

TRANSCRIPT: Love Hurts: Leadership, Quality, and the Future of Hospice & Palliative Care | Part Two

Framing The Hospice Challenge

Jeff Haffner 0:00

Welcome to TCN Talks, and Anatomy of Leadership. We continue our conversation in part two of Love Hurts, Leadership Quality, and the Future of Hospice and Palliative Care with the GeriPal Podcast. And now, here's Chris Comeaux.

Dr. Eric Widera 0:20

Cordt, what's your challenge?

Waste, Fraud, And Field Reputation

Ownership Models And Mission Tension

Cordt Kassner 0:22

What are you thinking? What are you worried about? You know, I think some of the themes that you've you've mentioned, the waste, fraud, and abuse is a concern. We have so many absolutely fantastic hospice and palliative care providers out there. And and yet the country often uh looks at hospice as it's a you know one-stop shop, like it's all one hospice, and they they don't get the differentiation between the providers. So when you see an article that that's talking about fraud or something inappropriate going on, it it tarnishes the entire field. And and that concerns me. I I think we need to to clean that up. Um the other thing that that kind of comes to mind is around uh some of the ownership issues. That a dozen years ago we were talking about nonprofit, for-profit. Well, today we've segmented both of those. So there are articles out now about differences between church-based nonprofits and freestanding nonprofits. That's interesting. I and then we segment the for-profit side into independent, uh publicly traded companies and private equity back. And what does that mean? I and I don't I honestly don't think we have answers to any of that yet. We're participating in some research studies around trying to answer those questions, but there's a there's a conflict between the mission and the money, and it's yet to be seen who's gonna win and how that's gonna impact patient care, which is what it boils down to me. If quality of care improves, ownership doesn't matter. I if it's going down, that's that's a concern. And and again, ownership doesn't really matter, but but we can probably segment this and and unpack this a little bit more than we have to date.

Does Ownership Affect Quality?

Dr. Eric Widera 2:17

Yeah. I think you know the research that we have is that it it does mat so there's good and bad hospices, um uh, and there's heterogeneity amongst hospices, but there seems to be more heterogeneity amongst for-profit hospices than non-for-profit hospices, knowing that the field is evolving, right? Like even in hospitals, we see that you know, nonprofits are starting to look a lot like for-profits and how they're acting and operating and what they're worried about. Is that your sense too?

Cordt Kassner 2:50

Keep an eye on it. It is, absolutely. And the the larger the provider, the more homogeneity there is, the more they all look the same. Yeah.

The RIS Framework Debated

Chris Comeaux 3:04

Chris, I think you're up. Yeah, so my question is um, since originally how we got together was around Ira's framework, what do you think of Ira's framework? And oh, maybe for the listeners, I'll repeat it. Zero tolerance for waste, fraud, and abuse, clinical and programmatic standards, making meaningful data readily available, driving competition based on quality, embracing and promoting our authentic brand. What do you think about it? Is it is it needed, and what's your opinion about it? You've debated it, talked to him about it. Cordt and I use it a heck of a lot.

Dr. Eric Widera 3:33

Yeah, you use it when you talk about kind of the I every time you bring up those stories, you you bring it up. Alex, I'll turn to you on this first. I took the first one.

Capitalism, Profit, And Quality Risks

Dr. Alex Smith 3:44

Uh just trying to put together my thoughts. I think it's a great framework. It's a great it's a it's aspirational, and I appreciate that. I think I I worry a little bit that it's um unobtainable in the United States because we live in a system that is so capitalist and for profit dominant and where um you can potentially um play end up playing whack-a-mole, squashing down one uh mechanism by which people are profiting off of people who are seriously ill and dying in ways that are concerning. Because profit by itself is not bad. It's just when the profit leads to motive leads to a decrease in quality that we become concerned. Um, so I guess the the critical part of me would say, can you really have zero tolerance? I mean, we should aspire to have zero tolerance for waste, fraud, and abuse.

And uh we don't live in a country with a national healthcare system. And we are almost always being reactionary. I would love it if we could be more proactive. But I remember Eric and I were giving grand rounds at UCSF, and you pulled up this slide that you'd done some research like about not just hospice, but like for-profit ownership of nursing homes and assisted livings. And weren't they also like 70, 80 percent? There's money and medicine. Yeah, so for all like hospice, you know, it just it is what it is. Like we are there are people out there who say we should have only nonprofit. I don't think I'm Byock's saying that. I'm not gonna put that on him. But um he specifically says that's he doesn't argue that.

Market Distortions And Medicare Compare

Dr. Eric Widera 5:39

I'm gonna be optimistic and say uh uh that is that's where our field has been. Like, oh, you know what, this is really bad, but it's not our problem. Uh and I think that there are things that we can advocate for, uh, and this is our problem. Like, if brand is important, like Cordt said, is this is tarnishing our brand. People are associating hospice with you know, people talking about fraud that's happening in places like LA. Like they're associating that with hospice. Then I have to have like 15 more minutes of discussion with the patients when I'm talking about that. And then I actually like even Medicare Compare, the reason I hate Medicare Compare is it starts off alphabetically, and if you're in a place like Los Angeles, it literally only goes to the letter C because it's letter C, you're at 300 and it maxes out at 300. It's it's pointless. Um, you could fix Medicare Compare, but that's not the problem. It's that you have over 300 hospices in one county, um uh, which is just insane. And I'm just gonna plug one podcast that TCN did on certificate of need. Because not every state looks like California, not every state looks like Texas, right? Chris, can I ask you what is certificate of need? Because our GeriPal podcast audience may not know that.

Certificate Of Need Explained

Chris Comeaux 7:07

Yep, you bet. In a lot of states, I think it's about 26, 23. Cordt actually looked it up for me. And um, so it's less than half of our states. There is a law called certificate of need. So um the opposite, it would be like the state of Texas. There is no C O N. I was having dinner with my godfather, serial entrepreneur, or hatress, what have you been doing your life, your career? Hospice, oh my God, a lot of people dying. That's a great business. I need to look into that. That's the problem. And so states where there's a certificate of need, you can't do that. Actually, there's a formula that determines if there is a need. And so it basically creates the ability to create controlled competition to make sure people have choice, but you balance resources. And if the capitalists are like, that's bad. You should

always have competition. I'm sorry. Free market works when all the elements of free market are in place. You don't have all the elements in free market in healthcare, which is why you need CON. I'm okay with a capitalist system. I'm during a capitalist in nature, but in healthcare, it does not work if you use just a free-for-all. If that was the case, you know, hey, let's go to Texas, let's go build a hospital in Dallas because there's a lot of people there. What about the poor people in Lubbock, Texas? You know what? We don't worry about them. We want to go where the people are. That's the point of CON, is it gets resources where you need it.

Dr. Eric Widera 8:18

Let's be honest. The the especially like in the hospital setting, the way hospital people in hospitals get selected into hospices, it's not Medicare compare, it's not a quality metric. It's who can admit this patient is fast enough so we can decrease our decrease our length of stay in the hospital for many hospitals. So it is not this is not a true free market. Um uh and people don't have say, they don't even know where to look for for that.

Why Free Markets Fail In Healthcare

Chris Comeaux 8:49

But I am optimistic that's changing with the baby boomers. I think we're on the cusp of a lot of sea change things blowing in the favor of things I think we would all believe in, like people choosing the best. You know, you go buy a car, you want to get the best, or whatever it is. Healthcare has not been that case. And maybe the baby boomers will be the generation of force, a lot of those good market things that it's it's not all free. You should have certificate of need and things. You have regulation and good rules and for a game to work. It's not, well, let's just throw all the rules out. Hell college football has rules. And so with healthcare, oh, we just don't need a certificate of need. Well, what game does that actually work in?

Choosing Care: Speed Over Quality

Cordt Kassner 9:22

Yeah, Eric, you were mentioning about your frustration with care compare. I I recently had the experience of helping a friend of mine out. He was looking for an oncologist. And I said, Well, I'm in healthcare-ish. I'm, you know, how can I help? So I look went to care compare and I'm looking up, you know, physician compare. And it says, Well, this one's half a mile from your house. This one's two miles from your house. Like, that was the rating. Like you said, alphabetical for physician compare, it's by distance to your location. And I'm like, you know what? If the if the best ontologist on the planet for this particular disease is at UCSF, I'm flying to UCSF. Like, this is that is not an issue. If I need to go to

Mayo or, you know, wherever, no problem. So mileage doesn't help me at all. And and so, how do we fix that? How do we correct that kind of a uh of a metric?

unknown 10:20

Yeah, yeah.

Dr. Eric Widera 10:21

And how do we make sure that every hospice has a quality measure? So when we're looking at them, like how many, how many, how many don't have are aren't aren't star rated in Medicare Compare?

Cordt Kassner 10:35

Over 70%. Like, why don't have a star rating?

Dr. Eric Widera 10:39

Why put them up there? Why name them? Like we should shame them. There should be like a dishonor roll on Medicare Compare if they don't have a star rating.

Chris Comeaux 10:50

Well said. Totally agree. And Eric, you started this by asking me my question about Ira. Alex, I wanted to say the the brilliance of what Ira's done is we're talking about it. That's the brilliant. And he will tell you he's gotten pot shots from the nonprofits and the for-profits. I'm like, that's when you know you're succeeding. You got him talking about it, you got him thinking about it.

Baby Boomers And Quality-Driven Choice

Dr. Alex Smith 11:09

I love that he started up and really started a conversation, pushing, pushing, pushing on this issue. Yeah.

Flawed Ratings And Missing Star Data

Cordt Kassner 11:15

Well, and I've been encouraging boards and organizations to consider, to talk about his paper and his strategies and assess, like, where are we today? What's our baseline measurement? And and I like how he is empowering clinicians and people in the field, leaders in the field, to have a structure to think about, well, I can plug in and make a difference here, because we should all be plugging in to our spheres of influence, right? And maybe that's in the research circles, maybe that's in the hospital setting. How do we do that? And he's he's kind of issued the challenge to say we should be involved in these conversations. We should not just be turfing this to Medicare and say, well, you made it, you broke it, you fix it. He's saying, no, we're the experts in this, and we need to be in the conversations. And I I completely agree.

Dr. Eric Widera 12:17

I guess that my question to you on the Ira topic, because he didn't just mention hospice, he mentioned palliative care. Um you know, same thing, standards for palliative care. Um what what what do you think we should we should do there? Because this is a tough nugget because hospice is a little bit standardized of what they should be delivering. And man, you see one palliative care program, you kind of see one palliative care program.

Naming And Shaming Low-Data Providers

Cordt Kassner 12:45

Absolutely right. And I I I think the challenge is there. What are the standards of care? And there are some standards that are out there, but there's there's not really that uh that data collection and transparent reporting of results to compare you like right now, I'm starting a research project across the state of we're contacting every hospital, every hospice, every known palliative care provider in the state of. And it it's really we're at the beginning stage. Like, who's providing palliative care? How many consults, how many patients? What does this look like? What's your interdisciplinary team look like?

Why RIS Works: It Starts Debate

Dr. Eric Widera 13:25

How do we define what palliative care is? Is it just like you know, somebody calling up and you know, setting somebody a squeeze ball? Um which I have seen as somebody wanting to label that a palliative care clinic.

Defining Palliative Care Standards

Cordt Kassner 13:39

Exactly. And in Maine, Maine, many states have a definition from the state legislature, or you default to the World Health Organization or AAHPM or you know, whoever some CAPsi's definition is often used. Yeah, I don't care. Like pick one and let's evaluate against it, not just the presence of it, but to your point, Eric, quality. Who's good at this? How do we actually assess quality and palliative care? And it's fascinating because it it seems in in my experience anyway, palliative care has a has a much stronger research base behind it from the beginning compared to hospice. And so these questions have been asked at a much earlier stage in the game, which excites me. I I think that's absolutely moving in the right direction. Alex, have you seen that kind of research in palliative care? Separate from hospice in terms of assessing quality within palliative care?

Data, Transparency, And Team Models

Dr. Alex Smith 14:46

I think it's just starting. I think it's too early to say um we have good published data about that. And that's part of the problem with a lot of research in this area, is there's a big lag between when data becomes available to study and when um we need it. Like, so I know people, including uh mentees who have grants to study this or have put in grants to study this, but you know, it's probably years away from publication. Uh, I'm sure there are some people out there who I'm not thinking of offhand who are working on this. Okay, is it my turn? Can I ask a question? Can we shift topics? Let's talk about leadership. Chris, major focus of your work, your podcast, your book is about leadership. And you interview people on TCN Talks who are leaders in hospice and palliative care, and leaders who are outside of hospice and palliative care. I'd love to hear from you and from Cordt and from Eric what you have learned that it's like take-home messages that are pearls of wisdom for our listeners about leadership.

The Lag In Quality Research

Pivot To Leadership Lessons

Go See For Yourself: Staying Close

Focus Your Influence, Cut Through Noise

Chris Comeaux 15:59

I love that question. Thank you. It's very much in the my place of passion. And I was thinking about what you were saying earlier, Alex, about these young people coming out, and maybe the road is going in a different direction than what they're thinking. So, a couple of great lessons I've learned over my life. I've had incredible mentors from growing up in corporate America, but yet I landed in a hospice at the age of 25. You got to go see for yourself. The Japanese call it gimba, which means go see for yourself. And no matter what I'm working on in leadership, like actually in about four weeks, I'm gonna go out in a full day with patient visits in the hospice. The beauty of you guys get to do still, you're in leadership, you're doing a podcast, but you're actually face to face with patients. I think it's important as leaders that no matter how your role evolves, maybe you're a uh senior vice president or chief of something, you got to go see for yourself. Always make sure you're still close to the action. Um, Abraham Lincoln was always one of my heroes. I love always reading history. Abraham Lincoln had this amazing team of rivals of leaders around him, but he had this news reporter and people on the battlefield that had the backdoor

access to him. That it was an ability for him to know what was really going on. He would go out himself. Those are great leadership lessons. And so now when you're young and face to face, be a sponge, all of that. But then as you evolve and you have leadership positions, don't forget some kind of way you've got to stay connected to the mission. And because you could get in your ivory tower and then making decisions, not based upon their audit. I think is the beauty of our just doing the podcast. You guys, as GeriPal, your listeners are in the action on a day-to-day basis, hospice about care. Most of my listeners are on the leadership side. And like your Eric was pushing a court earlier, like, give me the specifics. And he was giving you a framework. That's exactly kind of leadership on a day-to-day basis. The leaders are given a framework. Staff's like, but this is where the issue is. You need both to actually get great outcomes. So that's the first one. Never lose sight of going see for yourself. Second is we live at a time where there's so much coming at us. You know, instant messaging, social media, your email, all the stuff. Where you put your influence is one of the most powerful tools that you have in your toolbox. But yet everything's coming at you to diffuse yourself. If you turn off the light and you lit a cigarette lighter, it provides a little bit of light. A focus light as a eye-beam or a beam of light would actually cut through a steel I-beam. Where you put your focus is huge. We actually call that influence in the anatomy of leadership. So as you go forward, if you're too diffuse, it's hard to make a difference. So where you're putting your focus and your influence is absolutely huge. And we live at a time where everything is screaming at you to go wide. And yet, I'm not saying just go very, very thin, but where you put your influence is going to determine what your impact is on the world. That's a huge leadership lesson. I wish I would have gone back and someone could have told me that in my early 20s.

Servant Leadership And Grassroots Feedback

Dr. Eric Widera 18:58

I love the the what was what at the Japanese call you said? Gemba, which I just say go see. Like during COVID, uh, that was that was for me a a great place to see like who were the real leaders, like who were the people that um I looked up to. And it was the people that were there, that were present, that were like that, and that really influenced me kind of how I think about like the leader that I want to be is you gotta be there. You got yeah. How I don't want to use battle metaphor, but like in the trenches is a good metaphor. Um yeah. Cordt, what do you? What do you think?

Curiosity, Mission, And Interdisciplinary Work

Tackling Intractable Problems And Legacy

Cordt Kassner 19:39

You know, I I kind of echo what Chris was saying. I I I as a social worker background, uh, I I think about those grassroots movements and and Robert Greenleaf's, you know, the epic book, which is now probably a you know a thousand years old, servant leadership, that you think about the leader at the top who's making these decisions, but you have to have the feedback from from everybody. And I remember being the the CEO of the Colorado Hospice Organization, and one of the first things the board said was you need to go out on patient visits with each member of the interdisciplinary team to understand what we even do. I'm like, I absolutely need to do that. And and that was that was my favorite learning piece in that position was just going out and like I'm the tag along. And I loved that. I the other piece that that I would mention in terms of the leadership, I'm I'm taking a class right now around AI stuff, and and one of the questions posed was uh what's the greatest obstacle to integrating AI into your whatever your field is? And the first thought that came to mind was leadership is is the biggest obstacle like the that resistance to change, and you know, but really you need the support of the leaders in your organization, in your field to actually create change. Alex, what's yours?

Closing Thanks And Brain Bookmark

Dr. Alex Smith 21:13

I I I agree with the the uh this I mean there's so many good points could could be made here. I like Chris's idea of having a focusing effect that if you have a dark room and you light a lighter, everybody's gonna look at that lighter, right? And I think it's critical, especially at these times when um, as Chris was saying, there's so many distractions and different avenues you could go down that you have some focus. But I'll also be contrarian here and say that if you look at my career, even though when I write my like NIH bio sketch, I can try to come across as very focused. I'm incredibly unfocused. Like I can actually give like my one of my standard Grand Rounds talks is like confess. Of an unfocused researcher. Um, because I've really had like more like several areas in which I've had focus rather than like one specific, you know, dominant area of focus. But I think the underlying principle is that I'm I'm I'm dedicated to advancing hospice, palliative care, geriatrics, gerontology, aging research, serious illness research. Like I'm mission driven in that way. And if it aligns with that mission, then I'm all for it, you know? And within that um somewhat broad um uh purview, I just love the intellectual curiosity of like you know, working with different issues, different problems, whether they're like bioethics issues or epidemiologic issues. Um so I agree with the focus and also that it's it's gotta be interesting. Like it's gotta, you've gotta keep it interesting and gotta keep it fresh for you

and for the people who you lead, right? They have to continually have like a renewed sense of purpose.

Chris Comeaux 23:11

Can I reconcile that, Eric, before you go? I love where Alex just took it. Actually, I think Alex, you just took it to the wisdom of the hospice model. Interdisciplinary work is one of the secret sauces of hospice. So, in my focus, it absolutely doesn't mean you have to be monocular, but like you take someone who's so curious, like you. When I'd say you, you're focused, you just took it to the mission, but you're also hyper-focused on being curious. And so I think you could still make that a superpower in your focusedness. And I think the future is much more interdisciplinary. You know, I don't know what you think about Elon Musk, but he's brilliant in so many ways. He took interdisciplinary into the manufacturing area. No one ever did that. You had electrical, engineer, silo, uh, the mechanical. He put them in teams and like interdisciplinary. He like literally adopted the hospice model in manufacturing and transformed it. So I think that we have some secret sauces in the hospice space, palliative care space that are part of the future. So I love you took it in that direction.

Dr. Alex Smith 24:10

I'm sure there are some of our listeners who would like to euthanize their Teslas. Yeah.

Dr. Eric Widera 24:18

I actually feel from uh Elon perspective, it's not the leadership that I look at mainly because I think he takes credit for everybody else's innovations as his own. Uh and that's like the worst type of thing. He's very complicated. To um uh the intractable problems. Like, like you can think about like money in medicine as an intractable problem. You can think about like quality and palliative care. Like these are big hard problems. And I'm gonna bring it back to hospice too. Is you know, there was once a time a social worker slash nurse slash doctor who tackled an intractable problem, which is death um and medicine's reluctance to actually care for people who are dying. That was James Cicely Saunders who created the first hospice, um, and is still kind of like when we think about like an interdisciplinary team in one, kind of her, um, but also somebody that we we look at as somebody who tackled an intractable problem. Again, it it's not like all of a sudden we fixed it. You know, deck many decades later, we're still working on making this even a better model of care. And that's that's kind of the leadership that uh you know I think is important to model. Not just the fact that she had sherry behind her desk and that uh she she had people drink sherry with her during her one-on-one mentorship meetings. Uh you just break out the little glass. Um Alex can break out his guitar. Uh, we can have a little come in together. Well, uh, Cordt, Chris, I want to thank you to be on this podcast, uh, our shared podcast, TCNtalks and GeriPal. Thanks, Chris Cordt. Thank you guys. Thank you guys. And thank you to all of our listeners for your continued support.

Chris Comeaux 26:15

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Jeff Haffner 26:23

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