Transcript for TCNtalks with Dr. Will Faber (Extended Play)

Is Your Organization Truly Clinically Integrated?

00:02 - Melody King (Announcement)

Welcome to TCN Talks. The goal of our podcast is to provide concise and relevant information for busy Hospice and Palliative Care leaders and staff. We understand your busy schedules and believe that brevity signals respect. And now here's our host, Chris Comeaux.

00:24 - Chris Comeaux (Host)

Welcome to TCN Talks. I'm excited. Today Our guest is Dr Will Faber. Welcome, Will. Hey great to see you again, Chris. Good to have you, so Will. What does our audience need to know about you?

00:34 - Dr Will Faber (Guest)

Well, for purposes of this podcast. You should know I'm a board-certified family practice doctor and I practiced for 27 years, but I'm also a former hospice director. I've been very much attached to hospice work all throughout my career. I've also had about 35 years of executive leadership experience in health care, which has been an honor and a privilege. And another privilege was that I learned what I learned about clinical integration at one of the most effective, biggest, successful, early pioneering CINs in the country Advocate Physician Partners in Chicago. I was a clinician there, but I was also in the governance of that organization and the administration of that organization. That's where I learned so much about how to do clinically integrated work well. So much about how to do clinically integrated work well. And then it was really my privilege as a consultant to help found 10 clinically integrated networks over the last decade, and I am currently the chief medical officer of one of the ones I helped set up so long ago.

01:41 - Chris Comeaux (Host)

And Will. I think this should make you smile. I never even heard of a clinically integrated network until we bumped into it and did some research and then I was told there are two national experts you should reach out to. And you were one of those two and I just still remember you and I's first conversation and just like, oh my God, I love this man. There's just so much we had in common. You get you and I together and we're like electric and you know so many incredible people. But to other country now.

02:09

Clinically integrated networks are being discussed in a lot of different spaces. That was not the case, gosh. That was definitely not the case seven years ago when we started TCN out of what's dare say wasn't the case three years ago. And I just got back from a national conference and people are very much bantering around about yeah, we're a CIN, we're a CIN. And I thought, man, it'd be great to bring Will back and let's talk about what is a CIN first. It's a clinically integrated network. First off, for our listeners, the CIN is the acronym or just the abbreviation people throw about. But what is this thing that everybody's now talking about in the hospital? Some public airspace?

02:48 - Dr Will Faber (Guest)

Yeah, it's important that people understand that a clinically integrated network is a legal entity. It's an organization and that legal entity has got to follow certain guidelines that were set up by the Federal Trade Commission and the Department of Justice back in 1996 to 1997. You have to found this thing properly, with a lot of due diligence, because the Federal Trade Commission's business is to make sure that there aren't monopolies or trusts that are anti-competitive in the world. And what a clinically integrated network is? This legal structure that allows independent providers to get together in large numbers. For group effectiveness you have to be big to negotiate properly with payers. Their scale is so much bigger than any individual provider's scale.

03:52

You also have to be big if you're going to put together some of the infrastructure. You need to do the two things that the Federal Trade Commission requires of a clinically integrated network. One is to reduce the inflation of health care costs and the other is to constantly and objectively prove that there's quality improvement in the healthcare enterprise that you're putting together. If you weren't improving quality or restraining inflation, getting

together in large numbers would be considered anti-competitive, a kind of monopoly or a cartel. Ftc is not interested in letting people get together in large numbers just to jack up prices and run the competition out of town.

04:30 - Chris Comeaux (Host)

Wow. Well, something occurs to me that I didn't tell you. I was going to ask you this, but you, having had a background in hospice-impacted care and this amazing experience in a CIN several CINs obviously did you foresee a day that we were going to be having this conversation? Were you thinking like man one day I think the concept of clinically integrated networks is going to come to hospice and palliative care or were you kind of surprised?

04:55 - Dr Will Faber (Guest)

I never really thought about taking this chassis of clinically integrated networks that I knew so much about into the world of hospice. They were two passions of mine, but they'd not met till I met you, and we'll talk later on in this podcast about why it's interesting and unique for hospice and palliative care providers or serious illness providers to be getting together in this way. It's atypical, it's cutting edge, it's a new concept. It makes sense, but it is a relatively new concept in the world of clinically integrated networks. Many healthcare organizations and regular providers of medical care were getting together during the last 20 years to be clinically integrated networks, but in the Hospice and Serious Illness space it's a relatively new concept.

05:45 - Chris Comeaux (Host)

Well, again, it just feels so profound that it was you. I feel like you really have been the. You certainly are the pioneer and Sherpa for us, and we're just so blessed that we've had the opportunity to work with you, so I think you just kind of took us to a good place. Well, so why would a CIN be an attractive structure for hospice and palliative care organizations?

06:07 - Dr Will Faber (Guest)

Well, we talked a little bit about amassing in larger numbers. Most hospice providers in the country and palliative care programs are relatively small, independent, community-based.

God bless them. They're a wonderful part of our whole society and I've been a fan of the local hospice for many, many years. But unfortunately we're living in a world of big competition. The for-profit hospices with national reach, huge bucks, political clout and just the size that they have make it attractive for independent, small organizations to band together.

06:45

You noticed a minute ago when I talked about the definition of a clinically integrated network. It allows independent providers to get together. Now, if those providers got together in a financially integrated way as a merger, and they became all one organization, one company well, that's one way to get big. Became all one organization, one company? Well, that's one way to get big.

07:05

But if you want to maintain your independence, which most smaller-scale local community hospices are, they, in my opinion, need to get together in larger groups to compete effectively against the market forces that are out there in the world these days. And so to put together the kind of infrastructure that you need to do clinically integrated work, well, take some money. We'll talk a little bit about some of the investments a clinically integrated network needs to make. To be able to fit that number one or one of those two things that the FTC requires, you have to objectively demonstrate an improvement of quality and that's garnering a lot of information from disparate sources in multiple organizations. It usually requires some health information technology, which is expensive, and if everybody divides the expense of that infrastructure you can do it. No individual organization can do it on their own. So there's multiple benefits of getting larger and banding together.

08:12 - Chris Comeaux (Host)

There's something really key in what you said and it's really how we stumbled across this as a solution. Well, you know this I have 30 years now in this hospice and palliative care space and there's something about your local hospice. It's very unique, like you just walk in this hospice and palliative care space and there's something about your local hospice. It's very unique, like you just walk in a hospice and if you encounter the volunteers, that's their hospice. The closest analogy I come up with is because I like college football, but could you

ever imagine University of Alabama and LSU merging Not going to happen, but LSU fans or rabid Alabama fans that gets in the ballpark of your local hospice.

08:46

Now I do believe that there'll be more mergers and acquisitions as we go forward, but the CIN is an alternative as a way to part of something larger but stay independent. We didn't know that when we started TCN. That's the gist of what we were hoping we would find. And then stumbling across this as a great methodology for hospice to stay local and independent but be part of something bigger, like oh my gosh. And then the mission focus, especially community-based, nonprofit, mission-focused hospices and the fact that the core of a CIN is about improving quality that's square in the mission space, so to me it just checks a lot of boxes. I don't know if that provokes anything else you want to say to that, but it just gets me excited. In early days I couldn't articulate what I just said fairly succinctly. It's just been because of our journey with you and learning what it means to be SCIN, and at the end of the day it's about improving quality, which should make all of us smile, because that's straight by the bedside with patients and families.

09:46 - Dr Will Faber (Guest)

I don't think you could say it better. As we've come up with quality metrics for hospice and serious illness, we've been thinking out of the box what does quality mean? What does it look like? What does it mean to the patient and the patient's family Community? Not-for-profit hospices differentiate themselves in quality and certainly as perceived by the patient level of service, from the for-profits, and so clinical integration, which must improve quality, and clinically integrated networks are all about quality improvement completely aligns with the kind of quality emphasis that local hospices have always had.

10:23 - Chris Comeaux (Host)

Let me take it just a slightly different angle. Why would a CIN be attractive to a payer?

10:29 - Dr Will Faber (Guest)

Well, CINs got very attractive back in the decade, right after 2000. That's the decade in which I was helping set so many up. They were popping up all over the United States. Most

large healthcare systems have got a clinically integrated network because the payers were shifting the value and in the old days that was HMOs. Then HMOs fell out of popularity for good reason. They didn't balance the cost effectiveness so much with the quality.

11:03

New models like ACOs, which is what the federal government's gone to with Medicare and Medicare Advantage and all the mechanisms by which Medicare is going to be paying in the future, they're value-based. You have to balance finding ways to cut out waste and save money, therefore produce a margin and improve quality at the same time, which HMOs weren't so focused on. So as the payers, namely Medicare, medicaid in almost every state now, and now commercial plans are doing value-based contracts around the United States. As those products came up from the payers, they needed someone competent to deliver the care. They were looking for networks of people that would do all the elbow grease and the hard work here to define quality, create the infrastructure, to measure it and improve it, create the systems, the culture. Frankly, it takes to get everybody together and rolling in the same direction.

12:08

And CINs are the very best performers for the payers. If the payer is offering a value-based product, you can't do better than a CIN to service your product. You can't do better than a CIN to service your product. So back in this last 20 years payers in various markets have been begging CINs will you take our product? Can you service our product? Because you need a CIN and that kind of infrastructure to deliver on that product. And most of those payer programs, by the way, are shared savings, so the insurance company is going to do better if the provider does better. There's real incentive to cooperate because together they create savings which are then split between the payer and the provider once again. So it was kind of a marriage made in heaven, as these new value-based kinds of payments have burgeoned and they're continuing to grow. I think we've all recognized you can't just keep increasing insurance premiums, co-pays and co-insurance forever. The public's upset. They don't want to pay more, but they do want to have higher quality and that's what CINs can deliver.

13:23 - Chris Comeaux (Host)

You know something that occurred to me, will, when you're talking, I need to protect the conversation. Let's just say it was a conversation. It was with a payer and they had an aha moment and the gist of what they said is wow, there's a national chain that had approached them and they were smart enough to look, start to look across data and some of the CMS compare data and while there was one brand there, there wasn't one consistent product and they were like saying this out loud of but yet you as separate and independent organizations, but having the CIN approach or having a much more consistent approach to quality, and that felt weighty, that felt important and a good affirmation that we're on a good track. I think there's a side to us as Americans of I'll pick on something else like oh, the brand is Verizon or the brand is whatever, and that means a consistent in our product, but that has not been the case in healthcare. You may get mergers, but you may not actually get integration work. Does that resonate Anything you would add to that?

14:27 - Dr Will Faber (Guest)

Well, we all know that just because you're all under one logo, the quality of your product or service is not the same. Many big, large national organizations were merged out of many other little cultures. It takes them a long time to get their product unified. Merged out of many other little cultures, takes them a long time to get their product unified. Cins start out from the very beginning with a charter and a participating provider agreement. That gets everybody aligned to the same outcomes and incentives. And then, when you start getting into defining quality metrics and recording your data and comparing your data and helping each other improve, that aligns culture and actual outcomes, the consistency with the product as well or better than any other mechanism I can think of.

15:10 - Chris Comeaux (Host)

Great. Well, what are some of the things that a hospice and path organization needs to do to be on the journey to be a true CIN and I've used that word very deliberately?

15:21 - Dr Will Faber (Guest)

Yeah, this is where I get concerned when people toss this term around lightly. I've worked for two of the biggest and most successful CINs in the country. That's where I learned a lot, and they were both challenged by some people who didn't like the activity. And the Federal Trade Commission came in with a microscope and they crawled all over us microscope and they crawled all over us and we survived both challenges. We had done our due

diligence. But I'm going to remind you, this is a legal entity that is only allowed by the Federal Trade Commission if you do the two things we talked about earlier on.

15:58

And so you have to have good founding legal documents. There are a few law firms in the country that are particularly good at this. They're not cheap, but you have to pay to create your operational agreement, a good participating provider agreement bylaws, and you have to policies about due diligence, how you're going to accept people into membership, how you're going to let people go out of membership a lot of things that constrain. You need to be well-grounded in your legal documents, but that's just the beginning. Then you must put together governance that really drives the mission and the goals of these two very important outcomes, and the FTC has opined that it should be clinician-led. Doctors and nurses and other people that actually deliver health care should be making tough decisions about what is value-added expense and what isn't. If you're going to try to keep the cost under control and cut things out, well, it takes clinicians to figure out and it's hard work, by the way what you can cut out or do in a more cost-effective way that does not erode your quality. You still have to maintain quality at all times, so governance is really important.

17:13

The third one, and which is often the heaviest lift and the biggest impediment to someone starting a CIN, is the infrastructure that I talked about before. If you've got 30 different organizations and they're on 15 different EHRs, or even three different EHRs, you've got to find a way to reach into their EHRs and aggregate the data, and there's a number of vendors out there that do this, but you have to create first the buy-in of the organizations and then the infrastructure to pull that all together. And then, lastly I think well, I could probably mention other things you have to develop a culture. It's got to be a culture where people buy into the goal and the mission. Fortunately, everybody I've ever met in the Hospice world is very serious about improving quality.

18:03 - Chris Comeaux (Host)

But that feels weighty Will. I'm just thinking of our, just reflecting on our journey as you're speaking here. And that culture thing is a big point because and it's difficult because those individual organizations are maintaining their culture and then you're trying to create the

spirit of a culture, of a CIN, and there's a way to do it, but it is very hard. I don't know if you want to speak to that, but it is very hard.

18:29 - Dr Will Faber (Guest)

Well, you could say it's hard, but aren't most good things where?

18:33

you're going to get a result that you really like, at the end of the day, requires some due diligence and effort. I'm all about inclusivity. I'm all about governance. I like to get as many different key stakeholders together, representing a lot of different points of view, but all of them are thoughtful and they want to wrestle with it. And one will say, yeah, but what about this? And the other will say, well, I see it this way and I love to preside over those meetings and try to pull human beings into a consensus. We've done that many, many times. But all these different people should have a seat at the table as we're crafting the goal, the mission, the vision, the values, the specific metrics, how we're going to measure them, how high are we going to set the bar on each one of those metrics? It's hard work, but boy, it's rewarding work. I've never known anybody who was engaged in that. Even though it's many hours of great conversations that didn't think. The outcome was very gratifying personally and then for the whole group.

19:35 - Chris Comeaux (Host)

I want to affirm you in something. So in our sister podcast, the Anatomy of Leadership, based on my book, I ask each of the guests their superpower, and that's been a fascinating question to ask people. Part of your superpower is what you just alluded to, like how you're able to create this environment where people can push back, ask good questions and just create that spirit of learning, all for the betterment of the quality and the mission. Um, that is a superpower of yours and I'm just it's just hitting me of like, yeah, that's part of Will's superpower.

20:06 - Dr Will Faber (Guest)

Well, thanks for saying it. I'll take the compliment. It's a real joy and it's an absolute privilege to get different points of view and I I personally always try to create a culture and I

think this is the heart of any good CIN where it's not punitive at all If somebody doesn't meet the quality bar. We should all be rushing to help them and they should be raising their hand and saying how did you do it Joe, how did you do it Sally? How did you do it Hospice A? How did you do it Hospice B?

20:35

And we freely share best practices with one another because we want to raise all the ships, we want to collectively have such a powerful value proposition that people are going to pay us for the value that we've created. And so I always tell people it's never our intention to drum somebody out of the organization. We'll do everything we can throw them, every life lifeline and and tug motor we can can get to make sure that people succeed. And I think over time people realize that that's our intention. It's like anybody in process improvement doing a PDSA cycle you see what worked and you see what didn't work, and you stop doing what didn't work and you start doing some stuff that might work, and then you find what really does work, and it's very gratifying.

21:22 - Chris Comeaux (Host)

That's probably a good segue, will. What are some of the tough learning lessons that you've seen over the years of?

21:27 - Dr Will Faber (Guest)

you've spun up all these multiple cins ah, to come to mind of the 10 clinically integrated networks I had a personal hand in setting up, one was an absolute failure, and I don't mind saying so because we can learn a lot from that. They did exactly what we told them not to do when they put together governance. This is for healthcare systems and I won't reveal what market. They all got together back in the heyday when people were really talking about CINs all the time, and instead of creating a governing board of clinicians, they put one token doctor on that thing and everybody else was a ceo or a cfo of organizations that really kind of felt like they were in competition with one another. Retrospectively, after the whole thing blew up, it was pretty clear that these ceos had invested in this strategy mainly for marketing. They didn't have any intention to improve the quality of care or decrease the cost of care. They wanted to say they had a CIN. So if you're going to do one, do it in earnest and be really intentional that you want to improve quality of care and decreased health care expense and put clinicians in a position to make the tough decisions to make that

happen. And it failed miserably. They invested millions of dollars and three years later the organization didn't exist anymore.

22:48

But there's another learning that I want to share that has to do with organizations that have been able to hit the ground running quicker than others, and that is I encourage everybody, if you're going to set up a clinically integrated network, to be mindful of your payer opportunity. You could put together a lot of infrastructure before the market is ready for you. The problem is, if you wait till the market moves first, then you're behind three years, because it takes about three years to develop the infrastructure. So you're constantly reading the tea leaves. Are there people in my market with our particular value proposition that are going to be willing to pay for it? Because then, of course, you get the return on investment. Not just return on investment, but you can't be sustainable without contracts. So be very mindful of your market, what you're bringing to market, how it's unique, who your competitors are, and I've seen some organizations get out ahead of their skis. Others were behind and they had a lot to do to catch up.

23:54 - Chris Comeaux (Host)

Well, how do people utilize data in a CIN to facilitate just that learning and improvement cycle and then also not letting it kind of disintegrate into shaming or punitive tools? It feels like there's an interesting saying. It's a tightrope, is overstating it, but basically, how do you affect that true PD spirit of PDSEA? How do you do that?

24:20 - Dr Will Faber (Guest)

And then, using tools and technology Well, we alluded to this just a little bit ago about getting some thoughtful people together who don't mind feedback. I like to get people together who like feedback, who want to improve, who don't take it personally. But I'd say one of the most important things to do when you put together your governance for any kind of clinical integration is to get the very best chairperson you can get, because they need to set that tone, create that culture where the people around the room feel it. We're not about shaming anybody. We're not about a punitive approach whatsoever. We're always talking in very positive terms about what we could learn from failure and I think that's any growing good organization.

25:08

As a healthcare leader in hospital systems, for years bad things would happen. You know simple events. What did we focus on? How can we learn from this so that never happens again? So it's all about setting the right tone and not being punitive in approach and letting people have a very friendly kind of competition. But we actually want to help the other team when they didn't do as well as we did. We'd just see them get more goals in the next game than we got. Because we're all about good sportsmanship. You must set that tone and I think who you choose is the chairman of the board and the chairman of the subcommittees is very important. That's really good.

25:49 - Chris Comeaux (Host)

Well, I didn't tell you I was going to ask this, but I was just reflecting on our own journey and the whole movement of private equity in healthcare and then also just huge consolidation, you know, quite often very large I hate to use the word bureaucratic, but bureaucratic organizations are not usually where innovation comes from. Do you think that a CIN is maybe a better mechanism to foster and fuel innovation, maybe compared to a very large integrated organization? And I'm okay if you've got positives on both sides of that comparison. But I'm just curious your thoughts.

26:27 - Dr Will Faber (Guest)

Well, one thing right off the cuff is just the recognition that mergers and acquisitions are rampant and private equity and VC is fueling that whole merger mania. I'm not sure it's increasing the quality of care or decreasing the cost of care. I wish the Federal Trade Commission would speak up a little bit more frequently and make others follow the rules I was just referring to about what's in the public's interest and what isn't. So that's all the more impetus why I think smaller community-based hospice and serious illness providers need to band together, because let's not be naive about the big competitive marketplace out there.

27:10

I do think that the big organizations have got some advantages in terms of cloud and money and marketing. But to your point, if you've read Clayton Christensen, they are then prone to

a disruptive innovator, somebody who comes in with an actually better value proposition, who isn't as well known, and they kind of sneak in underneath the eaves or the edges of the tent and they can get some traction. And this again is why, if you're going to do a clinically integrated network, you need to speak with the payers in your market. You need to speak with the payers that are applicable to your value proposition, because sometimes you can topple Goliath by having a better product. You just have to get some attention and get around some of the political barriers and the kinds of things that big money can throw in your way as an obstacle.

28:03 - Chris Comeaux (Host)

I was thinking that when you were talking about reducing costs and quality improvement, we've used the quadruple aim as almost a rallying cry of sorts, and Don Berwick was really kind of the. I give him the credit. I don't know if he really was the original, but I certainly seem to attribute it to him. And now we're going to the quintuple aim. Can you just speak to that a little bit and reconcile that to where you started in the beginning?

28:28 - Dr Will Faber (Guest)

about the two specific areas of cost and quality. Well, I was about what was later called the triple aim ever since I was a young medical student many, many years ago and I got. I had the privilege of getting to know don Berwick personally and he did coin the triple aim, and then we turned it to the quadruple to make sure that provider satisfaction and sustainability was thrown in there. To me, however many aims we put into the recipe, the real point is we need to be guided by some overarching, really fundamental and compelling goals, visions.

29:08

I always got great satisfaction out of delivering better care for my patients at a lower cost of care, because personally I think the cost of care is ridiculous in our country and it's leading cause of bankruptcy for individuals medical bills and so I just think, whether we call it the triple, quadruple or quintuple aim, it's all about the real values that drive all of our behavior. Hospice and palliative care share those values a whole lot more than profit margin and greed and big logos and giving people something other than what was advertised, which really upsets me sometimes about people using the banner of hospice. The consumer thinks they're going to get the hospice that grandma got, but sometimes now they're getting

hospice with half the visits that grandma got, but sometimes now they're getting hospice with half the visits that grandma got, and that's not about the kinds of lofty goals and values that we were just talking about Well said, and then many, even my own family, went through this even worse, where then there's a acute exacerbation and then they discharge you and they're done sending you off to the hospital.

30:20 - Chris Comeaux (Host)

We discharge you, which is almost an unforgivable sin, when you get into the promise of what hospice really historically has been, as we've seen, that interesting shift of more for-profit, large conglomerate or even kind of local kind of for-profit, more about that dollar and less about the mission and quality care. Well, any final thoughts?

30:41 - Dr Will Faber (Guest)

that dollar and less about the mission and quality care. Well, any final thoughts? I would just say that clinically integrating in the world of hospice and private care is new. We are cutting edge, we're defining quality, we're creating a value proposition. Part of it is defensive We've got to do something different to compete these days, but I think it's a work in progress in terms of how to take this value proposition to market.

31:06

I personally believe the payers are going to always be interested in a better product for a lower cost. But there's some special wrinkles in that because of the way the hospices are always been paid for and let's just acknowledge this If payment is basically set, what's the main way to compete? Better quality for the same payment. So quality is always going to be a part of the value proposition regardless, and that's at the heart of what we're doing. But be aware that you're on the vanguard if you're going to set up a clinically integrated network. You are changing our culture. You are driving the kind of quality that most local hospices have and serious illness programs deeper so that it's got greater penetration in the market. And I'm privileged to be a part of that cutting edge and welcome you all to be in the cutting edge with us, but I hope I've been able to clarify some of the things you have to do to do it right and stay out of trouble. Nobody wants to be scrutinized by the Federal Trade Commission and found lacking.

32:10 - Chris Comeaux (Host)

Well, will I just want to thank you on behalf of our network, Teleios Collaborative Network. You've just been. I've alluded to you as our Sherpa I might come up with a better analogy but you've been a great, wise, sage and a Sherpa and it's just been a joy to work with you and knowing that what this work we're doing and how it does translate to what happens by the bedside, it's just been a true joy and I know we would not be where we are today if it wasn't for you. So thank you.

32:35 - Dr Will Faber (Guest)

It's been a great privilege. Thank you so much.

32:38 - Chris Comeaux (Host)

To our listeners. We always leave you in our podcast for TCN Talks a thought-provoking quote, something just to make you think about the subject matter of the podcast. And I ran two by Will and we both agreed they're both so good we got to go with both of them. So here's our two quotes. Measurement isn't the complete answer, because the best groups measure, they learn their lessons, then they adjust and then they review. That's by Max Dupree. And then the second quote is a longtime friend of mine, chuck Lee. We kind of grew up in the hospice movement together and he took a Peter Drucker quote and he re-engineered it. He said what gets measured gets managed, what gets managed gets results. Results affect people's lives for good and for the better. Thanks for listening to TCN Talks.

34:24 - Jeff Haffner (Ad)

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