TRANSCRIPT: Measures That Matter. How better Metrics Can Transform End-Of-Life Care | PART TWO

Jeff Haffner: 0:00
Welcome to TCN talks, and Anatomy Of Leadership. We continue the conversation in Part Two | Measures That Matter. How better Metrics Can Transform End-Of-Life Care. With our guests, Bob Tavares, Robin Heffernan, and Mindy Stewart-Coffee. Now here's our host, Chris Comeaux and Cordt Kassner.

Chris Comeaux: 0:22
So now where we're going to go next in the next segment is we're actually going to talk about, and Bob, I want you to pick up and talk about the task force that you created, the analysis that you guys conducted, and what are the metrics that matter most. So let's go there, Bob. Perfect.

Bob Tavares: 0:39
As mentioned, we convened this uh expert panel about monthly for about 18 months. It's how long it took to uh to pass through everything. I on the very first call, we universally dismissed uh the HIS measures as not being uh differentiating. Um we wanted measures that were differentiating, uh not redundant. Uh there's uh there's hospice visits in the last days of life, HVLDL, which is how many patients had visits in two out of the last three days. And then there's a HIS measure, uh no, there's a um HCI measure that is visits near death one out of the last three days. We don't need two measures that do pretty much the same thing. Uh and the task force agreed that we should endorse, if you will, HVLDL. So we didn't want measures that were redundant, that were non-differentiating, where the best performers get 100 and the worst performers get a 99. We wanted measures that were in the public domain, that everybody could understand. Uh health pivots has some really interesting views on quality, but it's a sort of a proprietary methodology where we're evaluating things. And we we didn't want that. We want ACO, a hospital, a health plan could get the vast majority of these measures out in the public domain, or they could easily work with somebody like myself or CORE or others to calculate some of these other measures. Everyone understood them. Uh live discharge is a good example. There's no publicly publicly available database of live discharge. It might appear in some pepper report somewhere along the way, but for the most part, you can't easily get access to that information, but you can through, you know, it's widely available in the market. So we wanted measures that were universally understood, if not in the public domain, truly differentiating, not non-overlapping, and also ones that were tied to value. We wanted to uh, you know, Medicare has a stated goal of getting 100% of beneficiaries into value-based care. And to us, that means either they're going to be in a Medicare Advantage plan where the NA plan holds the risk, or they're going to be delegated to an ACO where

the ACO holds the risk. But there won't be any panaged patients who are unmanaged, total cost of care. And as hospice providers, we and as a hospice industry, we need to know how and when do we deliver the biggest bang for the buck. A day of hospice care packed on after the patient leaves the hospital. That's not gonna lower total cost of care. It's check the box, yes, the patient died with hospice, but it's not lowering total cost. We have to get patients admitted to hospice prior to that last hospitalization, not immediately following it. And then they live a day or a week, and um, we're just you know, that's not our we can do better. So we went through this process. The measures that we settled on uh are GIP, CHC care. You have to provide all levels of care. As you know, in court, keep me honest here, uh only about half of providers in the country provide GIP care and or a combination of GIP and CHC care, continuous home care. Um if a patient's having a crisis and you can't provide that level of care, what do you do? You discharge them and send them to the hospital. And then conveniently, when they're done with their hospitalization, you bring them back on hospice. Right. That's called passing the buck. ACOs are paying for those defects now, and in the future world, you know, and and actually Mindy and I were talking offline. Don't kid yourself, Medicare Advantage plans also pay for that hospitalization in many cases. There's this notion that a patient who's a Medicare Advantage patient at a Lex Hospice leaves their MA plan and goes back on original Medicare, which is not the case. They're still in their plan, it's just that the hospice portion is carved out. So if they're discharged alive, they're back in their plan and the plan's picking up all the costs uh the first of the month following their discharge. So um long story short, you need to be able to provide continuous home care or and or GIP care because crises emerge. And uh now if you don't provide that level of care for many reasons, sometimes good reasons, the hospital won't give you a contract, the nursing home football. That's okay, you're not gonna be a bad apple. But how can you be a center of excellence without delivering that level of care? Number two is live discharges and burdensome transitions. In the context of value-based care, I would like to see those become never events. You know, you should be able to handle all crises as a hospice provider. And it's not gonna get to zero, but but it's close. And and maybe in the future, if you're a hospice and you've got a novel contract with a payer or ACL, maybe if the patient does have to go to the hospice, it's on your dime, not on their dime. But we're not there yet. But the point is, in the context of value-based care, it's the combination of those two. You can have a high burstone transition rate, but with a very low live discharge rate, it's not the same as having a high live discharge rate and a high burst of transition rate because one is a subset of the other. So that's four measures so far. Um providing GIP care and continuous overcare. Keep in mind, and for many of these measures, they're not linear systems where more is better in perpetuity. Providing a a sufficient amount of GIP care, maybe 1% is the national average, maybe three-quarters of a percent of your days of care at the GIP level, maybe two days, two percent. We don't want 20% of the days of care at GIP, where that's all you do and your median length of stay is two, right? So more is

better to a point, and then it's enough, I think. You're serving the community, you're providing that care, and you're providing it often, you know, 20%, 30%, maybe 40% of your patients are receiving some level of GIP care. But it shouldn't be 95% and your median length of stay is a day or two. Same thing with live discharge. Lower's better, but we don't want live discharge rates too. There's perfectly good reasons for a live discharge. And it would be suspicious. Typically, if you're doing 90% of your patients are receiving GIP care, you might have a 2-3% live discharge rate, but it's not we shouldn't be rewarding lower to the very to zero. Um but live discharge rates are critical. Burdism transition rates should be zero. Um, lower is better to the end. Um we also were looking at visit-based measures um and we settled on the uh HVLDL, as mentioned earlier. When the patient needs you the most, that last couple days of life is pretty important. And I've had hospices push back and say, you know, patients really want their privacy at those last days. That's fine. The goal isn't a hundred percent. But you if you're at twenty percent of your patients are receiving visit two out of the last that says something, right? So so yes, there's room for patients that want private but we're comparing apples to apples, right? And uh and and and and that number shouldn't be suspiciously low. And we also looked at um gaps in nursing visits. What percentage of patients were uh went seven days without a visit from a nurse? The nurse um you know, IRA was advocating for physicians being involved in the care team, which is unfortunately becoming a rarity. Um but at a minimum, the only clinician uh that's involved is uh a nurse. Social workers and and aides do amazing work, but they're not clinicians in that regard, uh, in the same way. And how can you go seven days and and if that's 80% of your patients or you're having gaps? Um that would that was concerning to the panel. So the final measure that was you know definitely received the the thumbs up was patient experience. And we don't need 10 different domains of patient experience. The court's point only you know 30 some odd percent of patients had uh or hospices have a star rating, whereas a little over 50% have a would you recommend. I'd rather have more data for more hospices than less data. So we settled on would you recommend and would you recommend also maps to the net promoter score, which all of corporate America uses. And and so it's a measure they could understand. Talk about redundancy, rate your hospice on a scale of one to ten, and then would you recommend your hospice? They're kind of measuring the same thing. They were extremely correlated with each other. Measures that didn't make the cut, I mentioned HIS, but also minutes on the weekend, skilled minutes on the weekend. We started peeling that apart, and and some of our panel members were saying, you know, most hospices are still on a Monday through Friday model. And if you're having a lot of visits on the weekend, maybe those are usually emergency ad hoc visits that could indicate poor quality care during the week. So we decided to look into that a little bit. We looked at the top 10% of hospices in the country that did a lot of minutes of the weekend. We compared them to the bottom 10% that rarely have minutes of the weekend. And their patient experience scores on timely help, pain and symptom management overall

were identical to each other. So you provide a lot of minutes, no minutes. It didn't seem to matter the patient's perception of timeliness and pain management. So um we don't think that measure is very sensitive or valuable. And that was dismissed. Along with a lot of others, early live discharge rates, late life discharge rates. I think we're splitting hairs there. Uh live discharge rates that are 30, 40, 50, sometimes 100% is a much bigger concern as to whether they're early or late. And you can just look at the rest of the rest of the data in terms of uh median length of stay and other things. A median length of stay is a measure that matters. It's difficult to put into some type of ranking report card because, again, there's so many factors. It's not lower is better in perpetuity. High is troublesome. If you're an ACO, a health plan, you don't want a hundred-day meeting length of stay. Those providers are over the cap, you know, and their excessive spending on hospice and that. Uh on the flip side of that, we don't want two-day meeting lengths of stay. And believe me, there are plenty of hospices in the country that are usually owned by a hospital, and their goal is to free up a bed, lower inpatient mortality rates, and check the box that the patient died with hospice. But that's not what we fought for 45 years ago. Uh, that hospice was going to evolve into a program that patients got for hours or maybe a day or two. So meaning length of stay is tricky. I would want to provide, and if you're doing all the GIP care, you're the only hospice in the hospice facility, your meaning length of stay is going to be much lower than those that only do routine home care or only do nursing home care. We thought about that as well. If you're cherry-picking patients, how do we uh account for that? And so I'm not going to go through the 30 sub-out measures that weren't included, but that's some of the reasoning.

Chris Comeaux: 11:17
Are all those measures in the report, Bob? Because we're going to make sure in the show notes we include the whole measures that matter report. So does it have some of those measures in the report that you guys did not go with?

Bob Tavares: 11:26
Yeah, we we talked about um, you know, other considerations and uh uh optimistic outlook for hope. You know, we hope that uh there is no good measure on whether a patient's pain was managed properly. It might show up in the patient experience a tiny bit, but ultimately we're we're hoping hope, we're we're hoping that produces really high quality data that's differentiating and can then ref be updated in version two of this report.

Chris Comeaux: 11:53
Yeah, something you reminded me of, Bob. I grew up in manufacturing. Fortune 50 company was a global manufacturer, and it was a great time to be in manufacturing because again, kind of dimming quality principles. And one of the interesting things is

that there's something about us in healthcare that, like you were talking about some of these measures. Oh, well, you know, the more is better. Well, this GIP 20%. In manufacturing, you had upper and lower control limits, and how they established those is you actually use the scientific method of thought. I have a hypothesis, you test the hypothesis, see what the data, and you start to get a distribution in the data, and you get an acceptable range of this is what we're shooting for. Like that's how we basically, you know, we get products that aren't wonky every time. Although, you know, back in the day in cars were there's a whole lot of wonkiness. This is where Toyota basically, you know, went double down in the whole process of quality. I wonder, and this is probably a good place to segue to Robin, considering your background, you know, maybe that's some of what we need to start to live into in healthcare. And I'm curious, Robin, you know, as impassion, um you have such a vast operation, 45 states. So what has your experience been as you've gotten more into the measures that matter, supporting those key findings and then also seeing it over 45 states?

Robin Heffernan: 13:06

Yeah. Um, I mean, look, loved the task force. We were actively involved in this, and and I think the small group of metrics we got to is a lot of what impassion uses when we initially identify hospice groups. Um and and what I would say is, you know, these metrics, they all have nuance, right? To your point of it's not higher is better or lower is better. There's nuance around each one. And so it was also really important that you get to a small enough handful of measures that you actually have the time for someone to think about the nuance, look at the right ranges for them, right? You can't do this on 30 different measures, um, and not to mention the burden it has on caregivers to collect all that information. So I like this small handful. We use it religiously to identify hospice providers in an initial geography or if we need to expand in a geography, you have to be in the top 50% of hospice agencies in that county in terms of these metrics. Otherwise, if someone comes to us and says, we really want to be part of your network, we say, Great, when you can be better at these things, because we know these things matter. Um, and then, you know, after they're in the network, well, now we have more data. How are they actually performing with the patients that we're giving them? Um, and we have more of the stories from the family and the caregivers, which I think also really matters. But it's a and and Mindy said this, it's a continual titration then, right? Of like each week, and literally like on Monday, we're deciding volume allocation for that week based on how someone did last week and last month, because it can really change um from week to week. And and I think you do start to see, you know, okay, this is a range for this KPI that we care about. And we know it's realistic, right? Um, but we also know this leads to better outcomes and better experiences. And and sort of gradually, month over month, you can get, you know, part of the reason we have a network approach is is you constantly have people competing. I think that competition in a market is really good and really healthy.

And and so you you can then sort of constantly drive up the bar. But but to this point, we said over and over you can't set it and forget it, uh, because these are moving targets. And so even the ranges themselves are moving.

Chris Comeaux: 15:52
That's great. Mindy, what about from your experience? Did you kind of did it affirm all these measures or yeah, yeah.

Mindy Stewart-Coffee: 15:58
Um, I I would say most of the measures were ones that similarly um we we had been using and and had agreed with. I think some of the discussion through the work group was around some of the process measures. And um, you know, we I don't think initially we realized that the process measures can be a little bit problematic, but through the discussion with the work group and then looking back to see how this is actually played out through through our day-to-day work, um, I'll I'll give you an example of that. Um so through the discussion, we were talking about things um sort of like the visits in the last days of life. And we actually had a discussion about that to say, well, most EMRs now sort of force uh like or serve up patients that they believe are within that last, you know, seven-ish days of life. Um, there's the service intensity add-on. There are other measures that we discussed that, you know, by and large, most of the group said, well, the EMR kind of like forces documentation on these things or sort of forces these processes to happen. So just is that an indicator of a quality agency or is that just an agency that's sort of following the process? And so in color by numbers. Yeah, yeah. And so um, so I, you know, I thought that that was um that was good and helpful. I I will say that good and helpful discussion. I'll say that in our work, um, you know, forming and managing networks, uh, we view the um this data as sort of the top of the funnel. And, you know, we we worked with health pivots, um, I think like from the beginning of you know our work in the VBID demonstration and going forward and other, you know, other scopes of work that we have. And and it is not um the only thing that we evaluate, but it definitely filters down to the agencies that you should be talking to. But but I would say for anybody who's initially using this data to form a network, to form partnerships, um, it you can't just sort of take that list and say, oh, without any, without any more evaluation, these are definitely the agencies that we should partner with. Um, you know, we we do sort of a multi-step process that includes also interviewing and having discussions with agencies to really make sure that they align with with what is important to us, with our population. The other thing I'll say is depending on on where you are in the country, um, you know, we've had some challenges in underserved communities, you know, sort of middle of nowhere USA, where sometimes you try to pull a report of you know who meets this criteria and there is nobody, or there's one or two agencies. Um, and so, you know, it to some extent too, um, then it then it becomes a matter of really trying to look at those sort

of, which is terrible, but looking at sort of those um, like the bottom 50% and saying, how can we work with these organizations to help them sort of pull up into the top 50%? But that is a real issue, lack of access in in some parts of the country. You know, you're not pulling a list with 50 agencies, you know, that are doing a really great job. There's maybe one, two, or none. Um, so that's sort of the next horizon, I think, of how to like how do we support those agencies that are sort of in that bottom, that bottom 50% to improve. And I'll I'll say one more thing. One of the other things that we've noticed through our work, and we did talk about a little bit um in the work group, is um just just demographic variances. Um, so you know, like a community that is predominantly um, you know, underserved or um low income or you know, has like different cultural variances um where you know they they have different preferences at end of life, that kind of makes the data look different as well. And so I think understanding the community that you're evaluating for um also kind of helps you use the data in a way that's really um kind of culturally relevant to for um for the population that you're serving.

Bob Tavares: 20:24

Yeah, you you know, the task force was not thinking about network adequacy. You know, you have to have a provider in this market, you've got members there. And that hospice may not meet your standards, but you have to have a network. Sort of related to that uh and raised in the report was a trend of nursing homes starting their own hospice or acquiring hospices. And lo and behold, a hundred they're the exclusive provider for that net for that facility. Um my very good friend, high school friend, uh mother uh is at the end of life and was in the hospital, discharged to a nursing home. And so I went into our database to see what's going on in that nursing home, what who which hospices do they offer, because it's that time for the you know for this uh family member. And there's only 100% of the days of care in that nursing home is delivered by one hospice who's owned by the nursing home. And I looked at their patient experience, I looked at their ranking report, and their their would you recommend was 59. The bottom decile in the country is 74. So they're in the bottom 1% of all hospices in the country. And I I brought, hey, you know, when the time comes, they're gonna force you into one choice, you have choice. They, you know, or you need to go find another nursing home. And so then it comes down to if I'm a ACO or I'm a health plan, I also now need to think about having preferred SNF networks as well, because it's Holistic. If that sniff has 911 on speed dial, no matter how you know the hospice is now at odds with nursing home and they're, you know, they they can be getting penalized in their scores because they want to deliver care there, but they can't intercept every emerging visit. You know, so um wanted to bring that up. There's a little bit of a concerning trend toward uh exclusivity in that way, um, and not giving not giving Medicare beneficiaries choice, even though they're legally should have it.

Chris Comeaux: 22:32
Yeah, I'm I'm feeling more empathy for Mindy and Robin's job on a day-to-day basis, thinking about all of these challenges. I I lament about, you know, we're trying, we're the ones on the ground trying to help those organizations improve. But as you kind of do this macro approach, man, how challenging that is. I've I know Cord's got some questions we need to get to. Cord, you want to go next?

Cordt Kassner: 22:53
Absolutely. As we shift into part two, uh, Robin, impassion is working on great hospice and pre-hospice palliative care. How does palliative care improve hospice and what are best practices or best metrics for palliative care?

Robin Heffernan: 23:08
Yeah, great. I'm extremely passionate about this one. Um, we think about palliative care really as you know, preventive care for end of life. Meaning one of the hugest levers for better hospice care is getting someone palliative care pre-hospice. Um, and so, you know, that allows you to ease into the conversations with the family, talk about various options, be way more proactive around the pain management and the crises management, right? And so um actually one of the other things we do in our network is uh you cannot be a hospice-only provider in our network. You need to be able to do both palliative care pre-hospice and hospice. Um it has routinely proved itself to be far better from an experience standpoint, right? I mean, if you're only doing palliative care and passing off to hospice, or if you're only a hospice provider, oftentimes even just that handoff when someone's ready for hospice, you have new DME equipment coming into your house. You have an entirely new provider team coming into your house, like literally at your most vulnerable moment. Um, so it's quite disruptive for the family. But but we found then, okay, we need to work with Bob and Health Pivots and with other analytic groups because palliative care is is very underutilized at this point, and and so it's under-tracked and under-monitored. Uh, we would say even, you know, it's probably only 5% of patients who need palliative care actually get palliative care right now. So the space for understanding these metrics is is very small. But we started in the same vein as the hospice test for us to look at okay, if we want these outcomes, what are the right early signals for good palliative care? Uh, and we found, again, just a small handful of things rise to the top. You know, number one, and and this reiterates Mindy's point on collaboration and sort of alignment of a group, is you need to be able to have a multidisciplinary team that is doing palliative care. If you're one of those groups that are only using NPs and you're doing sort of fee for service palliative visits right now, the month before hospice, just to tell someone about hospice, like that's not very good palliative care. You need social workers, you need RNs. Um, and then you need to actually be able to see these patients on a timely, regular basis. This this sounds like like basics and foundations and is, right? But there are very many palliative groups

that if you give them a referral, they're not seeing the patient for two to three weeks. That can't happen, right? These patients need to be seen within a week. And then, you know, someone needs to see them at least one time, sometimes up to three times a month. Um, we're also, and I think I think there's a debate in the industry, we we are big fans of in-person title care. It doesn't need to be 100% of the time, but it can't be 10% of the time. Um, and particularly on that initial assessment, it needs to be in-person because you're gonna see how this individual live, what is important to them, what are their SDOH issues, et cetera, et cetera. They're even doing, you know, home modification recommendations, right? But you can't do that over the phone. Um, and so we have found, you know, if you can get a group who is good on the process and making sure they see people timely and regularly, uh, you look at the visit documentation and you can pretty quickly tell, was this a like meaty visit where you're having real conversations, or was this a check the box type visit? Uh, and then you look at what is the hospice transition rate. You know, our our hospice transition rate now is 70%. Not national average, folks use hospice about 52% of the time. So we have actually found reliably with MA plans, their utilization is is largely in the 20%, right? It's quite low. Um and so again, not every person is going to be appropriate or want to have a hospice transition at the end, but it shouldn't be a very low number. And then paired to that, you you sort of get into the hospice metrics. We believe live discharges, burdensome transitions, that's a problem of palliative care as much as it is a problem of hospice care. If you have not appropriately educated the family and the patient about what hospice really means, no surprise, they are going to uh have a burdensome transition. And so that matters a lot. But but again, we try to keep it to a small handful of metrics. There's nuance in all these metrics. Um, the I guess the other key thing, and and any payer who has tried palliative care um will have scars around this of you can't do intensive in-person palliative care for 12 months or 18 months with a patient and expect to see an ROI on the program.

Cordt Kassner: 28:50
Interesting. Well, thanks so much. That's that's I I love how you're tying together the palliative care and the hospice and and the different uh mechanisms that are at play there. Uh Mindy, briefly, any uh how would you add to that based on your experience? And and then I have another quick question for both of you, or all three of you.

Mindy Stewart-Coffee: 29:10
I I couldn't agree more. The palliative care is um incredibly valuable upstream from hospice. I I do think a lot of times we um expect hospice to uh you know always perform incredibly well with patients when what they're actually receiving at the front door is um sort of anything and everything. You know, if if the referral to hospice was late, if if you know someone who's been engaging or interacting with this patient for months or years, you know, only starts to recognize um their decline or their hospice appropriateness in

the last three days of their life, was that the the fault of the hospice organization who's receiving that patient? No, you know, they had no interaction with that person upstream. Um and you know, similarly, you know, we've recognized this a little bit in um hospices who have a high percent of uh discharges, live discharges in the first seven days. Sometimes that is an issue with the hospice quality, with the conversation that was had, with misalignment of expectations. But we actually find, you know, even more so that it's in how hospice was teed up to that patient by whomever was placing the referral for evaluation for hospice. Um, you know, I so I think that upstream um, you know, engagement and work that palliative care does is incredibly important. Um, thinking about you know measures that matter in palliative care, I'm I'm a fan of process measures, um, which I know could be controversial and sometimes that just leads to box checking. But just looking at you know, clinical practice guidelines, I think you can start to measure, you know, frequently how the interdisciplinary team is really engaging with that patient. I agree, Robin, that that palliative care is more of an it is also an interdisciplinary um you know uh type program and and should not just be kind of one person essentially having hospice conversations and calling it palliative care. Um but I think with process measures, it's important to look at what happened next, not just was this assessment completed, did we do X, Y, or Z? But but um you know what happened after that? If we identify a patient's in pain, did we do something to address it? If they're having, you know, expressing feelings of depression or anxiety, did we engage social work or chaplain or address those symptoms in some other way? If the caregiver expressed burnout, did we get them support? Um and you know, I I also agree with the the transition to hospice as sort of a key measure of palliative. I think that's a little bit tricky too, you know. Um, and again, I'll I'll always go back to you you kind of have to look at the population and um the community that they're in. You know, New York, for example, New York's dual eligible population has roughly a 20% hospice utilization rate. So if you have a palliative program in New York and your decedents are utilizing hospice, you know, 35% of the time, you you might someone might look at that and say, oh, that's disappointing, 35, that's terrible. Well, it's 15% higher than the general decedent population that did not have palliative care. So um, so yeah, looking, looking at that measure can, you know, I think you have to have the right context. But um in all in all, I would say palliative care upstream of hospice and working in collaboration with hospice is really critical.

Cordt Kassner: 32:49

Yeah, couldn't couldn't agree more. Briefly for for all three of you, uh how do you move the needle with CMS to adopt these metrics to enforce accurate reporting? Bob, thoughts?

Bob Tavares: 33:03

Um You know, uh I I think it's the role of the NH, well, Knock uh for and former NHBCO and other um advocacy groups to bring it uh uh one voice. We you know, those two organizations have come together, they're they're now moving forward. Uh I I think it probably needs to start with somebody like them, um NPHI, others, to represent a unified voice from across hundreds and hundreds of everyone agrees that we should be simplifying the HCI measures or or modifying them or improving. Like what's the process? Are they going to look exactly the same 10 years from now? What's the process for reviewing, evaluating, and improving the measures that are in the public domain? Because I have I was on a call yesterday with a hospice team client of mine, and they're really stressed out about every single one of the HCI measures because their board of directors, who doesn't know any better, thinks they all matter a lot. And they don't. You're not going to get more or less referrals from a hospital based on your you got nine uh uh HCI overall score of nine versus ten. Like the board thinks it's important. Now this management team is forcing their team to go pump up the number of minutes on the weekend, you know, and it's just counterproductive.

Cordt Kassner: 34:25
So great points. Uh Mindy, thoughts on moving the needle with CMS?

Mindy Stewart-Coffee: 34:30
Yeah, I I would agree with Bob and um not to be you know wildly controversial, but I think there is um I also when when we sort of look at some of this data and you do see um outliers uh you know at the bottom of the pile. So sort of people who have you know arguably concerning outcomes, um it it does seem like from a uh regulatory or oversight perspective that perhaps you know CMS may be interested in looking at that information, you know, as a way to go to those providers that are again in not in the bottom 50, but in the maybe the bottom 25, bottom 10%, and and maybe start asking some questions. Because you know, I I do think that um you know having having agencies that are you know uh in the like out in the public serving patients, um, you know, if if the consumer is not really doing their research, if that hospice is, you know, in your example, Bob, just it is sort of the only one that is available to them and being recommended by their um nursing home. You know, I I think a lot of times consumers aren't aren't necessarily questioning, well, is this a good one? Can you tell me about it? How does it compare to others? Um and and so I do think it's maybe a little bit incumbent um on you know uh regulatory entities to to go in and sort of look at those um severely underperforming agencies and and maybe start to evaluate how to uh get get an improvement plan in place because you know, alternatively they're going to continue to serve people in the community and and you know there's a potential for harm there. I think more broadly, um, you know, hospices has in you know recent years um also kind of come under fire for quality concerns. And so I I do think maybe some proactive um management uh and

evaluation of uh agencies that are providing hospice care, like this gives a great tool for that. Um really establishing what measures uh we should be focused on and which ones are you know potentially indicative of of harm being done to patients is um something that we should evaluate.

Cordt Kassner: 36:55
So great thoughts. Thank you. Uh how about Robin? What do you think?

Robin Heffernan: 37:00
I agree with this. I think us doing the work to give a bottoms-up consolidation on these are the metrics that matter has to be done, right? Then we gotta talk about it. We gotta publish these numbers, you know, sometimes just by default of what gets out there the most often, then becomes the standard. Uh, I also think this is inevitable that CMS will start to pay more attention to it to the point you raised, Chris, in the beginning. This is 25% of Medicare spending. Right? And when you have these bad hospices who are leading to inpatient admissions and over-medicalization of patients who don't want that, then it's it becomes a problem. And so, you know, I I think we're just gonna see this squeeze. We're gonna get the information out there, CMS is gonna care more. Uh, and and sort of the hope is all right, great, like let's consolidate on this small number of measures so that we can all go move the needle on them.

Chris Comeaux: 38:06
Well, let me go ahead and try to help us land the plane. This is an awesome conversation. We could go on hours together, and I think this will be an interesting way to kind of pull it all together. So, this is gonna be a question for each of you, and of course, you weave any final thoughts. How do you define value in the last year of life? Bob, you go first.

Bob Tavares: 38:24
Well, I'm I'm gonna keep it simple and just uh you know, think about total cost of care. Um, value is is this the most affordable way to care for a patient that where that care is aligned with their goals and preferences? Um I told a story earlier about my uh two family members, both died of cancer, both were aggressively treated with extremely expensive interventions right up until the day before they died. And they were scheduling more chemo, more surgeries, more, more, more for people that were clearly anybody who had done an assessment um would have known. So hundreds of thousands of dollars of spending was really futile. And um and we failed uh the health system failed them both by never having the conversation about what they wanted, about prognosis, about survival rates of for their type of uh situation. That's extremely high spending. Um for what I would consider, yes, they're interventions. The interventions were executed flawlessly, you know, but what are we doing? Um I have some good news. Uh I'm gonna leave the group of

listeners with good news. And that is that we track ACOs that focus on a serious illness population, high needs ACOs. They are the most successful ACOs in the country. And they're generating double digit savings rate year after year after year. Um their use of hospice is often 80 to 90 percent. Their length of stay is often five, six months. So they're using all hospice often and with with very healthy lengths of stay. And their hospital death rates, these high-performing ACOs, the bluestones of the world, the sound physicians of the world, um, LTC, they are using hospice at very high rates. Their hospital death rates are in the low single digits. And so they've it we belong at the table for optimized total cost of care and value. Um, that's the good news. The bad news is we have a long way to go because that's the these high, these hyper-focused ACOs. The general ACOs that are hospital-centric, very large in your communities, um, will have 20 to 30 percent hospital death rates, much lower use of hospice, often with a couple days of care attacked on after the patients leave the hospital. So, for to simplify things, I think of value for hospice and palliative care is we need to we we also can't have a two-year length of stay because that is not cost effective, but neither is a two-day length of stay, particularly a two-day length of stay where the patient just left the hospital. So, value is has to be framed within total cost of care measurement. But of course, we've got the patient's goals and values as well. And if they want to seek aggressive period of care through the end of life, that's their definition of uh, you know, we need to be able to honor that. But I think most people, I don't know the statistics, but certainly 80% of patients would prefer to die at home with their family members by their side, not hooked up to a bunch of tubes and you know, blinking lights. And if we're not honoring that, and that's gonna be lower, it's gonna be hospice, it's gonna be lower total cost of care, but not too little, not too, not too late. And so I think um the good news is hospice is part of the value equation, and then we have a lot of work still to do. Well said, Bob. Robin?

Robin Heffernan: 41:57
I I would echo Bob, right? Value for us is great outcomes at scale. And so this is a space where you can get better patient experience, better caregiver experience, lower cost for payers. We actually know what good looks like. We just need to do good consistently across the US. And so I'm very optimistic about that. I think this is clearly a valuable service. It is both palliative and hospice care. And I'm thrilled that that this group, and you know, there's a lot of folks like us, are doing the work to try to make hospice even stronger.

Chris Comeaux: 42:39
That's very well said, Robin. Thank you, Mindy.

Mindy Stewart-Coffee: 42:42

Yeah, I agree. I think um goal concordant care. So, did their goals align with their treatment and their experience in the last 12 months of life? I think that's really key. And and that that is true for all people in this country, regardless of where they live, regardless of income level, that their their goals and wishes are honored in end of life.

Chris Comeaux: 43:06
Well said. Court, I'd love to hear your do you have a response to that question?

Cordt Kassner: 43:09
You know, briefly, I I think we're all saying the same thing in different ways. Uh I think traditionally value is very elusive because quality is typically quality divided by cost. Quality is that uh qualitative component based on patient wishes over cost. And part of that's financial cost, part of that is uh the staff satisfaction and staffing concerns. So I it's it's really I I think most providers focus on one side a bit more heavily than the other side, depending on who the provider is. But that's why it's challenging because we're trying to balance both the qualitative and the quantitative. Chris, you've given a lot of thought on this. What what do you think?

Chris Comeaux: 43:56
Well, first off, I want to give kudos to Bob and Mindy and Robin for being here. Today. But even more than that, Bob, kudos to you, man, being a leader. One of my heroes is Atul Guandi. And I love one of my checklist manifestos, one of my favorite books of his. And I usually tell the story. I'm like, you know, World Health Organization calls him up and says, hey, Dr. Guandi, worldwide surgical errors is on the increase. Would you like to take on that problem? Who the hell takes that phone call? And he goes, Not only am I going to take on that problem, I'm going to think about it. And he starts looking at why do airplanes not fall out of the sky and why do buildings not fall down. And he comes up with this amazing concept of checklist manifesto. I mean, Bob, you were looking at this variability and going, instead of just, well, that sucks, let's do something about it. That's being a leader. And I just want to give you kudos and then getting amazing people surrounding yourself with great people like Robin and Mindy. So kudos to you guys. Where my mind goes, listening, maybe this is a way to tie it all together. I think of the quintuple aim. We had the quadruple aim. We've now just adopted the quintuple aim. Don Berwick's great framing of hey, if you want to ticket to the future of healthcare, this is what you should be working on. Better service, better quality, lower cost, great work environment for employees, and access for as many people as possible. That's the first place my mind goes to. We use this as our rally and cry within Tilly S collaborative network, with our clinically integrated network. And then I actually have on my whiteboard in my office this equation. I'm kind of an accountant, I'm a geek, but I find it actually inspiring. It says value equals, and on the top part of the equation, quality, and I

don't mean just, oh yeah, quality. Quality in its deepest, richest sense. Service in its deepest and richest sense. Like Bob, I think of your family stories. Like anywhere along the way that anyone asks, hey, what matters most to you, Mr. Taveres? Or did they just the healthcare manufacturing conveyor belt just do what it does to people because it's a hammer and everything is a nail. And so service in the terms of what do people really want and how are we meeting those needs? And then access, so quality plus service plus access, divide it by cost. And I think like that's a great framing that to me ties together much of what we talked about today. You guys have taken on some complex work. We're gonna include whatever links that you want to, and we're gonna keep cheering you on and let us know how we can partner with you and keep furthering that work. So thank you guys and thank you for being here today. Child listeners, we want to thank you. The end of each episode, we always leave you with a quote, a visual. The idea is to create a brain bookmark, like a brain tattoo, a thought prodder about our podcast subject. This is gonna be a really fun brain bookmark to do. But the idea is we want to stick in your brain. So you really take away the key takeaways from today. Be sure to subscribe to our channel. Pay forward to your coworkers, your friends, your other leaders throughout your organization, your network throughout the whole country. And you know, it's easy for us to reel 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 today's podcast. And here's our brain bookmark to close today's show.

Jeff Haffner: 47:00

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