Transcript: **Measures That Matter: How Better Metrics Can Transform End-of-Life Care | Part One**

Melody King / Intro: 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 Como.

Chris Comeaux: 0:21
Hello and welcome. I'm excited today. This is my favorite time of the month when we do the top news stories of the month. Cordt Kassner, welcome.

Cordt Kassner: 0:29
Thanks so much. It's great to be back.

Chris Comeaux: 0:30
Yeah, I'm excited, Cordt. This is a show that we started envisioning last year instead of just going over the top news stories of the month using RS framework and bring some amazing guests. We've got some really amazing people with us today. This is the most people we've ever had on a podcast today. So let me tell our listeners who's with us. So we've got Bob Tavares, who's the VP and general manager of Health Pivots. Welcome, Bob.

Bob Tavares: 0:53
Thanks for having me.

Chris Comeaux: 0:54
Good, great to have you. We have Robin Heffernon, who's a PhD and co-founder and CEO of Impassion. Welcome, Robin.

Robin Heffernan: 1:01
Thanks very much, Chris. Excited.

Chris Comeaux: 1:03
So good to have you. And we have Mindy Stewart Coffey, who's the National Vice President of Palliative Care. Welcome, Mindy.

Mindy Stewart-Coffee: 1:09

Yeah, nice to be here.

Chris Comeaux: 1:11
Yeah, so this is gonna be Yeah, thank you. So this is gonna be really fun. So um to our listeners, you know, Cordt and I usually kick off the month, just like we're kicking off this month. And in the past, we go over Cordt would share the data from Hospice and Powered Care today, and I would share with you in my framework, hey, here's the articles from a C-suite perspective, director, leader level, that I hope you didn't miss this past month. And so we're gonna keep sharing that data with you. But this year, and actually it was really Cordt's brainchild, we had the gift to Hospice and Powder Care leaders. Um, and uh I think we kicked off December with it as kind of a Christmas gift, holiday gift to everyone. We talked, we brought Dr. Ira Byock, and he talked about his framework, but he also almost kind of feel like it was the because he's such a patriarch, um, kind of the father, one of the mentors of many of us in Hospice and Palliative Care, wrote amazing books. Well, he did his framework and kind of feel like he was speaking to the whole field um from his heart. It was just a beautiful show. And Codrt had this idea of why don't we use his framework? Because Cordt uses that framework every month to organize his articles. Why don't we kind of theme shows the beginning to kick off the moth? And so today's that. And so you really could take any parts of his framework: the zero tolerance for waste, clinical and programmatic standards, making meaningful data readily available, driving uh competition-based quality, embracing our authentic brand. I think having this amazing um panel that we have today, and we're really going to talk about the measures that matter. But I think as we get into the content, it's really going to touch on all of those. What do you think, Cordt?

Cordt Kassner: 2:44
You know, I think this is really amazing. I'm excited to kick off the year this way, and particularly with these three folks, we're just excited to operationalize to make Dr. Byock's uh principles kind of come alive and apply them in the hospice and palliative care space. Just as a quick reminder for listeners,

Speaker 1: 3:04
the top news stories from Chris's perspective and from our data collection side are still available online. So uh please click on those links and take advantage of those resources. And with that, Chris, you want to get us started?

Chris Comeaux: 3:18

Yeah, I do. In fact, what we do it this way. So, Bob, Robin, Mindy, why don't you introduce yourself? Because you have such amazing backgrounds. I'd love for our listeners just to get to know you a little bit better before we jump into the questions.

Bob Tavares: 3:30

I'll I'll kick it off. I'm uh Bob Tavares. Um uh as you mentioned, uh VP and GM at uh Health Pivots, um, which is a uh market analytics company helping hospices, home health agencies, and others um understand their place in the market and um their referral patterns, their quality, and so forth. And um I've been in healthcare analytics for about 25 years. Um and uh as I'll tee up in a minute, uh, the measures that matter really uh this effort that we've taken on uh is grounded in work I was doing 25 years ago to define hospital centers of excellence and hospital-tiered networks. And we were all looking at each other saying, what measures should we use to define a hospital's quality? Employers and health plans wanted to guide their members to better quality, better value providers. How do you do that? And those lessons learned, I've I've carried forward, I find my career coming full circle, uh, where I'm now helping the hospice market figure out how do we uh reward better quality and how do we do that in the context of value-based care. So I'm excited for this conversation and uh and and I've I've got two of our expert panelists that were working with us on the measures that matter effort uh joining us. So I'm excited, Robin?

Robin Heffernan: 4:48

Thanks so much, Bob. Um yeah, very excited to be on this podcast. Robin Heffernan, I'm the co-founder and CEO of Impassion. I'm a chemical engineer by training, so I love systems. Um, and I'm mostly at this point a serial entrepreneur. I've done a number of businesses really focused on how do you help more vulnerable populations stay healthy at home and out of hospitals. So I've done some analytics work, I've done uh transportation benefit, meal benefit, home health benefit. Um, found my way to impassion actually because in these other businesses, we would be serving patients. These patients would be quite sick um and sort of clearly going into their last year of life. They would have great TCP care, they would have specialists, oncologists very often, um, and yet no one was talking to them about end of life. They were confused about what hospice or palliative care was, which meant they were largely not taking advantage uh of these great services. And so we thought, you know, there's been a lot of focus around value-based primary care, around value-based kidney care, oncology care, and uh people have forgot that that palliative and hospice care really is the next place that we need to focus. And so started in passion about the third year of the business. We've grown to be the largest player in this space. We have a national network for palliative hospitals care. Um, have been working with Bob throughout on this task force because it's critical, particularly in I think there's like six thousand players. We'll get we'll get into this, but but the

variability is extreme. Right. And so how do you make sure that patients can get the best quality quality care wherever they are? Um, and that we can reinforce the benefits of possible.

Chris Comeaux: 6:49
Well said, Mindy?

Mindy Stewart-Coffee: 6:51
Hi, I'm Mindy Stewart Coffee. Um excited to be here with all of you today. I have a background in home and community-based care delivery. I actually started my career in senior living and then have kind of expanded over the last 20 years to lead long-term care, home health, hospice, palliative, and uh care management organizations. Um my background's in actually entrepreneurship and health care management, and I have a master's in um public health. I actually made a little bit of a pivot in my career about four years ago. I joined Optum through um Prospero Health and really wanted to deepen my work at the intersection of value-based care, post-acute care, and end-of-life care. They're all areas that I'm deeply passionate about. And uh I was excited to join Bob's task force to look at measures that matter, um, largely because of the work that we did as part of the VBID hospice demonstration. You know, I think working in the hospice industry, I didn't necessarily realize to Robin's point, the variability um between organizations and you know how difficult I think it is for consumers and you know, risk-bearing entities, payers, and others to really be able to identify quality um hospices and palliative programs over maybe lower value value or lower quality ones. So excited to have the discussion.

Chris Comeaux: 8:22
Excited to have you here. In fact, Mindy, you you and I, because we've known each other for quite a while, you'd call me and share with me. You probably don't know this part, but you kind of were giving wings win under my wings because of the work that we're doing in TeleAsh, trying to create a high performance hospice and powder care network and you see that variability, which we're going to get into. There was one more thing I probably should have said about what confluenced into today's show. Bob, my team at Teleios had heard a presentation from you on measures that matter. They text me real time and said, you have to get Bob on a podcast to talk about measures that matter, and you need to do it sooner rather than later. And I think this was probably was probably three weeks actually before you and I were together at the New York conference at Pip Kaney's. So before we jump in, Bob, into the measures that matter, can you just set the table on the discussion, some of the demographics and kind of macro statistics that paint the picture?

Bob Tavares: 9:12

Prior to joining Health Pivots as an employee, I was a customer. And I was in the data. Uh, I was helping build uh uh high-need ACOs, and I needed data to do so. Um and I fell in love with the Health Pivots platform and the data. And um, so here I find myself three years ago, uh January, so exactly three years ago, I started the Health Pivots, and I looked around at all of these quality measures, uh, 40 plus measures, and um I was surprised how many hospice CEOs had a poor understanding of what they were. Um they would often ask me, Bob, can you remind me what a burdensome transition is? And then a lot of the people that were in the know could barely articulate why they're important. So tell me more about early live discharge rates and late live discharge rates and per beneficiary spending. What's what's a clients would ask me, what's a good number for per beneficiary spending? Is lower better? Is lower better forever where zero a dollar of spending is good value? Like I don't understand what Medicare is trying to incentivize. So um,

Speaker 5: 10:20

and then the the real kicker was the HIS measures, the HISP measures, where the best performers in the country get a hundred percent score, and the worst performers of the country get a 99. So here we have these measures that everybody's frantically trying to uh track and improve, which are not differentiating at all, easy to gain, not valuable. So uh more measures is not better, fewer measures that everybody agrees um moves the needle on true definition of quality um was missing. And um, having spent time in the hospital world building high-performing hospital networks, I knew we need to come to a consensus. The uh we can't have, if you think about car ratings, if JD Power thinks that a Toyota Corolla is a top-value car, but then you know, Edmonds or somebody else is saying this is a terrible car. We can't come to a consensus of how we define quality. It was important to realize that these quality measures are really good for extremes. We can identify a high-performing hospice, a center of excellence. And we can use the data to identify fraud or identify bad apples. But let's not kid ourselves or fool ourselves that the data is that good to differentiate that big middle core. So, step one, if you're a VBID

Bob Tavares: 11:45

health plan, because think about this three years ago, I realized that VBID is coming. Uh, they couldn't build tiered networks, they couldn't build networks in the early days of VBID. But I think it was scheduled for 2026 that health plans would be allowed to build a true network, exclude hospices. Those who you want to exclude are those bad apples. But you also may want to reward centers of excellence. And let's not worry about the big network. There can be a lot of providers with good quality that are in the network. Let's carve out the bad apples, let's reward the centers of excellence. And I just realized that there is not a health plan in the country that has that expertise in-house to interpret, they've never paid for hospice, they don't have hospice networks. How are they going to build networks? And if they we leave them to their own devices, they're probably going to do it wrong. So,

can we pull a team of experts together to publish a report that explains and educates to accountable care organizations which already have hospice in their budgets and other risk-bearing entities, whether in or out of the CMS ACO models, as well as uh health plans, uh, how to interpret this information, how to properly build a network. Um the task force had about 20 participants, and two of them are on the call today. Uh we wanted to make sure we had representation from health plans, ACOs, the some of the largest for-profit hospices, some of the largest not-for-profit, folks from NPHI and NHPCO. IRA was on the task force, as well as one of my favorites, Martha Twaddle, uh, both past presidents of AHPM. So we pulled together a diverse group of folks, met monthly over the course of about 18 months to roll up our sleeves and hash these things out and settle on the measures that we felt were most important. Um we put out that in uh first report this past summer, and I'm hoping maybe Cordt can join us uh in keeping that updated, particularly as hope measures come out. Uh but that was that was the uh the genesis of this was um how do we provide guidance to ACOs, hospitals, at-risk provider groups, health plans on how to do this responsibly.

Chris Comeaux: 14:05
That's that's great. In fact, let me I'll this is well said, Bob. I'm gonna throw some some stats in here and then I'm gonna hand it to you because you probably need to do maybe a little hospice one-on-one, although our listeners are like or really, but I think it's gonna help us get into really the meat of the measures that matter. But big picture, right? We look at the silver tsunami, although I've tried to not say silver tsunami as much anymore. Um, John A. Hartford Foundation coached me to say you can't do much about a tsunami. We know there's this huge aging population as the baby boomers are aging. Seniors in their final year of their lives represent 3 to 4% of the Medicare total lives. But it's the Preto principle, 25% of our total Medicare spend is in that segment. And then we know hospice is a beautiful benefit. I'm super passionate about it. A lot of our listeners are. Um, and we know it reduced costs by 25 to 40 percent. But as you heard from Robin and Mindy and Bob's intros, there's a lot of variability. Not all hospices are the same throughout the country. And unfortunately, the word hospice has become like the word clean acts. People think from the consumer, they think all hospices are the same. But the data is showing much different. So, what we're gonna kind of get into is what they've learned through the measures that matter, what's currently measured and monitored. So let me segue now into a little bit more hospice 101 that sets the table. And so, and I know a lot of our listeners are in hospice, but I think this will level set. Of course, we know there are four levels of care: the routine home care, the general inpatient care, continuous care, and then respite care. But when we look nationally from a payer perspective, anywhere between 90 and 95% of most of hospices, Medicare is that primary payer. Then you might have another 2 or 3% that is Medicaid, and then your remaining is either indigent, unfunded, or private pay. So when you look throughout the country, the vast majority of hospice care is

paid for by Medicare. And then Medicare has a few things that it actually mandates, like hope is new, although there are some penalties that you could pay and then not report hope. Um, I think it's I think this one is 4% on hope and then cap scores. But then there are a lot of hospices that opt to not do caps or they don't because they're too small. And Core, does that end up like only is it 50% of hospices in America or is it less than that report cap scores?

Cordt Kassner: 16:28
Oh, you're right on target, Chris. You know, about uh 98 to 100% of hospices are reporting hospice item set and claims-based measure uh questions, and then with caps, it's about half. And then with the star ratings, only about a third. I think the the most recent numbers, about 29% of hospices have reportable star scores. Uh, so while it's great that Medicare has these quality measures available and that there's some utility and usefulness in what is available, when hospices are missing this information, it it really leaves the payers as well as the patients uh in a bind for not really being able to differentiate between quality providers.

Chris Comeaux: 17:15
Yeah, recently I had a conversation with a good friend Julie Oehlert Kennedy. She's the chief experience officer at ECU Health, and she was just sharing with me quite a bit. In fact, we might do a podcast this year about how a lot of people in healthcare are choosing based upon Google ratings. And think about like we're now in the Amazon world, right? How many of us we go to purchase something in Amazon? You're like, that one's got no reviews. I'm not gonna purchase that one. But this one has reviews, and they got this many five stores. I mean, it's becoming just part of our ethos, and yet you've got just such a mixed bag, which maybe Robin, that's a good segue. Just you alluded to this in the intro, just the variability that you see from your perspective.

Robin Heffernan: 17:53
Yeah, this is a really important topic. Um, I mean, I think sort of I would I would echo the framing in the beginning first of when hospice is done right, it is better for the patient, it is better for the caregiver, you know, you can save anywhere from 25 to 40 percent on total costs, right? And so that's why we care um about hospice being done well. And and the largest issue that we face is is how do you get consistently great hospice? So Impassion runs a network of hospice and palliative care. We have tens of thousands of providers across 45 states. Some providers are large nationals, whether they're for-profit uh or not for profit, some are regional, some are you know very small mom and pop. Uh, none of those dimensions is indicative of whether they will perform well or not. Um, and so we got really excited working with Bob and Health Pivots when we launched the business to look at some of these cap scores and outcome metrics and say, okay, can we be smart at least

about, you know, let's not pick someone to be in the network or if they're in the bottom 50% of a county coverage just at a base level. So you do that, and then what you still see is well, the discrepancy between the top 50% in that county is is still wildly extreme. You'll have some groups who are really good, you know, and and really good sort of means they get in there early, they're talking to the family members, you know, hospice isn't this surprise at the end, they're using a full care set. I thought I think we'll talk a lot in a lot more detail about the specific measures that matter, but some groups do that well uh and they do it well in a certain county, and then you can have the very same parent company in a separate state, state or a separate county, and they're miserable at it, right? Or you might have someone who's really good, and then you know, there's a lot of staffing challenges in this space, and so they lose key staff, and now they are not good anymore. Um, and so I I think this work that we've been doing to say, can we figure out some metrics that are not onerous for the people who need to deliver care, but that are really meaningful and give us good insight into who's gonna be high performing so that we can build these high performing networks and we can reward these great providers, and we can weed out the the really bad, fraudulent providers is gonna be critical for growing this industry.

Chris Comeaux: 20:50
That's good. Robin, I didn't tell I was gonna ask you this, but you know, I was so fascinated when we were in the green room about your background in in chemical engineering. If is there any lessons there? Like if we look back in the history of chemical engineering, was it standardization and process and measure, or either or that kind of helped? I mean, because that field is incredibly advanced now, right? Is there any lessons to be learned there? Is kind of my question.

Robin Heffernan: 21:14
Yeah, um this is a good question. I think, you know, the main thing for any engineer, right, is they look at the system and and this sort of gets into, you know, how do you describe value in this space? Um and we really think about it as okay, if this is the last year of life for this patient and their family, how is it as good as possible? How are they having as many good days as possible? And can we do that in as large a scale as possible? Right. So if you want to scale it, well, it needs to be financially sustainable. It needs to be something, you know, that's not a totally manual process with a bunch of Blue and duct tape. Um, but first and foremost, it needs to have great experiences. That's what we're trying to give patients and their families. That's why everybody goes into this field. Um, and so I I think as engineers, you are trained in the beginning to look at the whole system, you know, figure out where are the biggest levers in that system that you need to optimize and then go do the work to try to make each one of those levers as efficient as possible.

Chris Comeaux: 22:31
That's a that feels like a little mini masterclass just right there at the very end. That's awesome. Well, Mindy, let me ask you, what challenges that you've seen in building and operating a hospice network? Because you've done it at a pretty large scale.

Mindy Stewart-Coffee: 22:42
Yeah. Yep. I I would say one primary one is really just engagement and collaboration from hospices. You know, I I think most hospice organizations that we work with have not had a lot of experience working with like a risk-bearing entity or a value-based program. And I think that sort of ongoing collaboration is something that many of them weren't used to. You know, I think that they were used to receiving a referral, taking over the care of that patient, and then that's it. Then you're you're collaborating only within your interdisciplinary team and maybe some other care team members externally as needed. Um, but in, you know, I would say in like large sort of risk arrangements or population health strategies, um, you you have an interest as you know, the person that's sort of managing the risk on the population or the patient to stay engaged. And um, so I I think that kind of ongoing engagement and collaboration was something that was new for a lot of organizations. A lot of people were like skeptical. And I would say often we would find, you know, particularly smaller community-based um hospice programs that were amazing. They have amazing outcomes. But, you know, their attitudes were sometimes like, leave us alone. That's we're not interested in doing, you know, that kind of work. Um and, you know, the other thing, um, I'll just echo what Robin said as far as operating a hospice network long term. It's not a set it and forget it exercise. You can't just form the network network, and then the network sort of stays in place forever and for always. Um, things change, you know, quality improves, it declines. Processes fall apart within organizations. You know, you could have a really good process for, you know, referral, intake, collaboration, follow-up. Um, but it was it was writing on maybe like a really amazing intake coordinator or a really amazing clinical director. And if those people change, then you start to see, you know, changes in in the agency in the organization. Um, so you know, you could have top, top quality hospices that then start to fall to kind of the bottom of the pack. So you always have to be monitoring um for for what's going well, what's not going well, and who's maintaining high quality versus those that are kind of you know peaking and rising.

Chris Comeaux: 25:12
That's so well said, Mindy. You know, I'm always a student of Demming who was kind of the really the father of quality. And one of his adages that we teach is RPTH. You might remember Mindy's talking about that many years ago, which stands for resource processors training human factor. It really is hard to ball dim boil dimming down to like one principle, but that's the one that stuck in my brain. And you look throughout, I was

lamenting recently about this work that we do within Teleass Collaborative Network. I have a lot of gray hair now, because working within this network, you're right, you can't just kind of set it and forget it. But we do so much work around the do we have the resources? Do we have the processes in place? Do we have the training to make sure then the resources are properly deployed where we're reducing variability? And then the H is the last thing human factor. And Demming would often say, we go, oh, bad person, you didn't do the right thing, but you didn't say, did you have the resources? Did you have the processes? Did you have the training? And did you even do the training in the right way? Where is it really accessible? Then you get to the performance, the human factor. And quite often, I think in hospice for many years, we've just depended upon the human factor. Just are great people and they'll do great work. And this is why I think one reason why one of my theories of why we've seen this variability. So it feels like in this first segment, we've really just set the table.

Jeff Haffner: 26:33

We will be continuing this conversation, measures that matter. How better metrics can transform end-of-life care. This Friday, February 6th. Be sure and share this episode and subscribe to our channel.