Transcript: Part Two | The Healthcare Partnership Nobody Is Talking About: Hospice + FQHCs

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Why Hospice And FQHCs Matter

Jeff Haffner 0:41
Welcome to TCN talks, and Anatomy of Leadership. We continue our conversation with Kyle Ahlenstorf in part two, The Healthcare Partnership Nobody is Talking About, Hospice plus FQHC's — Federally Qualified Health Centers. And now here's Chris Comeaux.

Building Palliative Care Into Homes

Chris Comeaux 1:04
As we go to the next segment, I think this will be a good segue. From your perspective, maybe where are the greatest opportunities for powder care integration with FQHCs? And I use my words very specifically, powder care. You leave hospice for our side for a second. And do you know of models, Kyle, that are working particularly well or some maybe that you even envision?

Kyle Ahlenstorf 1:27
That's the models that are out there. Um, and back to the prior comment on the conversation that I had today in the state of Iowa with these co-locations is those are demonstrations and pilots that are out there that we're we're looking to try and find what

is the best way to collaborate? What is the best way to make sure services are offered at one location? So I don't know that there's a perfect model out there right now. Um, even right here in our community, the collaboration and the model that we're trying to work through with the hospital in specialized care is still on the work. So I wouldn't say that there's anything set in stone. Um, and if anybody creates that model and is willing to share it, that would be great.

Chris Comeaux 2:13
Well, let me let me take a flyer then at it, Kyle, because when you and I were actually talking about it, um, an FQHC is is basically a location, right? So one of the things that we would be a good partner is we go into the home. So we could be that tentacle arm into the home, providing palliative care community services and then coordinating with you guys or providing that broad broader primary care. This is an oversimplification, but what my antenna when you and I were having that campfire conversation is is wait a minute, I've never thought about you're this incredible primary care wraparound, but has a whole bunch more robust services. I go and try to partner with primary care people all the time as a referral source. Have many people thought about you as a referral source to them? So is that thinking right, or would you say it differently, especially the part that we're in the home and that fills a gap maybe that you don't have?

Kyle Ahlenstorf 3:08
And that is definitely one of the areas that we haven't pursued is getting into the home with those services. Um the the closest that we come is with our teleservices. Um we're able to connect with patients in the home, but we're not going directly into the home to provide those services. So that is definitely an area that the partnership, and again, that referral source comes into is what once we identify that patient, what what is that next step for them? How do we coordinate with the palliative care to make sure that they're getting the care that they need in the homes? Um, helping coordinate what is the transportation, if if there's transportation needs to continue to receive a few of the services here in our clinic, but what what does that model look like and and how do we coordinate those referral sources and resources together to make sure that the patient isn't on their own looking for those?

Chris Comeaux 4:05
Well,

Who Handles Referrals And Coordination

Chris Comeaux 4:06

and I think one reason why maybe a lot of people haven't connected the dots, because you are such a beautiful wraparound model, medical-centered home type model, you know, when you have, we'll call them community outreach specialists, liaisons, there's a bunch of different names, but basically they're salespeople trying to connect people that have the needs to the services of the hospital's body care program. Do you, if you were in our shoes, who's the one-stop shop within your place that I would need to be talking to? You you used the term care coordinators earlier. There was another term you used, and I wonder if that's part of the challenge is they need to be talking about five or six people in your organization, or is it the care coordinators the best people people to start with?

Kyle Ahlenstorf 4:46

And I think that it it comes down to the terminology or what that job title is. I think a lot of the same job responsibilities are tied to different names and what that title is. Um, and to your point, there's there's a referral specialist here, and they handle all the inbound and outbound referrals, but our care coordinator is the one that is communicating with our providers the most to make sure that they understand the resources that are available. So in our organization, it would be that referral specialist that you would want to talk to. And then the care coordinator would be the one that would help be identified when we have a patient to make sure that we're we're communicating to the outside organizations. Here's a patient that we've identified. Who do we need to get in contact with the organization to make sure that they have the information necessary to take that next step? The other one, and I don't know of all states are exploring this model, but the community health workers is another one. And it's a it's a similar job description is what we describe our care coordinators are. But those community health workers are actually out in the community. And I think that kind of helps with what you're talking about of being in the home. They're able to connect with them in their home, actually identify and see those services that they need firsthand instead of just having that patient report of what's actually going on in the home. And I think that's another one of those areas that could help mesh and bring this model together is if there's a community health worker out there that's working for an FQHC, getting them in contact with those palliative and hospice services and being able to explain that this is what we're seeing in the home. Where can you guys come in and provide those additional services or connect them with the resources that they're needing to stay comfortably where they're at?

Chris Comeaux 6:46

Another great example, because also there are a lot of palliative care programs nationally that are trying to uh graph in community health workers into their model. And then even like, well, what you know, where would you go and hire those people? How do you orient

those people? What do they do? And so that's just another area we just bumped into. Well, another big term for all of us in healthcare, social determinants

Medicaid Needs And Preventive Care

Chris Comeaux 7:07
of health. So, how do Medicaid populations and social determinants of health shape the way FQHCs approach serious illness care maybe differently than more traditional healthcare settings?

Kyle Ahlenstorf 7:19
Yeah, and I I think that's where FQHCs are really becoming more known nationally. Um, when you listen to HHS and you less listen to HERSA talk about preventive care, that's where FQHC really step into that spotlight. Um, and I think we pride ourselves as FQHCs of being known as a preventive care and really want to hold that standard high that we're creating better outcomes by focusing on preventive care instead of reacting to the chronic conditions that are further down the road. Um, if we can get our patients to understand up front, their preventive care are going to limit the negative consequences of delaying those services. Um, that's where we really feel like we're we're trying to get ahead of the system, um, focusing more upstream instead of waiting for them to float down to us when that chronic condition is out of control. And now we need to really step in and correct things. So education is a big proponent at the FQHC level of the outreach and community events that we're participating in. As an example for Infinity Health coming up in August, we'll have Community Health Center Week, and that's we try to get out in the community and educate schools or local organizations of what we offer, where the benefits come from partnering with us. So those are really the tactics that we try to take as an organization to get ahead of the preventive care model.

Chris Comeaux 8:58
That's awesome. Well, we kind of went there uh earlier, but let's go there deep now. Talk

Behavioral Health And SUD Integration

Chris Comeaux 9:03
to me about behavioral health services that FQHCs provide.

Kyle Ahlenstorf 9:06

So we are unique as an FQHC, um, and we have a very robust behavioral health um network of services that's we're fortunate enough that each of our clinics has a behavioral health component to it. So in our organization, we've got nine clinics that operate across South Central Iowa, and each one of them has either a therapist in place in person, or we've got the connectability to do clinic-to-clinic visits via telehealth services. In our behavioral health department, we've got our licensed LM LMSWs that provide your traditional therapy to patients. Um we've also got SUD counselors that are in our sites that are meeting in-person one-on-one and also in a group setting with some of those clients that they have. And then the other thing that we're able to offer is our ARMP psychiatric providers that are doing med management for those more complex medical conditions that require a little bit higher level of service. And what we're able to do with that is we're able to couple all three of those together. Um they may have good medication management, but they may have some other life circumstances that they need to go into some more traditional therapies to discuss and have conversations that to make sure that all of their condition is under control and that they're that they're making the progress that they need. We also see that transition for SUD patients that they've done a great job. They they've made some corrections and behavioral modifications in their life, but they haven't seen a dental provider or they haven't had medical. So that that transition from our behavioral health side into those other integrated cares really help um make sure that the patient care comes first.

Chris Comeaux 10:56

And whenever we had brought you to our group with DCN, a mental health challenge group that was working on it, I said this out loud, and you correct me if I'm wrong, but you do some um tele mental health, right? So you have the ability to do it virtually. There may be some licensing issues, but we have a lot of innovative programs out there that are thinking of launching their own behavioral health. Well, in healthcare, having a fractional partner because you don't have unlimited capacity. So, Kyle, if it's okay with you, we may include your contact information, but am I wrong in that? That you could be a partner for folks going, well, I don't have unlimited capacity. And as we know, the mental health needs in our country are way beyond the resources, which is another reason why I wanted to have you know a podcast, because a lot of our people didn't like, wait a minute, FQHCs do that? So is that is that true, or is that, or am I thinking wrong about a potential partnership?

Kyle Ahlenstorf 11:49

Yep, there there is that opportunity. Um, and I think that's one of the other unique things about FQHCs, is we're not bound um organizationally by state lines. That's we there's organizations across that actually participate or provide services in multiple states. We're actually fortunate to be one. We're right at the southern edge of Iowa, so we actually have

a behavioral health site down in northern Missouri. So so we're operating both in Iowa and Missouri. The other thing that we have is we have therapists that work for us remotely. We've got a therapist that provides services in Iowa and Missouri that actually work and live down in Arkansas. So we're we're spread across kind of the Midwest in a unique way, and we have actually had outsourced therapy providers that have worked out of the Southeast area that are providing services here in the state of Iowa for some of our patients just through a contracted agreement. There is that opportunity to your point of some of those fractional shared staffing models that we would be able to go into partnership and via the teleservices be able to provide those services to the patients that need it.

Chris Comeaux 13:01
All right. Well, this is a good segue then.

Financial Basics Hospice Must Know

Chris Comeaux 13:03
So for hospice leaders listening to this conversation, what are the operational and financial realities inside an FQH that they absolutely need to understand before perhaps even approaching their FQHC for trying to build a partnership?

Kyle Ahlenstorf 13:17
So the financial realities of the FQHC. So we operate um when we do a lot of our appex as you work, we talk about the three-legged stool. So we've got our operational cost or revenues that come in just from what we do on a daily basis and providing services. We also have the federal funding that help offset some of those expenditures and costs that we're providing services at a lesser rate. But the other third leg of that stool is our 340B program, which helps expand and provide additional resources for us to be able to spread the margins a little bit further to be able to provide those services. So from a financial side of things, we're able to go in and provide some of those services to patients that otherwise wouldn't necessarily be provided at your private medical practice. When we talk about the care coordination, when we talk about the community health workers, when those are non-reimbursable services, we're able to offset some of those expenses through some of the other revenue generating services that we have as an FQHC that are kind of special to FQH organizations and covered entities that otherwise might not be able to provide those services. From an operational level, we really don't function that much different than any of your other medical providers. Um, though we offer all the services under one roof or under one organization, if you separate out our behavioral health, our behavioral health would look like any other outpatient behavioral health services out

there participating in your community. Medicals, the same way. We've got providers, nurses, we've got receptionists that are scheduling, and we operate similar to any of your other medical clinics. Our dentistry, that is one that we as an organization probably struggle the most with just from a staffing level, um, and the increased need of the patients in our area. But we again, it it's called in, you schedule, you come see our dental hygienist, you see our dentist, um, they set up your treatment plan and it operates just as your traditional dental office would. So operationally, um, we are unique that we we as an administration get a wear a lot of different hats and learn all the different medical service lines that are in the industry. Um but when it comes down to the end of the day, each one of those services operates um and provides services just like you would any other outpatient service.

340B Drug Pricing And What Is Changing

Chris Comeaux 15:52
Say more about the 340B pricing, Kyle. I'm a subscriber to modern healthcare because years ago um where I was at a meeting and the lady was looking at all these hospice leaders and she goes, Do you people not read modern healthcare? I said, Okay, subscribe to modern healthcare. It always feels like there's an article about 340B drug pricing. But to be honest with you, I kind of know you get a discount on the drugs, but I don't understand it beyond that.

Kyle Ahlenstorf 16:14
So the 340B program was initially created for covered entities to be able to stretch those federal resources a little bit further. So when we're able to prescribe the medications to our patients, we're billing it out in a similar way, regardless if it's a retail pharmacy, whether you're going to CBS, Walgreens, or anybody for your prescriptions, we're still billing it the same way. As a covered entity, we have access to those drugs at a lesser cost. Um, so when we're buying and replenishing our meds for our pharmacy, we're getting a discount on the buy of those prescriptions. And part of the requirement for us getting those is to make sure that we turn around and use those dollars to provide patient care services. So the 340B program right now is going through a significant transition. Um it was the end of last year, URSA was looking at changing the 340B from an upfront discount to a rebate model. Um, and from a covered entity standpoint, that creates cash flow issues. Um, it also creates denial issues. So when you're used to all of your claims coming through, as long as you've followed the procedure, you don't have to fight the denial similar to your insurance reimbursement. You you've submitted the documentation, you build it cleanly, it got to your payer source, and they said, Yeah, something doesn't look right on this claim. We're gonna send it back, which delays that

reimbursement. Um, and that's similar to the model that they're trying to look at from a 340 B space. We've seen the patient filled the prescription, we submitted the documentation, it goes to the manufacturer, they see our request for the rebate, and they're like, eh, we're not sure that that's everything that we want. We're gonna deny that, send it back, and ask for some additional information on that script. Um, so in the 340B space, what our organization has really been pushing for is a neutral clearinghouse where all of the information in that model is in a central location that covered entities can see, manufacturers can see, URSA can see, and that allows the transparency for there's a new there's a neutral party making those decisions whether or not that claim was eligible for a 340B prescription. Um, and from a covered entity standpoint, that that feels like a better compromise than just shifting the entire integrity um format of the system the way that it has been since it was initially rolled out through HERSA. So kind of a long-winded answer to a fairly complex system that's going on. Uh but yeah, if if you ask any of your covered entities what's going on in 340p, you're probably going to get a quick eye roll.

EMR Data Sharing And Quality Reporting

Chris Comeaux 19:05
Um and we were talking about the patient within your when you talk about operations. Um, I imagine having a longitudinal view of your patients is huge. Um, there's no one in healthcare loves their EMR. If you talk to hospice people, we usually hate our EMRs. Do you generally have a good EMR system that provides that longitudinal view or kind of so we in the state of Iowa, we've been pretty fortunate here.

Kyle Ahlenstorf 19:31
Uh, we, as a network, 11 of the 14 health centers are all on the same platform here as an EMR. So we've got a lot of shared data. Uh, and when we look at that from longitudinal patient care services, it's a lot of that health information exchange that we're talking about. As long as they've come to our organization and even any of the hospitals that are on that same platform, we can see that information exchanged. Um, and Iowa is pretty heavy into one EMR system. Um, and we were fortunate as an organization to be able to get a piece of that. So if they go to a hospital in Des Moines that's on our platform, we get to see those records. Um, if they've been hospitalized across the street at the Critical Access Hospital, we get that information relatively quickly so we can get them in for that follow-up from the ER visit to make sure that we're able to transition them and prevent them from being readmitted into the hospital. But from that longitudinal piece of the EMR, it allows us, especially in our value-based care, to be able to track those patient

conditions, make sure that we're seeing improvements across the continuum of care for that patient.

Chris Comeaux 20:44
Do you get like quality add-ons? I mean, that's value-based care. Do you get some quality measures and you get some add-ons? Or that may get to my question a little bit later about value-based care, but as a general rule, do you have quality measures kind of across your patient population?

Kyle Ahlenstorf 21:00
Um, so from the quality standpoint, each of the community health centers, FUHCs, have to submit annually uh UDS report, uniform uh data something. Yeah, yeah, you know, uniform data system. Um that we're submitting basically all of our patient demographic information. We're looking at age, we're looking at race, we're looking at incomes, um, and then we're measured on the scores heatest measures that we're looking at our comparison. Um, and then they're able to see are we providing the care and are our quality measures going up year after year for the patients that we're serving? So, yeah, the annual UDS that's due in February is always a fun time around here, making sure that we're comparing data and making sure that we're seeing those improvements year after year.

ACOs Rural Grants And The Next Decade

Chris Comeaux 21:50
Very cool. Well, looking ahead, five to 10 years from now, what role do you think FQHCs will play in the future of healthcare in America? And why should hospice and palliative care Leaders care.

Kyle Ahlenstorf 22:01
And I think that builds off that last conversation of cost of care and making sure that we're following and providing a high quality preventive care is essentially a cost system to all of healthcare. If we're getting ahead and controlling those chronic conditions earlier, the cost and longevity of our patients are going to be much better. So that whole pars and care one-stop shop that FQHCs, I think that's something to really focus in on over the next five to 10 years. I think the administration that's currently in office is talking about what we can do from a preventive stand care um standpoint. And I think FQHCs are well positioned to be able to take on a lot of those challenges that are coming for the preventive care, making sure that we're doing screenings, making sure that we're getting patients with chronic conditions better connected with care before those conditions get

worse. So from a palliative care standpoint, I think those partnerships to make sure that you guys are getting healthier patients with less complex conditions is something that I would like to see us at community health centers really focusing on, making sure that we're preserving as much of that quality of life through the preventive care that once they get to those end stages, those chronic conditions, yes, they're there. But they've been managed better for you guys to be able to continue that continuum of care on to make sure that quality of life sustained as long as they can.

Chris Comeaux 23:39
And you are participating in ACOs, or do you own your own ACO, or is it a bit of both? Are you mostly participating?

Kyle Ahlenstorf 23:46
So we participate. So the Iowa PCA, Iowa Primary Care Association is our network. And under the Iowa PCA, we've got an HCC and health care collaborative network for a lot of our tech collaborative. And then we also have what is called the Iowa Health Plus, which is a separate ACO that functions that each of the health centers here in Iowa can participate in. And those are main contracts are around managed care organizations. So our Medicaid patients were participating in that ACO arrangement. And then we've also got a contract with another third party through the Iowa Health Plus for our MSSP for the Medicare patients. So we're really trying to find a niche and find a way to get into some of the commercial payers and show also on that side that we we have value and there's an ability to share some of those savings on the back end with the community health centers. But right now we're really building as a network a strong ACO in the state of Iowa to make sure that our Medicaid patients are having better outcomes based on the shared savings that we're seeing with the organizations.

Chris Comeaux 25:00
I didn't tell you I was going to ask you this one, but I picked up on earlier in the conversation. A lot of our members are trying to understand more about these rural transformation grants. Is there a potential collaboration opportunity with your local FQHC for some of these rural transformation grants?

Kyle Ahlenstorf 25:15
I think there are. What we're seeing in Iowa is some of some of those are being rolled out. And that was the meeting that I was in today was on co-location. And each state was able to write their own goals, targets, um, initiatives that they want to go through. But a lot of it should have a similar focus again on making sure that we're getting ahead of the preventive care, creating access points in the rural areas. So I would anticipate most states will have something similar to what we're doing here in Iowa. Um, but the co-location of

services is definitely something that palliative care should keep their eye on in making sure that they're they have a seat at the table of those conversations when when you're looking for multiple service providers coming together.

Chris Comeaux 26:06
Perfect.

Final Takeaways And Subscribe Request

Chris Comeaux 26:07
Kyle, what final thoughts do you have? I'd just like to share with these hospice and palliative care leaders.

Kyle Ahlenstorf 26:12
Uh think of us as partners. Um, we've we really do have that community focus at our community health centers. Um, we're looking to do as much as we can with the resources that we have. And the more connections and community partnerships that we have, the better we feel that we can serve our patients moving forward. So I appreciate the work that you guys do. Um, and and we really want to make sure that we can build a strong partnership in the future with organizations in our area.

Chris Comeaux 26:42
I'm not saying this is a solution, but I looked at Kyle when we were sitting around the campfire, and he reminded me one of the interesting ideas we explored that we never fully pursued, and eventually, of course, I became part of Teleios instead, but I had built a relationship with a local FQH, and we hypothesized the FQH coming together with our hospice and medical care program, and there was a local interesting kind of innovative Medicare Advantage plan that had some interesting technology around population health. And on paper, I thought, man, those would be a lot of great pieces of the puzzle working together. Of course, that never came to fruition, nor have I ever seen that throughout the country. So who knows? Maybe someone might be listening to this podcast and go, hmm, that's kind of interesting. And there's a lot more technology. I looking back, this was probably 10 years ago. That's probably maybe we're getting into a time where that innovation may actually be something someone might pursue, maybe from this conversation. There's a hospice CEO that I had lunch with right after you and I were together, Kyle, the very next week. And I mentioned about you and you and I were doing this podcast, and he had some background and he had failed to put the dots

together. And he looked at me and goes, that's a cool idea. So who knows what this podcast might might inspire.

Kyle Ahlenstorf 27:58
No, I look forward to what we what we can do in the future. And I think there's more conversation to be had about the collaborations um and initiatives and the patients that we serve.

Chris Comeaux 28:09
Perfect. Well, Kyle, thank you for the work that you and your team are doing. You are one of the more innovative FQHCs out there, and you're a great person. You have a great team, interestingly, one of your team members that work in hospice prior. And so just thank you for you and your team and the work that you're doing.

Kyle Ahlenstorf 28:24
Thanks for having me on, Chris.

Chris Comeaux 28:25
Yep. And to our listeners, we want to thank you. At the end of each episode, we share a quote visual. The idea is to create a Brain Bookmark and a thought prodder about 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. We're going to include Kyle's contact information. We don't want you to miss an episode as we go forward. Tell your friends, your coworkers about this one, especially leaders in the hospice and powder 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 TCNtalks / Anatomy of Leadership. And here's our Brain Bookmark to close today's show.

Brain Bookmark / Jeff Haffner 29:03
"What sets leaders apart is seeing more than others see. And seeing it before others see it. " by Kyle Ahlenstorf