Transcript / Torrie Fields on Palliative Care and Serious Illness Innovations

Melody King Intro

00:01

Welcome to TCNtalks. The goal of our podcast is to provide concise and relevant information for busy hospice and palliative care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host Chris Comeaux.

Chris Comeaux Host

00:23

Welcome to TCNtalks. I'm excited. Today Our guest is Torrie Fields. Torrie is the founder and chief executive officer of TFA Analytics. Welcome, Torrie.

Torrie Fields Guest

00:34

Thank you. Thank you so much for having me.

Chris Comeaux Host

00:36

It's great to have you, Torrie. What does our audience need to know about you?

Torrie Fields Guest

00:41

Wow, it's a great question. Great place to start. So I'm Torrie Fields. I am a health economist and an actuary by background I hope you don't hold that against me value-based reimbursement and value-based contracting. Before coming to own my own company analytics company, I worked in a number of different health plans, overseeing value-based contracting initiatives and specifically building out their strategic planning and all of their programs related to serious illness, and that was really the place where I fell in love with palliative care and what it does for people and their families. Prior to that, I worked in health delivery in large delivery systems, helping provider practices actually start billing and getting reimbursed for the services that they provided. And I'm a two-time cancer survivor

and a caregiver to somebody going through cancer treatment right now, so this hits home for me this is my cat.

Chris Comeaux Host

02:01

Wow. Well, Torrie, actually you made the joke about being an actuary, but I think you have so many superpowers, but I think about it, having that as a core competency has made you a bit of a unicorn. I remember the first time I met you was at a CTAC conference, and I have this sense, though, that you alluded to it, like you fell in love with powder care. Was it from the data analytics side, or was there just something at a deeper level that just connected with you and when you were doing that early work?

Torrie Fields Guest

02:33

I found out about Palliative Care through the data. I have my master's in public health and worked in Medicaid programs and state specifically focused on vulnerable populations and have really only spent my career in vulnerable populations, and so there is definitely something about the complexity of care delivery for this population that's really important to me. But what I found really really interesting about something like palliative care is that it is the right thing to do. It helps achieve patient and family goals, so it keeps people out of the hospital and the emergency department and skilled nursing facility if they don't want to be there. And there's a considerable cost offset when you introduce Palliative Care, because we're not treating people to death. That way, we're actually making sure that we're giving people goal-aligned care.

03:42

And so what I fell in love with about something like palliative care was that it was a really promising, strong financial instrument that aligned with all of my personal goals and values and my expectations about the delivery system, and so I see it as you know, just a way of sneaking public health into healthcare and sneaking quality into healthcare in a way that you know you just don't get to see every day.

04:17

And the other thing about about actuaries is that they, actuaries, really need to weigh the risks and benefits of financial decision making and need to really think about who gets access, who gets coverage, from a very objective lens. And so actuaries can't become your biggest advocate once they understand the mechanisms that go into something that

contains costs and improves quality. And so the arguments around palliative care that we often hear about are that, you know, it's not getting reimbursed enough, it's not being valued high enough, things like that, and those are all really actuarial. There are actuarial definitions around that leadership team at the insurance company to say this is something that we should invest in because it's, you know, it's an important strategy for us. It didn't always necessarily have to be a patient story, so to speak.

Chris Comeaux Host

05:38

Well, you've done some amazing work nationally to bring about a future with palliative care reimbursement. In fact, again I can remember where I was sitting. I could picture myself in the room when you were presenting at CTAC because you of course knew my mentor, Dr Janet Bull, Dr John Morris. I feel like they kind of raised me in many respects. And I was 30 when I became the CEO of Four Seasons and trying to get a hospice to thrive into the future and trying to be this innovative pioneering organization to launch Palliative Care in a really difficult kind of area of the country. We didn't have like rich reimbursement, we didn't have an amazing Torrie within maybe our payers within the state, at least during that time. So can you just talk about just some of the work that you're doing? And the great thing is you're continuing and really ramping up that work right now.

Torrie Fields Guest

06:26

Yeah, it's so funny. I remember the day I met you too, so this is a beautiful reconnection here. I was really fortunate very early on in working at Blue Cross, Blue Shield in Oregon, at Cambia Health Solutions, to get the opportunity to test out a pilot for palliative care case management, and that was really the first project that I worked on was giving nurses and social workers the opportunity to, you know, identify patients with a serious illness, assess them for palliative care need and then connect them to services and to also provide caregiver support, and a lot of those mechanisms that we saw in our first model are things that actually are being taken up by the guide model today. So caregiver support, ongoing care coordination, making sure that you're bringing all of the best elements of palliative care services into disease-directed care, so into specialties, and so my team has continued to advance that model of case management and coordination between palliative care providers and specialists and are supporting some of the guide participants this year, some of the new entrants, so that they have a good cost model, good workflows set up to be able to meet the growing demand of Medicare beneficiaries with dementia across heart failure and value-based oncology and complex care for children, and so really

have a component of the work that we are doing to embed palliative care everywhere, and that's something where I think it's really necessary to help our colleagues further upstream understand the value of bringing supportive care or palliative care into the disease experience so that it doesn't seem like a false choice for people when they're diagnosed with a serious illness.

09:00

The other thing that we've been able to really do is around developing and defining palliative care benefits, and in Medicaid there is this growing movement to offer palliative care, specifically community palliative care, as an essential health benefit for Medicaid recipients.

09:27

So, if you're thinking about our most vulnerable, most seriously ill populations, they need a dedicated, ongoing team of specialists at home.

09:39

That's more than just primary palliative care and that requires a big change in reimbursement. It requires standards and staffing and a full interdisciplinary team approach to care that I'm really committed to from a quality perspective, and so this year in May, we got our first big win where the state of Hawaii, who we've been working with for three and a half years, now became the first state in the country to become authorized by the federal government to offer palliative care services in the community as a standard benefit, and that means it's not a pilot. It's not a waiver, it cannot be undone and it sets federal precedent for all these other states to be able to do that too, and so a lot of the work that we have in our portfolio this year are helping states file these state plan amendments with the federal government so that we can actually start standardizing reimbursement for Medicaid, which then allows private funds to start doing that and hopefully put some pressure on the Medicare program by supporting dual eligibles across the country. Big changes.

Chris Comeaux Host

11:10

Torrie, I was bragging on you the other day. I was in a meeting, and I was talking about that, but someone asked me a question I couldn't answer, because you did so much great work in California. What you just accomplished in your team and the incredible people in Hawaii, how is it different than what some of your original work that you did in California?

Torrie Fields Guest

11:31

It's a great question. So California was the first state to require managed care plans, require health insurance companies to deliver palliative care as a benefit for their Medicaid recipients, and I had the opportunity to work with the Department of Health Care Services in California on that SB 1004, that Senate bill, and then to implement palliative care across the state in a leadership role at Blue Shield of California, and we learned a lot of lessons from that experience. Only mandates this for insurance companies to do it. They don't tie a new reimbursement model to that mandate, and so what we saw in California was this huge variability between health plans and how much they paid, what they paid for and what they called palliative care services.

12:46

And so the difference between what we did in California as a managed care mandate and what we did in Hawaii is that Hawaii asked the federal government to put palliative care on the fee schedule, to standardize the reimbursement model and the care model at the state level, so that there is a standard definition of care, standard expectations about staffing and services provided and then a standardized way to get reimbursed for those services, so that, regardless what insurance type you have, you're getting the same experience. And I think that's really important for providers, especially because it's really hard to build programs by insurance company. You lose a lot of money building six programs for six different health plans and then hoping that you're going to get enough patients to fill all of the slots. So, this is really a hope to make it so that it's a lot more sustainable for providers to get reimbursed and to start building out your workforce capacity.

Chris Comeaux Host

14:04

It's so incredible, Torrie, I was, you know, those of us that kind of grown up trying to build a palliative care model on the Part B Medicare, part B billing chassis. You know, kudos to the pioneers the Janet Bowles of the world, Diane Myers, et cetera. Those folks are just you know, they really were the pioneers, but this really could create a future where this is the norm. Do you feel like you know really interesting times? Right by the time this show is going to air, we're going to be into 2025. So, we're going to have a lot of interesting things going on politically. Do you feel like the windsock is blowing in a direction that the time is coming for what it feels like? You're kind of painting a beautiful picture of potential. Are you optimistic? Are you concerned? What would you say?

Torrie Fields Guest

14:50

I have found palliative care to be a bipartisan issue. So just to administration. What I do see is the opportunity to continue having states file these budget amendments that add palliative care to the fee schedule across the country and to create a precedent for health plans across the country and just an operational mechanism for them to do it too. And we're seeing that there's a lot more momentum in reimbursing differently across the board and understanding that, as you were saying, that the Part B reimbursement does not include all of the other supportive services that people really need in their complex lives, and so one of the big sticking points that CMS has had for a really long time was the how to reimburse through the fee schedule for a bundled payment or a PNPM type model. And we see a per diem in hospice, we see some of the challenges around the prospective payment system with home health and you see some of the diagnostic-related group stuff happening in the inpatient side.

16:47

But there hasn't been a lot of innovation payment rate to a code on the fee schedule, and that's something that CMMI is testing out through the guide model. So it's the first place that you really see this nod to what the future could look like. So the guide model pays a bundled payment rate for services through the fee schedule. And that is going to open up a lot of opportunities and a lot of doors to be able to think about, to be able to think about interdisciplinary teams being paid in a bundle to a provider organization who has the ability to administer that team.

17:37

And I sort of bring this up in that landscape that you're saying because I'm really optimistic just seeing that CMMI is already testing this out. They have the authority to do it now, and it's a lot easier to add palliative care in the fee schedule than it is to get the political will and the legislative support to make a brand new benefit or to even reform hospice. And so you know, if we're thinking about palliative care, there's such an opportunity to sort of add it in to your standard set of services that people get. Even if you're billing Part B, then you'd at least be able to, you know, cover all of your costs.

Chris Comeaux Host

18:24

Wow, I guess I never actually connected those dots and someone who's grown up in hospice 30 years now you know the per diem being a holistic, unholistic IDG model. With

that per diem, I mean it really was brilliant in 1983. What is there? Something that happened around 2022, or is it like several things that have kind of created this opportunity?

Torrie Fields Guest

18:51

Back in 2015, a group of insurance company executives got together and we had all been wanting to align our strategies around serious illness programs, and so these were organizations like Anthem, Blue Cross, Blue Shield, Fimarc in Pennsylvania and New York, Hawaii Medical Services Association in Hawaii, Blue Shield of California and a select health plan, Intermountain Health Plan a bunch of other folks who came together and said you know, we're not going to be able to change the system or change the experience of care for people with serious illness if we're only giving providers a tiny slice of patients. But if we're able to pull together and ask for the same thing, maybe we will get CMS to give us a way to test out something together in a standard way. A way to test out something together in a standard way. And so, as part of that, the private insurers actually got what they wanted. So, they got some codes that they were able to test and they were able to collect data related to the outcomes from community-based palliative care the outcomes from community-based palliative care.

20:31

And so that actually proved that you can pay for these things through claims, and I know that sounds so simple, but it's a lot easier to pay things through claims than it is to go and get a vendor or to have invoices sent to you as an insurance company.

20:46

And so there has been a concerted effort since that time to do work really collaboratively with CMS about how to allow health insurance companies the ability to be really flexible and to cover programs that they think are really important and a value add cover programs that they think are really important and a value add. And so, you know, under the Biden administration, there were just a lot of leaders and people who had been in CMS for a number of years, who had taken that journey with the payers, who understood how to navigate the administration, who understood how to ask for what they wanted internally and then were able to then get the regulatory or legal approvals that they needed in order to start opening up new models. And, under CMMI, the primary care models group has been really great, you know, really really wanted to research all these issues.

Chris Comeaux Host

21:54

It just, it's just sitting here listening to you, tori. I mean obviously you're speaking my language. You know we were kind of a first mover for Palliative Care. I just want you to speak for a second to some of those hospice leaders. Maybe they're still thinking well, gosh, we need to do a palliative care program. It feels like the urgency of that needs to be at a very high level. Can you just speak to those hospice leaders that have a sense they need to launch Palliative Care? Why do they need to do this soon from your perspective?

Torrie Fields Guest

22:26

I don't think that you can afford not to deliver Palliative Care services, especially if you are a hospice organization. What we're seeing is that there is much more momentum in disease-specific models. You have CMMI, who has a whole portfolio of disease-specific models, plus ACO REACH, which is really shifting all of the attribution, all of the risk, to specialists and primary care providers, and so you have a choice to stay only delivering hospice care or moving upstream to meet the demands and the needs and expectations of this new changing delivery system that we see so oftentimes we talk about. You know what is primary palliative care versus specialty palliative care, care versus specialty Palliative Care? And primary palliative care is what oncologists can do. They can have goals of care conversations, they can do advanced care planning, they can staff a clinic to help support care coordination.

23:39

But when a person has a very serious illness who is sort of on that ongoing trajectory, that is where the hospice community can move upstream with your IDG to meet the growing demand and that has proven to increase length of stay on hospice, increase hospice referral rates and make sure that your colleagues who you want to refer to earlier and more often actually see your value growing over time and with the increase to access to advanced interventions and longer life trajectories, longer longevity. That's happening with new treatments and protocols. People are getting sicker and are having to make more difficult choices about do I choose this treatment or do I choose comfort care. And there is nobody more equipped than hospice care providers to help people understand the risks and benefits from their treatment and to start delivering the specialty level, complex care that can help people understand which way to go in that circumstance. Plus, there's reimbursement that will be tied to it. That is the awesome part compared to those that have been Once there's reimbursement that will be a tie to it.

Chris Comeaux Host

25:07

That is the awesome part compared to those that have been like the early movers without that the other thing. So you've obviously again convinced me. I love what you just said, one of the things that I've so loved about you over the years I realized, compared to our early conversations, I feel like I've been like the kindergartner in the class, but like you speak. So like the kindergartner in the class, but like you, you speak so well the payer language. And I started to realize early on because I grew up in Hospice I didn't have that language.

25:35

So you've got the ear of a lot of Hospice and Palliative Care people. Um, because again I could kind of look back and like, literally you were speaking fluent French and I'm still at like grade school English, but realizing, well, the payer is so important to our future I can't speak through my language. I have to understand their perspective, understand what they're saying. So, could you give a little bit of a class to a lot of these Hospice and Palliative Care leaders? You know what do you wish? That they knew how to speak to them, how to be better partners for payers going forward.

Torrie Fields Guest

26:08

The thing that I learned very quickly while working at an insurance company about the challenges that hospice and palliative care providers had was that when I asked what services they delivered, they asked me what I wanted, and health insurance companies are not direct care providers. So I need to know from you what you do. Who is eligible for services, who is your target population? What services do you provide by who? What's that? How often? I don't know any of that. I'm not close enough to it, not as close as you are, and you have inherent value in sharing what you do. If you have an evidence-based model, if you are certified by an organization like Mission or ACHC or CHAP, or you have an advanced certification that's related to you know palliative care and heart failure or hospice heart failure, these are things that are really important to a health plan, because it shows that you really care about your clinical quality and that you know your business, and so that's where you can really meet a health plan in the middle. Cost or prices or reimbursement is actually set by how well you communicate about the staffing and the services that you provide, because the only way that these reimbursement models are constructed is by taking what you say and then costing it out. So, the more articulate you are about length of stay on service, the more articulate you are about how many visits by discipline, the easier it will be for a health plan to understand in enough detail about what you do and who you are and who you serve.

28:32

The other thing to note is that if you're a hospice organization and you're talking to a Medicare Advantage company, Medicare Advantage has not had enough experience with the hospice benefit to know what Hospice is.

28:52

So if you're talking about palliative care not being like hospice care, you're assuming that the person you're talking to knows what Hospice is.

29:05

But what they know about hospice is the experience that they had, which is usually a very short length of stay in a really, really dire circumstance, and they don't know that it can be available for a longer period of time and be such a valuable, enriching experience to people's lives. So, start to bring in some of your expertise and experience to the table and assume that health plans want the best for their populations and assume that they don't always want to focus on saving money, but they want to pay for the right things and pay less often for the wrong things. And so if the benefit of hospice and palliative care is to keep people out of the hospital because families don't want to be there. You should tell them that, because they can do the math in their head about how much it costs to go to the hospital. I mean, that's something that health insurance companies are steeped in every day. They just rarely have the solution to the problem that you already have in front of you.

Chris Comeaux Host

30:24

That is so good. Torrie, I actually had a conversation with the payer this morning and you know, growing up in hospice because we've not necessarily been, you know, raised on like a DRG We've had to care for all these disease groups. So we're kind of like just, you know, like they used to say, the Statue of Liberty, right, you know, just send us your old, your infirm, just send them all, we can take care of them. But being able to articulate this is what we do. It just became so apparent to me exactly what you said to articulate this is what we can do for you. And painting that picture, because we all usually say, yes, we could keep them out of the hospital. But here's the things that we do that are super unique, that enable us. We created this beautiful model of care, this multidisciplinary.

31:14

A lot of nonprofits that we work with usually have a good investment in physicians as part of their model. Well, why does that actually add value from a care standpoint? Why does that

actually tend to keep patients out of the hospital a lot? More? Mutual friend of you and I. It was almost a year ago. I had Dr Byock on the podcast. He was super articulate about that, about physician involvement, what that means for specifically nonprofit programs. So, what you just said is so dead on. I have found that I've gotten better and better and more succinct in that conversation and I've seen the uptake with the payer, as opposed in the past. Like you know, we'll just send them. We can take care of them. You got to do a much better job of that. What is our unique value proposition? What is it that enables the model of your program to take care of very seriously ill, complex patients and we're super confident we can keep them in our home? I don't know if that provokes additional comments from you, but I see you shaking your head.

Torrie Fields Guest

32:14

The thing that's yeah, it resonates, so, so, um. The other thing that I find myself explaining to health plan partners that we have, or Medicaid program partners that we have, is where does something like palliative care fit into the portfolio of options for people with serious illness? And it's more of a nuanced answer than, like what's the difference between palliative care and hospice care? Right, there are all of these other services that are available to people with serious illness. So, if you think about home health, you think about hospice, you think about home and community-based services, you think about some places having health homes in addition to home health. All of these benefits and programs. They sound similar, but the eligibility criteria is slightly similar.

33:21

And then, on top of that, Palliative Care is currently being delivered in the market today, right, and so there's this question of like why would we need to pay differently for it?

33:33

Or why do you need palliative care services?

33:36

And what I found to be really effective and impactful has been to help health plans, and you know folks in policy understand that the intentions behind what some of these programs and service lines really are. So you know, home health is about rehabilitation or an episodic period of time you can also be serially ill and a lot are but the intention is not pain and symptom management, care coordination, goals of care, et cetera, and helping people live well while pursuing treatment and helping people live well while pursuing treatment. And then you look at hospice and you look at the same team and it can look like very similar

eligibility criteria. But when you say that the intent of hospice is related to care coordination and comfort care, whereas the intent of palliative care is care coordination, pain and symptom management and helping people live fuller lives while during treatment, then those things become different, things that are equally as important and equally as reimbursable. And it's a lot about being able to articulate where it fits into the framework of what people could get, because people could get a lot of things these days.

Chris Comeaux Host

35:06

Yeah, that is so well, said Torrie, a friend of mine. We went to the Master's of Leadership program at the same time and she was part of an integrated healthcare system. She was a hospice and healthcare leader and one of the things she said just felt so impactful to me is because all of the just different multiple disease type programs there were so many different care navigators, case managers involved, threaded throughout and especially being an integrated system and number one, the patient was confused about the number of people coming to them and everybody standing up and saying I'm creating the cost savings. But yet who was really creating the cost savings? And it was kind of this was probably now.

35:46

This was almost 12 years ago, so you can imagine like in those early days, just a free for all that. Hey, now you have a cardiac care navigator and you have a Palliative Care team and you have a hospice team and multiple other care navigators and case managers up the value stream and conceptually all those value propositions were somewhat similar keeping people in the home, trying to keep them out of the hospital, et cetera. And I just remember her talking about that and I felt like in some respects, oh my gosh, this is going to be more of a challenge going forward in the future. So, I feel like that's another way of saying what you're saying. I don't know if you have got a comment to that. In fact, if I said the healthcare system, you'd know exactly what I was talking about.

Torrie Fields Guest

36:29

There are hands in multiple pots. Now, everyone's going into healthcare coordinator everywhere you go. So the question is, what's the new, updated business case that you need to say? And it is. You know, it's not always about saving money. It can also be about adding value and making sure that people with a serious illness are getting the right

specialist at the right time, and palliative care serves a specialty role. That's why the doctor is important, as Dr Byock was saying right.

37:03

There's an important piece to this to say. This is a specialty. It required the team to deliver it in the right way and it needs to be longitudinal and ongoing. And we know that there are going to be short-term and long-term case managers, short-term and long-term care coordinators, and sometimes people need multiple care coordinators in order to get their needs met. So, just as important an oncology case manager, oncology care coordinator, is, you know, palliative care is something that comes in and picks up the payment symptom management, the complex prescribing, all those things that are just really, really new to somebody's. You know, new experience and I think that there's we're so afraid of, of extra, because we we want to prove this cost savings argument so much that we forget sometimes that the end goal is an improved patient experience and that we're all just trying to keep people at home for longer with better outcomes from their treatment, rather than it always being who gets the savings from reducing the admission. You know we all have to work together in order to fix that.

Chris Comeaux Host

38:28

That's so well said and again, the reason why I love you so much, because you're an actuary who just articulated the mission in a beautiful way. You kind of apologized in the beginning, but this is what makes you so unique, because at the end of the day you know our mission is care, as it should be. You took us directly back to that. The other thing that occurs to me, tori, this might be getting a little technical, but I think it'll be helpful to our listeners. But those of us that kind of grew up on that Part B chassis because the palliative care needs that are out there are so vast we started off with more of a consultative model, but now the inertia is going much more towards a co-management model. For Palliative Care to really add value to the system. Can you just unpack that a little bit? Absolutely.

Torrie Fields Guest

39:16

Two things when you're thinking about a consulting model. When you're thinking about a consulting model, that means you're anticipating that a specialist or primary care provider has the time, effort and experience to actually work with you to do the prescribing, do the supply ordering, do the durable medical equipment management, et cetera. From general healthcare is that specialists are overwhelmed, primary care providers are taking on bigger

panels of patients and by offering only a consulting model, you are delaying care, and so that's something where we need to. When you're thinking about, as you said, care as it should be, we don't want delays in care that we can reduce ourselves. So that's why a shift is going toward a more co-management, prescribing and the need to think through medication reconciliation and side effects from both treatment and medications that people are receiving.

40:29

And there's a when you're just an oncologist but somebody also has hypertension or perhaps dementia or heart failure. That's a very complex patient that you know is a little bit out of your wheelhouse when it comes to what meds to offer and how to manage them. And so there is a huge value in palliative care providers being able to offer that support to the specialists that they're partnering with to be able to manage the you know the pain meds manage the side effects from treatment and you see that increase, especially in the complex opiate pain. There's just not enough training or enough time for specialists to feel really confident about how to dial up or down things like opiates.

Chris Comeaux Host

41:22

Wow. Well, as we kind of land the plane, Torrie, I'm just getting thinking about the CEOs of hospice and power to cure organizations are listening to this. This might be a good way to kind of summarize, maybe for your final thoughts, but what specific strategies you know? If, tori I know I don't want to say I feel like it'd be a waste of your incredible skill set but if, for some reason, tori woke up tomorrow and she's the CEO of a hospice-empowered care program, what are the strategies that you would be deploying to make sure that that organization is surviving in the future?

Torrie Fields Guest

42:10

and to really understand how you might be able to move into a thought process of being a more multidisciplinary practice that has a sort of central core where then you can provide or deliver what is necessary to people and their family across a continuum of care.

42:30

I think that when you start to think about reorganization or re-engineering or sort of building out your program or your organization program or your organization, starting from like a core

structure and then being able to adjust by service line, is really the future for home-based care or care delivery for people with serious illness.

42:55

That also means that having policies and procedures and clear staffing ratios and clear strategies around when you need this fire versus contract, versus share are going to be really important things as we sort of manage the finite workforce but want to expand our. And when you think about you know partnering with payers or partnering with delivery systems. They have patients all over the place, and so your ability to know what your infrastructure, what your staffing, your services, your costs, your ability to sort of be flexible on that will only allow you to scale a lot faster from a service line or a geography perspective, and that is ultimately what payers are looking for in a partner is that ability to be flexible but mindful in your approach, so that you're delivering the same experience, the same quality, every time.

Chris Comeaux Host

44:02

Wow, that is so well said, Torrie. That was solid gold right there. Any final thoughts for our listeners? Again, you got the era of hospice-empowered care leaders. You've got such a unique perspective. I appreciate you so much. I've always had a deep appreciation just listening to you today, especially how you took it back to mission. I just have a deeper appreciation for you every time I interact with you. So any final thoughts you'd love to share?

Torrie Fields Guest

44:25

Well, thank, you so much for having me. I think that, even though this whole conversation is quite complicated, diving into delivering these services participating in models, participating in pilots is really the goal. We're seeing a lot of momentum, we're seeing a lot of change, and what I find really promising is that there's so much more acknowledgement about the need for us, upfront investment, who can sort of share the load in that new build or that that you're going through. So feel like you're behind. You're not, we're all just really getting started. But the future is going to require something more than we're delivering right now. But the future is going to require something more so, and we're, and we're delivering right now.

Chris Comeaux Host

45:25

That again, that is incredibly well said, Torrie. Well, Torrie, we're going to include your contact information If folks are interested in getting in touch with you. TFA analytics I imagine you just encourage them to reach out to you, Is that correct?

Torrie Fields Guest

45:37

I would love that.

Chris Comeaux Host

45:39

Perfect. All right, and I asked Torrie if she had a quote, and she did so to our TCN listeners. We always appreciate you. Make sure you subscribe, pay this show forward. There are a lot of your peers, your coworkers, maybe even your board of directors, that could benefit from the show. So please do that. And, as we always do, we usually choose a quote that makes you think about today's show. This one was just perfect. Again, Torrie actually picked it. It's actually from Ursula Le Guin. It is good to have an end to journey toward, but it is the journey that matters in the end. Thanks for listening to TCNtalk sponsor Dragonfly Health.

Jeff Haffner Ad

46:36

Dragonfly Health is also the title sponsor for April and November 2024 Leadership Immersion courses. Dragonfly Health is a leading care-at-home data technology and service platform with a 20-year history. Dragonfly Health uses advanced technology and robust analytics to manage durable medical equipment and pharmaceutical services as part of a single, efficient solution for caregivers, patients and their families. The company serves millions of patients annually across all 50 states. Thank you, Dragonfly Health, for all the great work that you do.