Innovations in Serious Illness Care with Bree Owens

[00:00:00] **Melody King:** Welcome to TCNtalks . 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.

[00:00:22] **Chris Comeaux:** Hello and welcome to TCNtalks. I'm excited, our guest today is Bree Owens. She is a licensed clinical social worker and a co-founder of The Holding Group. Welcome Bree.

[00:00:32] **Bree Owens:** Thank you. Thank you so much for having me on Chris. I'm really excited to talk with you today.

[00:00:37] **Chris Comeaux:** I'm super excited too. I was reflecting as kind of as we're doing show prep and like it just felt so by chance when I first met you at home care 100 and we almost felt like we were just walking and Katy Lanz was the common point.

And I've just so appreciated getting to know you and especially the work and which is a probably a good segue. What does our audience need to know about you?

[00:00:57] **Bree Owens:** Um, well, in addition to being the co-founder of The Holding Group and a licensed clinical social worker, I'm a mom to a nine and a seven year old, which is definitely the hardest.

But most rewarding job I've had. Um, I have a very supportive partner. He's wonderful. And, um, as I was reflecting for this podcast, I was thinking about, uh, what I want people to know. And one of the things is that My roots and entrepreneurship is kind of in my blood. My parents, um, opened an auto repair and body shop when I was two and my dad would be working on a car in our driveway and put me in the car seat and throw me snacks to keep me happy.

Um, and then they built that business to now it's been here 42 years. in Denver and employs 25 people. Um, and actually my husband, uh, is one of the owners now. So I, I was [00:02:00] taught from a very early age that you can build meaningful things and you don't have to wait for permission.

[00:02:06] **Chris Comeaux:** That's pretty awesome.

Well, how did you come to, um, The Holding Group? Well, how did, what's it, where's that in the story?

[00:02:13] **Bree Owens:** Yeah. Um, well, it's a long story, but a good one. Um, so I began my career at a level one trauma center here in Colorado. Um, and just seeing how much traumatic based end of life came in. to that ER and the heartache around that, uh, was so eye opening to me.

Lots of accidents and gunshot wounds and things of that nature. Um, and my job was to find the families, bring the families there, uh, bring in the, the physician to tell them what had happened and then to support them in their grief. And through that process, I learned one that. That role had a shelf life for me.

Um, I was there [00:03:00] two years, but two, you know, what those people would have given to know five minutes or an hour before what was going to happen and what they would have done with that time, what they would have told the person that they love. Um, and then I saw all of these folks coming in with serious illness.

And it felt to me like as a system, we were robbing them of that time by not having conversation about the progressive nature of their illness, what to anticipate, helping them to figure out what the paths available to them were. So that's really where. I fell in love, um, with palliative care and found that.

And so, um, we, I then went to work at a hospice who had a palliative care branch, uh, and met some incredible like-minded social workers and realized that that Um, that there was a lot of power in the social work role. And so, we really began building this model 15 years ago and have researched and iteratively improved it ever since.

Um, and we developed this model and it, it reflecting on our history. It really sits at the intersection of value-based care versus fee for service. So I would not have had those words at the time, but we were passionate social workers trying to make a meaningful impact for those that we were seeing with serious illness who were not yet connected to hospice.

And The work did and does require a profound amount of indirect time where you're not face to face with a patient. And the way our contract had been set up

between our employer and the payer, um, we could only bill the payer and be reimbursed for face-to-face visits. Sounds like our fee for service system.

Um, so we would be told to see a vented, unresponsive patient in the long-term acute care setting for the sixth time, um, so that we could place the claim. When the real work that needed to be done, for example, was with the medical power of attorney out of state, helping them by phone. Um, in their process, having hard conversations about what their person would want and coordinating with the medical team when we discovered that there were gaps in understanding, um, and their medical understanding that they needed to hear from a medical provider.

So we would assess what that was really titrate that information down or distill down that information rather to the. provider, they would be able to come and fill that piece in, and then we could help them move forward in their process. So, you know, we didn't set out to build value-based care, but that's kind of a natural consequence when you're solely focused on the patient and whoever they define as their family.

Um, so, you know, you had asked about our name before, and we really, we built this intervention at its core to hold these patients and families, thus our name, the holding group, um, to create that space, that container, that sense that they could bring their full selves. What we didn't realize. being our idealistic and very focused social workers was that the larger community would see that, uh, that word or that term of the holding group as a financial institution.

So we still struggle with that today, but that's the purpose of, of the term.

[00:06:39] **Chris Comeaux:** I think that's beautiful. And actually, the more I've, I've gotten to just appreciate you, Bree, I think you've got some incredible superpowers. Um, we actually use that in our Anatomy Of Leadership podcast. We'll ask people, what do you think your superpower is?

But listening to your story, I mean, being a social worker, but having entrepreneurial skills, that's a bit of a unicorn kind of skill set of the two together. But as you were describing your pathway, um, I kept asking myself, Oh, is that where the name came from? Because holding space for people, which is so antithetical because if you follow the dollars, um, I had a really interesting first mentor in hospice.

He was a really hard person to work for because he was just so crass. His background was in kind of naval, um, like the VA naval hospital. Um, but he

had these really Terse learning lessons. And he'd say, Comeaux, if you want to figure out why people do what they do in healthcare, follow the dollars. And it's a very perverse way to explain why, like, why is this crazy thing happening?

But yet you're just such someone in the learning mode. And I just, I totally get it now. Holding space is really what you guys do. Well, maybe that's a good segue. So, so what's the unique value proposition going forward in the healthcare continuum that you're creating and maybe some successes you guys have had.

[00:07:56] **Bree Owens:** Yeah, absolutely. Well, we, we founded the holding group in [00:08:00] 2012. Um, so we've now had a 12-year history and I've learned a lot along the way. We've also had the good fortune to team up with a principal investigator, palliative physician at university, Dr Sarguni Singh, and she has really helped to propel it.

The research of this model forward, um, and it's, you know, when you do academic research, you have to come up with some sort of fancy acronym. So ours is ALIGN, um, which is assessing and listening to individual goals and needs. Um, and so really this, this intervention looks really different in its deployment depending on what the unique needs of a patient and family are.

Um, And as we said, you know, we're creating space for people to bring their full selves. And our goal is to help them achieve informed consent. So informed consent of the various implications, um, of the paths available to them. Of course, they have to understand their medical picture. Um, but also, I mean, it is a financial, practical, psychosocial, spiritual journey, and I think sometimes social workers and medical models can become resource hand routers, or that's kind of what they're seen as, is their value is to hand out resources.

When instead, if, if we bring them to the front of this intervention, they have the ability to provide psychotherapy, helping people in their process as it relates to their disease progression. And that humanistic view is what the change maker is. And so, from very early on, our outcomes were pretty astounding in the sense of saving money.

Um, and that is not because that's what we set out to do. That is a result of helping people understand that the paths before them and the choices available in the context of their specific serious illness. and their, um, status and their disease progression. And, you know, people don't want to die in acute settings.

They don't want to die on a ventilator. They want, they don't want their world to be interrupted by the cyclical revolving door of hospital, subacute, home, hospital, subacute. Maybe never home into long term care, you know, if we can have these conversations more upstream, we prevent that acute expenditure.

Um, and so, you know, our very first pilot was in the L tax and the long-term acute care and that showed a 30 percent decrease and rehospitalization. Um. and a 30 percent increase in the patient and family satisfaction. And so as we've looked at this over and over, um, goal, concurrent care, uh, overall cost of care is tremendously decreased by having these conversations upstream into there's a social work saying, start where the patient is or start where the client is.

And so that's what we do. We meet with, with them, and we listen to who they are, and, and who is around them. And we build our plans of care based on that unique individual. And, and so, if you do that, right, and you're helping them to achieve informed consent, and then supporting them in whatever path that they choose.

It's not our job to decide what path they choose, but it is our job to make sure that they're informed, and therefore, informed. Can know which path is most aligned with their values.

[00:11:45] **Chris Comeaux:** Wow. Bree, how many employees do you have now?

[00:11:48] **Bree Owens:** We are a team of 14.

[00:11:50] **Chris Comeaux:** Wow.

[00:11:51] **Bree Owens:** Uh huh. We were, we were four social workers who started this in a garage in, in 2012.

So yeah, we've been building and you know, the opportunities are, it's just the right time in history for this work.

[00:12:05] **Chris Comeaux:** So, as you, so it does feel like. Um, and this is helping me because I feel like I'm even learning your model better as we're doing this podcast It does feel like that care plan is part of the just unique value proposition and how you discover it so in that care plan you probably um Discover the need for other coordination of other aspects and maybe even a little bit more the medicalized aspect So is that true?

And then has that evolved as your? other collaborative partners that you've had to seek out.

[00:12:37] **Bree Owens:** Yeah, absolutely. So, I think you nailed it. I mean, certainly if there's a symptom crisis of some kind going on with a patient, um, then the first step needs to be that medical intervention because we can't engage in these conversations if someone, um, is in pain or discomfort.

And so that those cases make the most sense to have the medical provider. be the first point of intervention. Um, but there is many, many more for which sending a skilled and trained palliative care social worker to that patient and family to do a comprehensive assessment. And so, our, our model, um, covers five major domains.

So, their understanding of their illness and treatment options. including their eligibility for hospice and other palliative care programs, their goals of care and completion of advanced directives, their living situation and custodial needs. I mean, this is a huge one. Um, that brings in Medicaid eligibility, caregiver needs, caregiver fatigue.

Um, certainly the. caregiver or patient defined family concerns and then the emotional and spiritual support needs. So, we are looking at those domains. Uh, one of the problems with palliative social work is there hasn't been a whole lot of structure built around that role. And so that's what we've really sought to do and have done.

And that assessment then serves as who do we need to bring to the table. to help this person and their needs and in there and meeting informed consent. So, did we assess in that initial visit that they're receiving chemotherapy for a cancer that they believe to be possible to be cured when it's very clear that that treatment is to prolong their life?

But that cancer can't be cured, but the patient and the family have either not been told or have not observed that, uh, or rather, um, have not really digested that. And so, our goal then is to bring the oncologist to the table. They have that relationship with the oncologist, and we can tell the oncologist.

Hey, we met with them. This is the specific piece that they're missing. So it's about using the provider, the medical providers time. Effectively and efficiently to be able to come in and fill that gap in knowledge, and then we can process further. So, it does, we could not do this work without being able to leverage our medical colleagues, uh, but it's, it's a matter of trying to be efficient,

effective, um, and just patient and family focused where social workers are very good at assessment, very good at understanding systems and family dynamics.

And so, we are the right person, um, to build these plans of care and bring in the needed providers to address.

[00:15:41] (Sponsor Ad) **Jeff Haffner:** To our TCNtalk sponsor, Dragonfly Health. Dragonfly Health is also the title sponsor for Leadership Immersion Courses. Dragonfly Health is a leading care at home data, technology, and service platform. With a 20 year history, Dragonfly Health uses advanced technology and robust analytics to manage durable medical equipment and pharmaceutical services as part of a single efficient solution for caregivers, patients, and their families. The company serves millions of patients annually across all 50 states.

Thank you, Dragonfly Health for all the great work that you do.

[00:16:28] **Chris Comeaux:** Well, one of the. I hate it. You know, sometimes wonderful phrases become cliche potentially, but just listening to something. I think Dr. Morris taught it to me. Dr. John Morris, who you know, both know is right care, right place, right time.

[00:16:43] **Bree Owens:** Yeah.

[00:16:43] **Chris Comeaux:** That feels like keeps coming to me listening to you. Does that feel pretty accurate?

Like there's this overarching like theme of what you're after here, what your team is able to do is really get that right care, right place, right time and add incredible value, which, yeah. You'd almost sit there and people go, wow, there's a real need for that. Yeah. Because of the way the system works today and all the perverse incentives.

Does that provoke any comments?

[00:17:06] **Bree Owens:** Yeah, I think it provokes a lot of comments. I mean, right care, right place, right time. Um, I think that's what I am motivated to build towards. I don't think we're there. I mean, I think we get parachuted into these cases, oftentimes very late in illness progression. Um, and sometimes we're having a single encounter, you know, our average initial visits are 90 minutes to 2 hours.

Um, we're having that initial assessment encounter and we realize right away this patient is hospice eligible and they really are aligned. They just didn't really realize X, Y, or Z about that. And so one of the things that are our intervention does is increase hospice length of stay, but if we couldn't move upstream.

Um, we would just be much more able to provide right care, right place, right time. And our, our data analytics are getting so much better that we really can identify the right people better. Um, I think that was, was less sophisticated even a couple of years ago. So, I hope to get there. Um, but that's why our, our intervention looks so different.

The deployment, depending on the unique needs of the patient and family is, is because. We never know exactly what we're dropping into and where they're at in their illness progression.

[00:18:33] **Chris Comeaux:** I love your answer. I mean, there's so much wisdom packed into that answer of, you know, compared to where we are today to maybe more idealistically where we'd like the whole system to get to.

Um, yeah, I love the way you answered that. And as something occurred to me, Brie, just as setting the table, because so many of our listeners are hospice leaders, a lot of palliative care leaders. And the reason why I thought you'd be such a great guest, I think we may call this like innovations in this serious illness space.

Um, because you are in this innovative space. It feels like the serious illness space is kind of the wild, wild West right now. And I mean that in a good way that they're incredible entrepreneurs like yourself and your team that are. creating great value, doing great work. And, um, maybe some of my, our hospice peers might be like, well, that's what we're supposed to do.

But, um, and the fact that you worked early on in a powder cure team that was part of a hospice organization. This is why many of our TCN members have created powder care programs themselves because hospice on to its own. Yes. In the ideal world, we get that referral at a perfect place in the perfect time and the system would deliver them.

Appropriately and eligibly, but we all know day to day that doesn't occur that way and so I don't know if that just provoked but, that's why I thought you'd be such a great guest.

[00:19:52] **Bree Owens:** Yeah, I you asked me kind of who is our Competition in this space or who is doing similar or dissimilar work And I have so much that I want to say, so I hope our listeners have a ton of time.

Um, but, you know, Dame Cicely Saunders was the start of hospice. She was a British social worker and nurse, um, and kind of came up with the originating philosophy behind hospice. And when we started to build palliative care, we built that off the hospice model originally. Um, However, we built it without a payment mechanism, and so it did not have a structured, reimbursable vehicle through which to provide the work, and so when I was really looking into innovations happening, a lot of them happen in the inpatient centers because there's a lot more flexibility around how you deploy resources in short term Acute care hospitals.

Uh, so lots of, I mean, there's tons of efficacy around the ability of palliative social work to make outcome differences. However, we've really expanded into the home setting and to wherever someone calls home, uh, assisted living, independent living, memory care, residential homes, and. It has been really hard to figure out how to provide this work.

And so yes, hospices 100 percent are in the place of, of wanting to provide more upstream support and innovation, but the payment mechanisms for that are not easily accessible. And so, what is accessible, most palliative care that happens outpatient. It's from, uh, APP who is providing E& M codes, um, you know, at, at some periodic frequency to try to meet this need.

And so we've been really constrained by what's available in the fee for service system and social workers. You know, I wanna give a shout out to ctac, the Center to transform Advanced Care because they put a bill in front of Congress to allow social workers to bill for advanced care planning. So, there is movement happening to bring social workers more, um, into this work in a financial, I mean, as you say, no margin, no mission.

We have to be able to figure out how to make this work financially. Um, and I would say that we're still as a. society figuring out the best way to define palliative care and to deliver palliative care. And that's where this push to value-based care To training providers, social work providers within ACOs, um, within provider risk group providers that are taking risk groups, there's an opportunity for us finally to scale, but our, our, uh, partnerships thus far, you know, we, we were a little bit before our time, I think.

And so we've had kind of this hockey stick style growth. Because it, it took the early adapter of Kaiser, our big partner in this area, um, to now get to the point as a society that, that people are moving towards value based and taking risk and being financially incentivized to take risks. So, I would say that, you know, hospice isn't a great place, but it's, it's not easy because of the lack of available payment methodology in the outpatient.

[00:23:26] **Chris Comeaux:** Well, probably a good segue, Bree, because you are such an innovator. You probably also have a good bead of, you know, what are other innovations that you're seeing out there in kind of this, this space? Some of them might be similar, maybe dissimilar because I use the analogy, maybe it's not a perfect word, but like the wild, wild west, um, I've used the analogy, asked someone the other day, I'm like, do you know where the 49ers football team gets her name from?

And most people go, no, like it was the gold rush of 1849. And that's where the 40 people are like, Oh, I didn't know that. And like, and my analogy is that's kind of the serious illness base. So, you probably go, well, where's the gold. People are seeing the potential for gold because just the aging of America, the silver tsunami, how many people are dealing with chronic illness and what that's doing to the overall already somewhat stretched healthcare system.

So, my guess is you're probably have a fairly good bead of just other innovations are out there. So, could you speak to that a little bit?

[00:24:23] **Bree Owens:** You know, I have yet to find an outpatient in the home, social work driven, serious illness intervention. And, you know, I just think that's because it's very hard to deploy financially, that you have to make these relationships directly with M.A. plans or A. C. O. s. But there is just a ton of innovation in this space happening. And I think of, I just read on Hospice News, Jim Parker, um, wrote an interview with Tom Lally, who is a physician here who has headed Blooms. ACO reach and Tom Lally was doing fee for service primary care in the home for, you know, decades.

Um, I don't know the exact year he started, but I know it goes back as far as our history and was getting just whatever reimbursement. Was available, right? Not not, um, able to scale in that way, but was meeting this need. And then C. O. A. C. O. Reach came along, um, the high needs A. C. O. And they have proven themselves the strongest saver in the country, um, under that program with the reports that have just come out.

And Jim Parker in this, interview was asking about how they've done that. And one of the main ways is they're following these patients longitudinally, like we do. Um, but they're getting involved upstream, creating rapport, and then they're having these conversations over time as the illness progresses.

And that is what is just preventing this downstream expenditure that people don't want. And I think the baby boomers, um, are really taking a little bit more control and wanting to engage in these conversations as well. And so, there's just so much change that is happening, uh, and so much potential. to do good in this, in this field.

And, and, you know, I want what we provide. I want it for myself. I want it for the people that I love. Um, and I, I think if we just all keep our eyes on where a patient and family are struggling and try to find creative solutions to meet their needs, it's going to be a lot better.

[00:26:53] **Chris Comeaux:** There's a pretty cool innovation that's happening that's put out by CMMI, the guide model, and I think you're pretty excited about that. Can you just talk about that a little bit?

[00:27:02] **Bree Owens:** Yeah, I'd love to. I'd love to. So yeah, the Center for Medicare and Medicaid Innovations, which is the same one that, uh, that kind of the testing side of CMS. I didn't know all this. So, your listeners may be more sophisticated than I was. But, um, they are the folks who put out ACO REACH and do all of these kind of test payment models to study them before they decide what's rolled out to the larger Medicare and Medicare Advantage population.

Um, so they released a program called GUIDE. Again, you have to have those acronyms, right? So, it stands, it doesn't completely line up, but it stands for Guiding an Improved Dementia Experience. And it's an eight-year model. And it is to provide wrap around comprehensive dementia support care to patients and their caregiver, um, who have any stage of dementia, any type of dementia.

And we were one of 390 participants that were awarded participation to deliver the guide model. And 90 of us started this year, in July. Um, and the reason we decided to apply for this program, it was very close to what we were already providing. Um, except for a couple of things, which is, it is much more upstream.

So you have folks who are, uh, fast, scale, And they are able to engage in their own advanced care planning, which is really unique in the dementia space.

Because oftentimes when you're having those conversations and completing those advanced directives, it's with the medical power of attorney. Uh, so being able to, as.

you know, we're talking about just bringing things more and more upstream, giving people more autonomy and control. That is a really exciting aspect of this program. And then you follow them for the duration of their illness progression until they admit to hospice, which again, hopefully we're doing that at the right time because what a gift hospice is, right?

I think that's the other thing that I want to really Tell and show your listeners is it's about getting folks to hospice sooner who are eligible and aligned, and we've proven the ability to do that. We don't own a hospice. We wanted to remain independent, but we know that are that they will be well served under that, and they will have time if we can get them there to do all the things that we all want to do at the end of our lives to leave in peace.

Right? And so, I just, yeah, I think there's just so, so much to think about.

[00:29:39] **Chris Comeaux:** You were kind of, I think you were going there that there are a couple of things within the guide that your organization doesn't do. You, do you want to, um?

[00:29:46] **Bree Owens:** Yes. Thank you, Chris. Thanks for getting me on track.

[00:29:50] **Chris Comeaux:** That's my part of this, this, this job here.

[00:29:53] **Bree Owens:** You can see my passion. Okay. Yes. Thank you. So the other incredible thing that Medicare has done, I think for the first time under this program, is they are paying for non-medical and home care giving. So, they are paying for respite care for the caregivers for the first time ever. Um, those who are in the, uh, moderate or high complexity tiers of dementia.

So not in the early stages, but in the moderate and high. And if they have a caregiver, they are entitled to 2, 500 annually of respite services. So that can be, they have to be offered in home respite. Uh, but you can also offer them day centers and facilities. And that is revolutionary. And I saw Katie land speak at home care 100 a couple of times ago, and she had just talked about the pivotal role that caregivers are going to need to play that in home nonmedical caregiving.

And we have not. Invested in that, uh, you know, it's never been provided through Medicare. And so I think there's some movement happening there. We're realizing kind of the [00:31:00] linchpins of society. I remember in COVID, um, realizing how, how much, you know, teachers were the linchpin of society to keep everything else running.

You know, if we don't have kids in school, then what is that? What is that ripple effect? Kind of same thing with if we don't have caregivers and a way to pay for those caregivers. Um, it, you know, it really is a huge detriment. Um, so that, that is the exciting part. We're partnered with Home Instead, uh, here in our region, who has been a phenomenal partner.

Um, you know, there's, there's things I could also say about wanting the rate to be more at market rate than CMS is providing. I will take this opportunity to say that, but it's a step in the right direction.

[00:31:41] **Chris Comeaux:** Good deal. Um, and so do you see a role for like, let's say you're doing guide in a market. Is there, there, you can't allude to it.

So, there's still that role for a hospice. So, um, can you just unpack that just a little bit more? Like I imagine you want good hospice partners because you providing that guide, there's the need for sounds like a good private duty partner, some good respite options, but then also that good hospice program at the end and that stitches together the continuum.

Um,

[00:32:10] **Bree Owens:** Absolutely. And that's always been our goal, is to decrease silos and care and bring all the right people to the table. And so I think the thing that can be so devastating about dementia and the disease progression is the slowness. Um, and how progressed the illness has to be if you're qualifying under a dementia diagnosis to be hospice eligible.

You know, how many years of struggle have that patient and family gone through? Um, and so especially in this disease, we want to make sure that the second they're eligible, that we've had all of these conversations upstream, that we've done all of the seed planting and letting those seeds germinate around what exists.

under home hospice when that time comes, so that we can make sure that they're connected. Once, once someone is engaged in hospice, they are no longer eligible for the guide program and that's the intention, providing this

support upstream and connecting them to the incredibly robust services provided.

under hospice services. And so, but, but I'm excited to see how those conversations over time with patients and families will inform their readiness for hospice when that time comes. And, uh, you know, we're having hospice partners here who are meeting with patients who are not yet eligible. And so they're connecting them back with our guide program so that we can provide support until they do make that criteria.

[00:33:45] **Chris Comeaux:** I guess I'll just go ahead and ask it to you this way. I mean, I love what you're doing. I love the innovation, the entrepreneurial spirit. It is kind of this wild, wild west. I've grown up in hospice. Most of our listeners are hospice. What do you see is the place for hospice in this future healthcare continuum?

We're all these amazing innovations are being deployed. Um, and maybe I'll put a little bit more kind of meat on the bone. Like I'm thinking, you know, Elizabeth Kubler Ross and just what she was to this country and, you know, the catalyst that she was the people dying in the acute care space. Um, the hospital, these dying patients that were like almost the untouchables on these wards.

And out of that Kubler Ross and, um, what she did. And then of course, what was going on with doc, with doc Cicily actually did know she was a social worker. Thank you. Um, I forgot about that part of it. I knew she was a nurse and she had to become a physician. I forgot she was a social worker as well.

That's right. But the confluence of all that, and then, you know, first off, hospices were kind of this all innovative, like a bit out of care, a bit hospice, because there wasn't a defined benefit. But then 83, there becomes this defined benefit. I came in and about 95, 60, 70%, or maybe 75 percent of hospices were nonprofit.

25 percent for profit, fast forward to present day. It's now, you get 75 percent for profit, 25 percent nonprofit. You get a lot of skewing of what is hospice. And then yet you still have all these problems in the serious illness space. You've got the graying aging of America, the huge number of chronic diseases.

So, all that kind of sets the table for my question, Bri. I think you've got a unique perspective of what is the position. In place for hospice in the future.

[00:35:32] **Bree Owens:** I think that's a great question. Like we're dreaming up the future that We want to build and that we will be the beneficiaries of at at one point if we make these changes Um, so I mean I think from a patient and family perspective all of the different silos that exist and the handoffs that exist are wildly disruptive for patients and families.

Like you think about people who [00:36:00] do really well under hospice care because it's comprehensive and they, they improve and then you have to discharge them, right? That is, there is a, uh, social justice component to that. And I would like to see, you know, primary care continuing to get strengthened as the patient's medical home, but then have primary cares and hospices reach their arms to one another and create, you know, this continuous.

and it would be wonderful if, you know, interventions like ours could, could be deployed at the right times. Um, and then, you know, hospice services and palliative care services can be titrated up and down as needed. But the, the patients and families, um, remain under a continuous. care team. And so I, you know, I think that's happening in some innovative [00:37:00] ways.

But, you know, hospice is really moving upstream and finding ways to do that. So we can better support these people. They're already going through so much and they're changing bodies. Um, and they're, you know, changing spirits as they approach end of life that, you know, to give them. Continuity and not have to know, Oh wait, I'm not on that anymore.

This is my person to call. You know, that's the future I want to see. So how do we build that?

[00:37:30] **Chris Comeaux:** That's a great question. I was, I was sitting there kind of processing as you said that, you know, if I found myself as a hospice CEO, again, I would love to find a brewery and a holding group in my market service here, if you will.

Yes, I would probably build a more palliative care provider model. So nurse practitioner centric. Find a great partner like you, stitch that together with my palliative care program, have incredible relationships with primary care as you described. I don't want to totally disrupt hospitals, but I would hope we would become the center of healthcare in the future and a little bit less acute as the center of that healthcare universe.

Would you push back on that or maybe reframe that a little?

[00:38:07] **Bree Owens:** You know, I wouldn't, and, and as we've been growing our work. I, my vision has always been for an army of very skilled social work practitioners, trained and ready to do this work. And so, I would embed them. I guess that's the only change that I would make is that we are moving towards trying to educate, building educational and training institutes so that on the nurse practitioner centric team that you're building that we can have a social worker there on the palliative care team that is taking risk that we can have a social worker there doing this model and the ACOs, um, that that their members can access training for to be able to deploy, uh, this type of model.

So, so I, I would not push back on it. I think that's the goal is to get this care to more people, however. We embed that

[00:39:03] **Chris Comeaux:** you are such a bit of a unicorn. Where do you go? Where's the brief factory? Where's the, you know, where do you go find these amazing LCSW social workers that have your skill set? Like if have you found the perfect fishing pond?

Like is there a university in Colorado? Or some social work school somewhere that you found, um, I've always been an interesting student of like, uh, like I grew up at KPMG, people are like Arthur Anderson and the early days would actually target a lot of Midwest colleges because of the ethic and ethos of people that were raised in that kind of culture.

Then they had these like straight, like if you ever, Arthur Anderson was the guys with the white shirts and the dark ties. But they, they had an ethos they were looking for. There was a skillset and a common skillset that kind of came out of a lot of colleges like Notre Dame and colleges like that. And so, and it's interesting when they lost their way, they were no longer able to go fish in that fishing pond of staff.

Have you found something? Cause you have such a unique team that you've put together or are you. are looking for those social work schools that are cranking out people with those skill sets?

[00:40:08] **Bree Owens:** That's a great question. Um, and you know, I, as much as I'm a unicorn, the, the three social workers that I started this with were unicorns and we all, it was this very serendipitous, we all had different skills and there's no way that I would be able to be here.

Without what they brought to the table. So, I think, you know, they were unicorns, um, in their own ways. And it really was a, together we were able to

build this. Um, I, you know, there's no way I wouldn't have thrown my hands up and, um, long ago, if, if I didn't have all of us working towards this dream, but it's, it is an issue.

I mean, I think our team that we've built has had a lot of folks who have had. palliative experience, and the schools are not training for this. They might do some serious illness theory, some education, but ours is is a model, much like in the behavioral health fields, EMDR has a rigid protocol of how to, you know, perform and to get trained in that or emotionally focused couples therapy or any of the various behavioral health models that are, uh, efficacious and, and needing advanced training.

So I think that's what we're set out to. to do is to be able to, we are recruiting a specific type of social worker, um, you know, someone who is relentlessly, um, trying to help people achieve informed consent, someone who is up for learning all of the medical components. But I think we have yet to see how we can create.

Mass numbers of people who are well trained and this and so I'll maybe next year you and I can connect and we'll see where we're at with that.

[00:42:06] **Chris Comeaux:** A good problem to be solved. Well, what final thoughts do you have, Bree?

[00:42:10] **Bree Owens:** Um, gosh, I'm just grateful to be in this space and I'm grateful to all of the people who in their various disciplines, uh, in their various venues are working towards creating a better serious illness and end of life space.

And so, um, thank you to everyone who's just bringing their unique lens and whatever skills they have, uh, on the benefits of, of patients and families. And thank you to

[00:42:37] **Chris Comeaux:** you Such a beautiful way for you to answer that question. I literally was having a flashback And you know Katy, you don't stand there talking to Katy.

You walk and you talk to Katy Lanz. So I was walking and talking to Katy and I said hey Katy I'm thinking of a podcast and I was going to call it a flight of substitution competitions If you come to Asheville, we have all these amazing breweries and they'll give you a flight of beers. It's like a A sample of a bunch

of, because I was trying to get my mind wrapped around all the different kind of flavors of innovations that are arising in the serious illness space.

And she kind of sprung around and looked at me and she goes, why do you frame them as substitution competitions? And it's a very Businessy technical term. Um, Clay Christensen has kind of coined the term. It's become very kind of almost in vogue to talk about, you know, substitution competitions, disruptive innovations.

And she goes, you know, why do you look at him as competition? And it's more about collaboration. And like, you literally walked by and she's like, you need to meet Bree. And that's literally how I met you. That was like the whole frame. You probably didn't even know that part. And it's so cool to say it in that way, because it's so cool.

If I was just like, well, I'm in this hospice and gosh, what you're doing is competitive to me. No, what you're doing is incredibly innovative and so complimentary. You know, quite often we just rail against why, you know, why did this physician just dump this referral? And the family doesn't even know what they're expecting.

And you've just been a beautiful innovation. So just, I could think about getting to know you, what you're doing, how Katie introduced us. It just encapsulates how my understanding is shifting, and I think that these incredible innovations in the serious illness space, we have so much collaborative opportunity.

And I love your answer earlier, right care, right place, right time is still more visionary of where we can go. And there's a good chance we could probably do that together. So just thank you for what you and your team are doing.

[00:44:29] **Bree Owens:** Absolutely. Absolutely. It's, it's my honor. That's the truth.

[00:44:34] **Chris Comeaux:** Well, thanks. And thanks to your team, Bree.

And to our listeners, thanks to you. Make sure you subscribe to TCNtalks, pay it forward to friends, coworkers to make sure they get the benefit as well. And as we always do, we always like to close this show with a quote. And Brie picked this one and loved Dr. Atul Gawande. So, this actually comes from his book, Being Mortal.

And Bree picked this. A few conclusions become clear when we understand this. That our most cruel failure in how we treat the sick and the aged is the failure to recognize that they have priorities. Beyond merely being safe and living longer, that the chance to shape one's story is absolutely essential to sustaining meaning in life.

That we have the opportunity to refashion our institutions, our culture, and our conversations in ways that transform the possibilities for the last chapters of everyone's lives. That is so well chosen, considering our conversation today, Bree, that was very visionary on your part.

Thanks for listening to TCNtalks.