Episode:

The Value of Hospice Today and into the Future

Chris Comeaux Host00:00

Hello and welcome to TCN Talks. I'm excited about today's show. Our guest today is Carla Davis. She's a senior vice president of Hospice and Powder Care Operations and business development for LHC Group. Welcome, Carla.

Carla Davis Guest00:14

Thanks, Chris, i'm looking forward to it.

Chris Comeaux Host00:16

I'm looking forward to it as well. I've been a fan for a long time. I haven't been stalking you, but I've been a fan. I just remember the first time I heard Andrew Reed talk about you and I'm like I want to meet this Carla, and I've said for years I think you're probably one of the two smartest people in our industry, and I met you at the NHPCO conference many years ago. It was at Wild Horse Pass. It was the one that Jim Collins was at and made such a great impression on me. You lived up to all the expectations. It feels like our past has been crossing in interesting ways. I remember hearing the story about when Dave Reem and Caroline Kasin discovered you. Maybe you might weave that story in.

Carla Davis Guest00:59

Out of proportion, i think, over the years. The funny story about Andrew Reed is I first, my first job out of college was working at Medicare, and

on the desk were a stack of the Medicare regulations, right, but on top of the Medicare regulations was a note from my predecessor And she said if you have any questions, call Andrew Reed.

Chris Comeaux Host01:22

Oh, that's too cool Yeah that's too cool. And you, of course, ended up taking over a hospice where I was a coach for a while, fell in love with the wonderful people based out of Lafayette, Louisiana, hard of hospice there, and I know you did a phenomenal job with them. So again, i feel like our past has crossed in multiple ways, but we've never really spent much time together, so I'm super excited about today. So let's just start with first, what does our audience need to know about you?

Carla Davis Guest01:49

Well, i have been in hospice all of my life. So I went to Davidson College in North Carolina, right down the street from you, and this was around 1990 when Bill Clinton was running for president, and I was in this class on rationing medical care And I learned at that time that we were spending about a third of our Medicare dollars in the last year of life, and most of that in the last few months of life. And I think this is kind of relevant to this conversation because that's where I started And I didn't know that hospice existed, but I knew people were dying these miserable deaths behind curtains and hospitals, and so I decided I'd write my paper for that class on end of life care and basically how this could be the solution to this impending health care crisis that we had. And I remember typing into the card catalog thing because the Google, as my mom calls it, did not exist at the time And you typed in things and then out popped on the printer with the holes on the side, the paper, you know all the articles and books and things about end of life care and health care cost, and of course all of them were about hospice. This is even in 1990.

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And so I took all of these things home and for Thanksgiving break and I learned about hospice And I can tell you where I was sitting and I feel like

I had a calling at that point to help people at the end of their life. I knew that this was part of our solution to our health care crisis, but it was also just the right thing for people. So that's when I was 19. I ended up writing my creating my own major in medical ethics and focus specifically on how the American health care system should change to better integrate the hospice philosophy, which is sort of nerdy when you're 19 and 20 to focus on end of life care at that time. But I just, i just knew, and never in a million years would I have guessed that God would have had me on the path that I have been on. But I feel really blessed to be where I am now and helping to lead LHCs, hospice and palliative care and help more people, because that's what it's all about.

Chris Comeaux Host04:03

Wow, that's awesome And that I learned some stuff I didn't know there Carla. I, didn't know about the Davidson connection. That's actually really cool.

Carla Davis Guest04:10

We did more than Steph Curry.

Chris Comeaux Host04:15

So talk a little bit more about the seat that you're in now. You're now part of one of the few vertically integrated health systems and really the largest one in America. So maybe what are some of the positives and maybe some of the challenges?

Carla Davis Guest04:27

Yeah Well, just to orient the audience a little bit, lhc has been a part of and building really a vertically integrated care continuum in the home for 25 years, starting in 1994 with Home Health and 1998 with Hospice, home and Community-Based Services and other services sort of complimentary. But in March of this year we were purchased by Optum Health Services And so just at this point we're just in the beginning stages of trying to integrate in. I mean, i'm excited about it because we

are in a position to be able to create really the most comprehensive suite of services to wrap around the beneficiaries that are aging in our country and to help shepherd them through whatever needs they have as they wax and as they wane, and especially people that are living with serious illness. It's exciting to me to be a part of a payer organization because I think that will allow us to innovate and to change and figure out what the care delivery model needs to look like and not just improve the quality but also come up with solutions to knock down barriers to people getting the right care at the end of life And I don't know that it's going to look like it does today And I quite frankly hope that it doesn't But to kind of get to the challenges, i think you know, and just even in my career, i started after Medicare.

06:14

I worked for what is now Kindred well, argentina whatever the name is now But at that time it was nursing homes and LTCHs and also Home Health and Hospice. And I've also worked for HCR or Medicare, which of course is a large post-acute healthcare continuum and just because you are inadvertently integrated continuum doesn't make it function that way right.

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And I think today in America, unfortunately, you know, reimbursement tends to drive us to be relatively siloed, and I think that's what we're all trying to solve, for I mean, we all want the patient to get the right care at the right time, but the structure of the way that we're reimbursed, you know, isn't all the incentives are aligned. So that's why I'm honestly thrilled about this opt-in purchasing us, because I think that we are in a place that we can really figure out what it needs to look like to transform end-of-life care, and I'm not naive enough to think that it's not going to be a lot of work.

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And we're going to mess up and we're going to have to figure some things out, because to really change end-of-life care we have to change

ourselves, and so what that looks like I don't know, but I'm excited to be a part of helping figure it out.

Chris Comeaux Host07:40

Well, i'm excited for you to be in that role as well. I've said for years I've watched LHC Group, because I don't know if you know this so I grew up in Appalachus, louisiana, which was the Oh my gosh, I didn't.

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Yeah, so you know the connection then, because that's where Key started. Really. LHC Group is really that think it was that Doctors' Hospital Home Health Program, something like that. So a lot of interesting kind of connections to that. So I've said for years gosh, if they get an incredible leader, it'd be really interesting to see what someone does with that platform. So I think you found yourself in an amazing position to shape what the future looks like.

Carla Davis Guest08:14

Yeah, I'm very excited.

Chris Comeaux Host08:15

Well, let's talk about some really good common ground, which is the NORC study, and you're on the board for HPCO, is that right, carla?

Carla Davis Guest08:25

I am.

Chris Comeaux Host08:26

So talk so that study has been huge. I'm a huge Don Taylor fan. You probably remember before the NORC study. That's the last thing that we've really had to say data. We know Hospice Saves Money because of

this wonderful study. So talk to me about the study. What have you kind of taken away from it? Have you utilized it? Anything along those lines?

Carla Davis Guest08:47

Well, i think it's one of the most comprehensive studies, looking at the claims data for all of the Medicare decedents in 2019. So I think it is one of the most comprehensive studies And it shows what I think we all know is that the problem isn't that people are getting too much care too early. They're getting referred to Hospice too early. It's that they're getting referred to later not at all. And it proved certainly cost savings 3.1%, which was about three and a half billion dollars, compared to people that were end of life that did not access the hospice benefit. I really think those estimates are incredibly low, because what it also proved two sides of the coin that I think were maybe surprising to some people although I think not most of us that have been in this work for a long time And the first side is that the patients that actually cost Medicare more money than anything are the patients that are in the last two weeks of life, really the last 10 days of life. In fact, the line is really a day between day 10 and day 11. And yet 25% of the people we see die in five days are less. So we have those patients deserve care They deserve. of course, we're going to serve them, even though we are referred an actively dying patient And we're going to move with expediency to help take care of them. but they are expensive to hospices, they are expensive to the system that that patient.

10:32

if that patient had gotten access to care earlier, they would have had a better experience.

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They would have been with the people that they love, comfortable, not not in the ICU.

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you know spending all of these resources, but we also would have saved Medicare money. So I think it you know the front side of things the only patients that were proven to actually cost the system more were the patients that that live less than a couple of weeks and really less than 11 days. And on the flip side of that, what I think was really interesting is that even for the patients who live greater than six months, regardless of diagnostic category which I think shocked a lot of people, including, you know, neurology, respiratory and all of them they, those patients also saved Medicare money, in fact 11%. So so I think that the sort of the position that MedPAC has taken historically over the last few years and concerns about patients living too long and abuse in the system and we'll kind of get into this in the next article as well. But really the problem is get more people care that are facing end of life and get it to them earlier. And we know that, like we know that when we talk to patients and families.

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they are so relieved to actually have someone coordinating this discombobulated healthcare system that we live in And to have everything centered around them to be patient centered, to really be patient centered, and to have all of the support and resources that hospice provides in the comfort of their home. But they're almost angry sometimes when they wish they'd known about it sooner.

Chris Comeaux Host12:22

Like why?

Carla Davis Guest12:24

did someone not let us know sooner? So I think it proved what we know. But it is the definitely the most current and most comprehensive research based off the claims data. So in terms of how we should use it and how I'm using it right now within our organization, so just, i think, first of all, it has incredible policy implications with Congress, certainly with MedPAC too, and anybody who's in a position to influence policy and influence the future of our reimbursement rates. Certainly this is in

the context of MedPAC recommending, over a period of years, a significant reduction in our reimbursement rate At the same time that we all experienced all of the inflation through COVID, you know where not only are nurses more expensive and social workers more expensive and physicians more expensive, but mileage is more expensive, dme is more expensive, all of the things. So I think it puts that declaration that MedPAC and others have been concerned about.

13:43

It puts it in perspective Like we're focused on the wrong thing here We need to focus together on how to get more people this care, not how to, you know, to cut the hospices and basically and send them to serve less people. So I think it's a really, really powerful statement. We're also using it organizationally in our communities. We've developed educational tools using all of the materials from the study that NOC and HPCO sponsored Both of them co-sponsored it which I think also is a great step forward for the industry to work together on this kind of thing, and we're using it to educate people in our communities, whether those are more regional health plans, whether those are ACOs certainly health systems And I think physicians care about this too.

14:41

You know, periodically you'll hear physicians talk about the. You know they read something somewhere about the expensive hospice And I think this is really really helpful for them to understand that in fact, the opposite. So we do follow up on all referrals with our referral sources, including physicians, and if that referral source or if that physician referred a patient that either died before we were able to get them care, despite how fast we moved, or, you know, died within the first month, we try to follow up very specifically to help provide education about how together, we could have identified this patient earlier And I think this study and again, we're just starting to use it now, but I think this study will be a helpful part of that conversation.

Chris Comeaux Host15:32

That's great, carla. Well, carla, there's another study, and actually I want to give Craig Jeffries with Compass's credit He's the one who brought it to my attention The abbreviations of the NBER study, the N-B-E-R study, and Jonathan Gruber is one of the main authors on that paper. I don't think it's kind of hit like national press yet, so it's not in everybody's hands. Trying to see what NBER stands for National Bureau of. Economic Research. There you go, so, if you had a chance to take a look at it, and what were your impressions from it.

Carla Davis Guest16:06

I did. I did not read all 75 pages.

Chris Comeaux Host16:09

Me neither, in all honesty.

Carla Davis Guest16:11

In all honesty, so just for the audience who may not be as familiar with it, it was focused on patients with Alzheimer's disease and related dementia, with the hypothesis that those patients are more profitable and, with the rise of for-profits over the last 15, 20 years in America, that they're incented to serve these patients disproportionately and that that's potentially bad for the Medicare system.

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And, in fact, what it proved was opposite that even these patients these patients who tend to have a maybe a longer length of stay and therefore maybe more profitable even these patients save Medicare money, and it really is both primarily cost avoidance, like nursing facilities, home health, pharmaceuticals, of course, hospitalizations, and so the article goes on and I think it probably didn't get as much traction because it wasn't peer reviewed in terms of that category But it even goes on to really kind of assert that the policy issues that are going after the potentially longer length of stay patients, like Medicare caps or any kind of antifraud lawsuits or those kinds of things those have an inadvertent

impact or could have an inadvertent impact on restricting access, and even if a patient lives longer than six months with Alzheimer's, they still save the system money.

18:00

So I looked at the 2020 data, which, of course is the last data and of course, is a little bit skewed because of what we were all dealing with in 2020. But the average length of stay, even for that Alzheimer's category of patients, was 143 days And the median length of stay was 56 days.

18:21

So certainly, where there's a few patients that live longer, definitely. But even with it, it saves Medicare money. And when hospice behavior, because of all of the either the cap or government regulation targeting the nickels rates or whatever it is, when that behavior starts to create a pendulum swing such that we start to restrict access because we're so fearful to take a risk on a patient who looks like they're dying but may not be checking all of the boxes, it ends up actually costing the government money. So to me, to put these two important pieces of research together and for them to come out in the earlier part of 2023 together really does say something very strong, and we need to sort of shout it from the mountaintops to make sure that all of our regulators, including the max, understand it, because they have the way that they've been doing things for a long time And I think that, because they laid off during COVID, they're definitely in full force now trying to catch up for all of that downtime.

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But we need to certainly get the message out And I just want to say, to be clear, that doesn't mean that there aren't bad apples out there and we don't need to do something about that. The National Hospice Organization and NOC have also been a very vocal about recommending 34 different strategies to mitigate some of the fraud and abuse that has developed over the last few years. Again, some of that happening during COVID, when maybe the survey processes weren't quite as tight as they

were in years past, or are now, and I think we have really an entry issue for the most part with the proliferation of hospices that opened in 2020, 2021, and 2022. And there are solutions and not one of them is going to be a panacea to solving that section, but it is a very limited section.

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And I think what we have to be very careful about is that we don't have unintended consequences to providers who are doing the right thing and helping people live the last stage of their life and saving Medicare money. So if we need to be able to sort of incisively address the fraud and there is some, but for the most of the hospices out there they're trying to do the right thing, doing the right thing and that's high quality here And that's, i think. but both of these articles stated regardless of the tax status.

Chris Comeaux Host21:19

Yeah. So when we do these, Carla, we usually we're taping several podcasts. So I have Joan Tino later today Her show will be aired And so, Joan, in the prep for the show she said something profound. She said you know all this, the fraudulent stuff, Her back of the envelope calculation is about 7 to 8%. Let me be very clear 7 to 8% of the providers. So you know you're. And then, of course, that's what gets sensationalized in the past, etc. You said something a couple moments ago, Years ago.

21:51

There's a physician that both you and I know said something that literally was like a brain tattoo, Said wouldn't it be awesome if the distribution of our patients looked like a bell shaped curve? But it doesn't right. It actually looks like someone's, like a backwards J, depending upon the tail of longer length of stay patients, And I've always held on to that. I'm a bit of an idealist as part of my kind of part of my issue, But I love kind of that would be so ideal. And what do you think about that? Like when I'm hearing you talk about this study, I mean could, could we use that to one day? It really did look like a bell shaped curve or like maybe our median

was 50 or 60. And the tail you didn't have a lot of short length of stay and you didn't have a lot of long length of stay. What would it take for us to live in that kind of panacea, if you will?

Carla Davis Guest22:37

Well, I don't know that. that's the answer I think that's not how.

22:44

I mean. I'm not saying that what he said wasn't correct, i mean it is dreamy, right, but how do you drive behavior to be bell shaped And how it, when we all live and die of such variety of diseases and there are so many things that impact prognosis that are not on an LCD, you know, worksheet? I think about my dad. My dad died five years ago, father's Day, and he outlived every prognostication. You know there's no absolute reason he would be the tail, right? I mean, he was the tail, of course I'm his daughter, so I did advocate strongly for him to get hospice, of course, but there was no reason. Physically he was alive at the you know the last bit of his life. But I know now, looking back on it, that they found his brother who was shot down over Laos in the Vietnam War, 50 years almost to the month that he was shot down and they found his friends And my dad got told that.

23:56

I got to tell him and my dad got to go to the funeral And there's no way he should have been there. He was bed bound in a nursing home But he got to go and he got to say goodbye and hello to his brother. So there's so many things that are off the bell curve chart.

Chris Comeaux Host24:13

I'm sorry I forget the national. No, that's awesome.

Carla Davis Guest24:17

That don't fit right. So how do I think it should be? at this point in my thinking, i wish honestly and this is not going to happen tomorrow, but this is one of the things I'm excited about I wish we could kind of get rid of the word hospice or the word palliative care and have these artificial lines of demarcation that are based off prognosis.

24:42

You know, eventually I would like for it to be based off of need and every person living with a serious illness, you know could receive the care that they needed at that time And perhaps there would need to be some kind of stratification or some kind of case mix that helped go up and down with patients as their needs went up and down, But it wasn't prognosis based And I think ultimately that's the new bell curve And I have a dream that that happens. I'm so glad to ask you that Thank you.

Chris Comeaux Host25:14

And then thanks for sharing that personal story, because you know, as I think, about some tools out there that retrospectively look at claims data and then say they're going to be predictive. I mean, you know, i've grown up in this, you've grown up in this, you've grown up in this. We see stories like your dad's and You know the human, the will of your human being, and then the care and love that hospice brings, that is so hard to build into an algorithm And and and then see how that becomes predictive and so well. Last question, Carla, and then we'll wrap up and so maybe, or there's some unanswered questions that you think, maybe future studies need to Kind of address that neither the Niber or they know our C study that have kind of addressed.

Carla Davis Guest25:58

Yeah, and I, you know, I think it to me it goes, it goes towards what I just said. Actually, you know, like, so what, what would that need to look like if we took away everything that we know to define benefit structure right now and we really looked at and and Studied what do people really need and want and at what phase and what would that cost? I think that that something around more comprehensive care for the seriously ill and

Look and trying to figure out what the reimbursement structure should look like. I think that's one thing to deal with what we have today and to sort of move from you know 1.0 to 1.3 or something, versus sort of 2.0 or 3.0 that I just described. I mean I think we should start to test stuff more comprehensively than the CCM.

26:57

You know demonstration so so What would it cost if hospice, when it complete full risk and by that I mean really No non-related, related, you know, full risk, i mean we are mostly with all risk, especially the way that the government has, you know, come back and reemphasize that we expect Most everything to be related but full risk, and what would it? what so do that? What would it do to add concurrent treatment? What does that need to add to our PPD? Because of course the hospice benefit today does cover palliative treatments, but most hospices are not able to afford to do that or to do that as thoroughly and extensively, both because of the advent of medicine and how Advanced it's gotten. Inexpensive It's gotten. But what would that look like? What would palliative concurrent care really cost if we were really to reimburse the hospice separately for that? I think those things could move the needle More towards your bell curve With the benefit structure that we have today.

Chris Comeaux Host28:07

That's awesome. Well, Carla, any final thoughts?

Carla Davis Guest28:10

No that is it.

Chris Comeaux Host28:11

Awesome. Well, you've been great and Carla gave me a quote, so we always in our podcast for our listeners It's a Marcus Aurelius quote had no idea she loved Marcus Aurelius. I love Marcus Aurelius as from his meditation's book 5.2 or 5.20 is the quote the mind adapts and converts

to its own purposes. "The obstacle to our acting, the impediment to action, advances action. What stands in the way becomes the way." Thanks for listening to TCNtalks.

28:38 / 00:00