our population not everyone and we've also integrated behavioral health counseling, like I talked about earlier, which I think you know has been a really powerful resource for our patients' well-being. In an ideal world, if money was no object and I had, you know, all the resources at my disposal, I would do a few things to sort of bolster the structural resources and care resources for our patients. I would definitely add more behavioral health support across all of our programs. We've been dreaming about integrating a behavioral health prescriber like a psychiatric nurse practitioner, but we haven't found a way to cover the costs of that. So so far, we haven't done that, and I also think we could really use some more substance use disorder expertise. We would definitely seek out culturally specific traditional healthcare workers for our programs. This is something that Oregon is actually a national leader in creating certification processes for what a lot of people would call community health workers or lay health workers we actually use the term traditional health worker in our state. So, there's certification programs now and there are also some payment models that have been established in our employee base and on our teams. It would also facilitate a more culturally diverse pipeline of future home-based clinicians, I think. I think we would also integrate occupational and physical health service or physical therapy services, because these are services that we often refer out to and there's not always the capacity that we would like, longer wait times than we would like.

Rebecca Ramsay: 48:03

We would definitely integrate caregiving services, daily living Chris caregiving services. I think this would be beneficial for a couple of reasons. I think we would be able to oversee the training for these caregivers and tailor their training to the needs of our specific population, and I think we'd probably be able to use them a bit more efficiently if they were integrated as needs of our specific population. And I think we'd probably be able to use them a bit more efficiently if they were integrated as part of our care team. And then I think, finally, two more things I would. I just think that there is so much more need for supporting our caregivers, particularly our family caregivers, and you know, this could look like a dementia care training program for caregivers and a facilitated support group for family caregivers, much like the new Medicare guide model is proposing.

Rebecca Ramsay: 48:55

And then, when I'm thinking really big, Chris, I and I have had a few conversations over the last year or so with some partners, but I have dreams of partnering with low-income housing providers to build housing that's specific to the needs of low-income elders, at-risk elders and seriously ill patients, with integrated clinical care services, behavioral health

services, even eviction prevention services. And I think you know we have this incredible organization in our community called Central City Concern and they started they have this unique background, kind of like House Call providers, where they started as a low-income housing provider and then, as they started caring for those residents in their buildings, they realized, oh my gosh, we need to bring in behavioral health services, vocational health services and then, finally, primary care services. So, they have that model, but they don't have housing specific for an older population and we know the needs of that population are different. So, we've been talking about what would it look like if we were able to create that kind of model specifically for individuals that are like 55 and older.

Chris Comeaux: 50:22
Wow, man, I love it when Rebecca dreams. There's so much in Chris you just said, gosh, we could go on hours. Rebecca, let me just give you the opportunity. What final thoughts for our listeners would you like to share?

Rebecca Ramsay: 50:33
Yeah Well, first of all, I just want to thank you again, Chris, for having me on your podcast. This has been a really rewarding time, and I want to thank you for inviting me. Final thoughts Okay so, since most of your listeners are probably working in that hospice and palliative care field or somewhere close to that field, I just want to emphasize that this is absolutely the right time to diversify into additional home-based services and, ideally, services that are more upstream from hospice care. There's just no doubt in my mind that the hospice benefit, as it has stood for the last four decades, will be reformed in the next several years. So, you know and the reason I think that is, you know, it's the only Medicare benefit that I'm aware of that hasn't seen really significant modernization. You know, and we're starting to see that happen, also with the VBID demo, even though it was subsequently canceled, but also with the HOPE tool introduction this year.

Rebecca Ramsay: 51:43
And I think even a stronger signal was that massive hospice reform bill, the Hospice Care Act that was introduced last year by Representative Blumenauer, who is from my home state. I don't think that bill will be enacted without a lot of changes, but I think it's a signal that CMS and Congress are ready to redesign the benefit and the payment model, so hospices need to be preparing now for what is to come and, in my opinion, given all the societal changes that we've discussed and the legislative excitement about palliative care programs across the community, I think this is the time to build more home-based care models, and I think hospice organizations palliative care organizations are perfectly positioned to do a great job at that.

Chris Comeaux: 52:33

That's perfect, Rebecca. Well, thank you Again. We could go on hours together. Probably again, this would be a perfect kind of long-form podcast to do this together. Thank you for the work that you're doing, Thank you for the innovation.

Chris Comeaux: 52:46

I think we're going to get a lot of great feedback recording this show, and I asked Rebecca to pick a quote. We always want to leave our listeners with just something to keep thinking about the subject and also, we're going to give you a link. We're going to have Rebecca do those papers and, if she's also willing, we'll also get her email address in case you want to reach out to her, to our listeners, we do. Thank you. We want to make sure to subscribe If you have not pay it forward to your peers. We do this show in service to you.

Chris Comeaux: 53:15

There's a lot coming at us and we think 2025 is going Rebecca to be a really interesting year. In fact, the term that came out of our first podcast that we did of the year with the top news stories and predictions is it's going to be a predictably unpredictable year within 2025. But I think a lot of great things coming. So, here's the quote that Rebecca picked. It's from Tagore. “I slept and dreamt that life was joy. I awoke and saw that life was service. I acted and behold, service was joy.” Thanks for listening to TCNtalks.