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John Marchica:

Welcome to Health Care Rounds. I'm your host, John Marchica, CEO of Darwin Research Group and faculty associate at the Arizona State University College of Health Solutions. Here, we explore the vast and rapidly evolving healthcare ecosystem with leaders across the spectrum of healthcare delivery.

John Marchica:

Our goal is to promote ideas that advance the quadruple aim including improving the patient experience, improving the health of populations, lowering the cost of care, and attaining joy and work. Please, send your questions, comments, or ideas for Health Care Rounds to podcast@darwinresearch.com. If you like what you hear, please don't forget to rate and review us wherever you get your podcast. Let's get started.

Kim Asciutto:

Today, John speaks with Paul VerHoeve, CEO and member of the board of directors for Mission Healthcare. Paul brings over 20 years of healthcare leadership experience to Mission and has been recognized as a driver of healthy workplace culture. Prior to his involvement with Mission Healthcare, Paul was president of the West Region with Louisville, Kentucky-based Kindred Healthcare, one of the largest post-acute care systems in the country.

Kim Asciutto:

Before joining Kindred Healthcare, Paul served in several leadership positions with Gentiva Health Care, Haven Health Care and Vitas Health Care.

John Marchica:

So, Paul, thank you for joining us today. Appreciate you're giving me some time to talk a little home health care. So, just to kind of orient people, tell me a little bit about your background and about Mission Health.

Paul VerHoeve:

Sure. John, thanks for having me too. Really appreciate it. Looking forward to chatting with you here for the next half, hour 45 minutes. So, personally, I run Mission Healthcare today. I'm the CEO of the organization. We're a San Diego-based company. Prior to joining Mission, I spent 20 years in the post-acute care space, so, really everything outside of the acute care hospital, predominantly in-home services with rehab, home health, and hospice and palliative care with some of the largest publicly traded companies in the country.

Paul VerHoeve:

So, had a great orientation through those organizations and had an opportunity to join Mission which is a relatively young company, has only been in existence for about 11 years. I was founder-led for a number of those years, and they just really felt like they could do something different, really focusing in on employees and employee satisfaction with the belief that if you took care of people, they would take great care of patients in the home and built a culture in an organization that had so much success that they just continued to grow organically.

Paul VerHoeve:

And being in California, there's a lot of people, and county lines don't necessarily separate cities. So, there was always opportunity to kind of continue to expand off of what would have been their flagship office in San Diego. And today, they're an organization that has 14 offices throughout California, both home health and hospice and palliative care, a highly successful company that takes care of about 2200 patients every day and admits roughly 1500 people every single month. So, a regional provider, but one that definitely plays a large role in the post-acute care environment in the southwest.

John Marchica:

Well, we'll get to your secret sauce in a few minutes, but I want to get some definitions out of the way. The first is the difference between home health care, and we'll call it home care or personal care in the home.

Paul VerHoeve:

Yeah. So, it's very confusing especially for the senior population because, usually, when they're trying to figure out what they have access to and what insurance pays for versus what it doesn't pay for, it's usually when the time that they need help, and that can be one of the most challenging times for a family member or for the patient themselves.

Paul VerHoeve:

So, with home health, it's really the skilled need. So, this is skilled registered nurses, LVNs, skilled physical therapists, PTAs, social workers coming in to try to address an acute care need of that patient or a rehabilitation need of that patient. The qualifications are that you have to be home bound for that period of time, and you have to have a skilled need.

Paul VerHoeve:

So, that can range anywhere from a patient who just had a knee replacement and is going home and is obviously homebound, won't be forever, but will be for some period of time, and is going to need home health in order to regain their strength and get back to a good quality of life all the way up to folks who have more chronic conditions, things like congestive heart failure or COPD, things where they're going to need some additional acute care more nursing-focused for some period of time in the home in order to address some issue that they may be having.

Paul VerHoeve:

On the home care side, that's really more kind of the day-to-day stuff that would be things like helping with bathing, meal preparation, maybe taking patients to appointments, running errands for them. It's very custodial in nature. And most of that is private pay. So, there are some insurances, long-term care insurances that do cover some of those expenses or even some insurance coverage may be available. But for the most part, that's really an out-of-pocket expense to the patient and/or family.

John Marchica:

Okay. Now, that's challenging for people to understand those differences. I mean being in the industry or being at least on the research side, it took me a while to kind of get that. Another challenging definitional thing is the difference between hospice and palliative care.

Paul VerHoeve:

Yeah. And really, the definition of those is who you're speaking to at the time. You're going to get about a hundred different answers if you talk to a hundred different people. So, I'll just explain it in my words. Really, palliative care is for somebody who has some type of a diagnosis that has a limiting prognosis where there really isn't aggressive treatment for what they may be going through or the probability of them coming out of that disease state isn't positive. And yet, they either select to not choose the hospice path or they may have a longer period of time.

Paul VerHoeve:

So, hospice requires a certification of less than six months of life. And palliative care can be something that can extend much, much longer for patients who either don't want hospice or folks who are really above that six-month threshold, but they're still getting the in-home support to manage whatever needs they may have. So, still, skilled care coming into the home really taking care of folks who are kind of in between home health and or hospice.

John Marchica:

Okay. So, how has COVID-19 impacted home health and hospice and palliative care? Before you answer that, I've heard mixed results by asking health system leaders these questions over the last year in interviews. Some say that it could be a preferred venue to keep folks away from the hospital, and that they're increasing their use of any care in the home.

John Marchica:

Others have said that sending workers from house to house in the middle of a pandemic may not be the best approach. So, what's been your sense of the reality a year into this, little more than a year of the effect of COVID-19 on the industry?

Paul VerHoeve:

I think it's a series of waves, John. In the beginning I think the entire country, whether you were in healthcare or not, we were all kind of in a panic mode of not really understanding what COVID really was. And the fear factors of how do you contract it and is it airborne, it reminded me a lot of the AIDS pandemic in the '80s where there was more uncertainty than there was gnomes which created a lot of fear specifically for the direct caregiver as well as the folks who are receiving care.

Paul VerHoeve:

As you heard of all the hospitals that had large COVID units, that I believe frightened patients from wanting to be in those environments. I think the same thing happened in the nursing home environment. So, I don't know that there was a perfect place. But what we found was that as we had nurses going in and out of the homes who were fully protected with full PPE and actually switching those out in between patients was probably the safest way for somebody who needed care to be able to receive care and feel like there was some comfort level.

Paul VerHoeve:

We obviously took a number of precautions as well too with our staff where they were doing daily checks of themselves making sure that they hadn't been around any exposures. Those things were really critical to our processes. But in the very beginning of the pandemic, I think it was tale of two stories. So, for home health, we saw a significant drop in home health utilization right out of the gate. So, who we would have normally have taken care of really significantly declined.

Paul VerHoeve:

I think, there's a couple of reasons for that. In home health, a lot of your care can be done in assisted livings. And assisted livings were kind of locking down their buildings and not having outside vendors come in as they were trying to really minimize the COVID spread within their four walls. The other piece too was that elective surgeries really stopped in most acute care institutions and outpatient rehab facilities.

Paul VerHoeve:

So, when you think about folks who are getting hip, shoulder, and knee surgeries, most of them would have some type of a home health experience once they got home. And with all of those surgeries going away, it took all of those patients essentially out of kind of the home health need. As we kind of progressed through the past year, we saw that loosening almost month after month. And even with elective surgeries not coming back, we saw utilization going up in home health and in hospice.

Paul VerHoeve:

We were caring for a lot of hospice patients who were active COVID, and these were very, very sick patients, people who had lots of other ailments in addition to COVID, other diagnoses. And obviously, COVID's a respiratory disease. So, that's a very scary thing for a patient and a family to have to address when you can't breathe.

John Marchica:

Yeah. Of course.

Paul VerHoeve:

So, hospice did some amazing work with some of those COVID patients, and we took care of over 600 COVID active patients over the last year and in our organization, and really saw just the need for that across the board. With home health, what we found was that as folks got a little bit more comfortable as time went on, they were more fearful of going out of the home to receive any type of care. And I think it's been pretty well documented across the board, that the number of even preventative visits or regular doctor's appointments, it, all but, slowed down across the board which was putting a lot of our elderly population in the home and, in many cases, with very little contact with the outside.

Paul VerHoeve:

So, what we found was that patients became more accepting of care coming into the home versus them leaving the home and being exposed to kind of the greater world which probably had a lot more concerns for many of them. So, home health played a huge role in really the COVID pandemic, in my

opinion, where folks who would not have normally have access care were able to have resources brought in.

Paul VerHoeve:

And I think about some of the stories of some patients who were so fearful, in many cases folks who didn't speak English or English wasn't their first language, and there was just a ton of confusion, the accessibility of getting to the grocery store, getting food, some very day-to-day things that we take for granted that you wouldn't necessarily associate with home health are things that we were able to address with our social service teams going in and helping address all of the concerns not just the direct patient care, but kind of the all the other things that were going on with a patient or family given their circumstances.

John Marchica:

So, were you also partnered with kind of a personal care services company as well to get some of those things done?

Paul VerHoeve:

Yeah. So, social services is a part of home health and hospice services which we really find to be a huge add-on service. It's not something that people tend to refer to home health or hospice for. Because of that, it's usually very clinically driven, but the social workers in every one of the communities that we serve have just an inordinate amount of both community resources available whether it's things like Meals on Wheels or nutritional services as well as some preferred vendors that we work with for the custodial care, folks who need help with the bathing in the morning, the getting out of bed, the getting dressed, maybe some help with laundry, the lighthouse keeping.

Paul VerHoeve:

And we work with a number of different companies, but have one in particular that we've partnered with that we tend to work closely with as we try to really come up with a coordinated care plan to mix in the non-skilled care along with whatever skilled care we may be providing.

John Marchica:

Got it. So, in August 2015, I'll give you a little background. I'm going to read you a couple of quotes, and I want to get your reaction to it. In August 2015, so, that's almost six years ago, I wrote a piece in health affairs called Reinventing Home Health, and it was interesting. You'll have to look it up and see. I think it was the head of the VNA kind of wrote a sort of a scathing response to what I wrote, didn't agree with a lot of what I had said, but-

Paul VerHoeve:

You're not setting this up well for me, John.

John Marchica:

No. You can be honest. I want you to be honest. I'm going to read two quotes, the first one. And so, this is right when the CMS was launching the value-based reimbursement pilot. So, again, going back August

2015. Okay. Here we go. In the current reality of home health care, if you're a home health provider and not part of a hospital or health system, your world looks something like this. A hospital discharge planner, your customer, chooses which agency will care for the home bound patient, also your customer.

John Marchica:

CMS, another customer dictates how much you get paid and has recently decided to pay you less every year. Three, you itemize every last thing you do and spend hours learning coding techniques to maximize how much you can get reimbursed. Four, and by the way, you have a hard time finding people to work for you at a wage where you can be profitable.

John Marchica:

Home health care sounds like a miserable business to be in. And if there ever was a golden age for home care, it certainly became a more challenging endeavor after CMS set its sights on value-based payments. Everything about home health is fee for service which is bad news if CMS is writing the checks. Your thoughts. Discuss.

Paul VerHoeve:

Yeah. No. I'll be brutally honest with you here. I think there's a couple of things. As we all recognize, care being provided in an institutional setting is becoming less and less. And when you think about 10, 15 years ago, somebody would be in the ICU and then, they'd go to a step-down unit within the hospital. And then, they'd go to maybe an outpatient or an off-site rehabilitation location, maybe even a skilled nursing facility. And then, they would go home. And they'd really experience multiple levels of care within the care continuum from kind of hospital to home.

Paul VerHoeve:

Today, I think what you find is that those stays have gotten shorter and shorter in all of those other environments and the ability to provide care in the home has gotten more sophisticated over the years in comparison to what it once used to be. I think home health used to be relatively vanilla and didn't do high-level acuity care in the home 10, 15 years ago like we do today.

Paul VerHoeve:

So, I think what we see today is patients are going home faster, and they're usually sicker. And I think that's very much the way that the government has kind of pushed hospitals, nursing homes. And then, ultimately the home health provider who's doing the in-home care is now taking care of a patient who usually needs more than what they did 10 years ago. And to your point, there's been an inordinate amount of rate pressure on home health over the last 10 years both at the federal level as well as with managed care organizations.

Paul VerHoeve:

As far as value-based care goes, my personal opinion has always been that you need to be able to measure what it is that you're doing, and there's got to be some component of outcomes and patient satisfaction. And I think home health has been later to adopt that in comparison to a lot of other verticals within healthcare.

Paul VerHoeve:

And honestly, some of the data depending on how you capture it, it can read a lot of different ways. Sometimes, less care can be better. Sometimes, more care can be better. But at the end of the day, you're absolutely right. You have a workforce that is challenged. Trying to find enough nurses and therapists to provide in-home supportive care is not a place where a lot of folks have had great comfort in working in that environment. I think it's been evolving for that population for a number of years.

Paul VerHoeve:

So, you've always been staff challenged to find the right skill sets to take care of these patients. So, as you've seen increases in rates for clinicians and you see drops in reimbursement while simultaneously the acuity of the patient is rising, they don't all intersect the way that I think everyone thinks that they should. If we're trying to put people in the home with more cost-effective care, the place that we should not be looking to cut resources is in the home, in my opinion, especially when you think about just a general reimbursement for a home health patient who's on service for 30 or 60 days in comparison to what a daily rate is in a hospital or in a nursing home. It's very cost effective for the federal government.

Paul VerHoeve:

So, I think they're trying to find some ways to be able to evaluate the good performers from the not so good performers. And as you know being in healthcare, there's always your top 10%, and there's your bottom 10%. I think good majority of them fall somewhere in the middle. And I think folks who are smaller have really struggled with a lot of the changes that have come down the pipe because home health has been relatively slow to invest in technology, much slower than other verticals within healthcare. And they just didn't have the tools to be able to maneuver within some of the changes and also to be able to produce some of the outcomes that folks were starting to ask for, whether it be managed care organizations or whether it be CMS.

Paul VerHoeve:

So, we've always had the belief that being able to serve a larger patient population is ultimately going to allow us to be more successful because we'll have not only the technology resources, but also the human talent that understands how to manage the business effectively so that you can have great outcomes and, hopefully, do it in a scenario to where you're not losing money.

Paul VerHoeve:

The other piece too that I'll just make mention of, is that a lot of data gets pulled from health systems. And health systems look at home health very differently than non-health system home health providers do. And the reason why I say that is you'll find a lot of health systems who use their home health to really help manage bed days to help manage expense risk. So, home health is a much more cost-effective way. But as a standalone business, those home health units tend to be very unsuccessful financially because of the dynamic that's created within the health system where stand-alones don't have that scenario, and you have to balance all the different types of patients that you have as well as making sure you have good mix and good payer relationships.

Paul VerHoeve:

But it's highly complex. It's gotten harder and harder over the last 10 years. There was also another big reimbursement shift at the beginning of 2020 right before the pandemic began which was kind of the largest change in the last 20 years which had a lot of home health providers extremely concerned about whether they were going to be cash-strapped or whether they were going to potentially have to close their doors.

Paul VerHoeve:

I think the blessing in disguise was, with the pandemic, there was a lot of government aid that came to home health providers to help them not only through the pandemic, but also to help offset some of the reimbursement challenges that they may have been faced with, with PDGM.

John Marchica:

Yeah. I had somebody tell me once. You don't need to comment on this, but said that it was the combination of under representation in MedPAC and poor lobbying and maybe over representation by health systems in MedPAC is one of the reasons for why they kept chipping away at reimbursement rates. To me, and I've said this before, it makes so much more sense from a cost effectiveness standpoint as you said to care for people in the home.

John Marchica:

If the care is as good or better and people are more comfortable in the home, and it's, what? A 10th the price of a hospital stay or probably even less than that, it just makes sense. But it seems like over the years, at least the time when I was really studying home health pretty in detail, it just seemed like there was a bias against it, and I don't know the root cause as I mentioned. The gentleman had suggested that it was internal stuff at MedPAC and not very good lobbying on behalf of these organizations.

John Marchica:

So, yeah. I did have a question around health systems seeming to be many of them either getting out of the business altogether and recognizing that maybe that delivering acute care services, they're better off at that than the complexities of dealing with the patient in the home.

Paul VerHoeve:

Yeah. John, we're seeing that as well too. I think a lot of hospital systems actually did have their own kind of post-acute care services and define that for whatever it is. But anything that would happen kind of in the home, so to speak, so, a lot of home health hospice infusion services. And I think what you saw a number of years ago was it's hard to be the master of all and really understand all the nuances of each of them respectively. And I think that it put financial pressure on a lot of health systems over the years. And many of them got away from it. I think then, in turn, as reimbursement started to shift for hospitals, in particular, being able to manage patients more effectively became really important.

Paul VerHoeve:

So, I think a lot of systems started to re-evaluate whether they needed to do it. I think many of them came to the conclusion that let's partner with other organizations who wake up, and think about this all day every day and have the systems and the technology and kind of the management and training that

goes to support what would be a robust health offering. And you've seen more joint ventures with health systems and home health providers over the years.

Paul VerHoeve:

I can just tell you just recently, we have a health system here in Southern California big teaching hospital that we just bought their home health from them. They felt like we'd be a better partner for their health system being the experts in this arena and allowing us to really manage the employee, the training, the patient care delivery.

Paul VerHoeve:

I think you're going to see more and more of that as time moves on where folks are trying to get the best of the best and recognizing that they can't be the best at absolutely everything that they do especially when you think about a health system's financials. A small home health business is probably a rounding error on most of their financials, hard to say that you're going to resource that the same exact way.

Paul VerHoeve:

So, therefore, it becomes an afterthought or more of an ancillary thing because at the end of the day, the focus really is on managing the acute care bed which makes a ton of sense to me, but I think a lot of health system CEOs and operators have really come around to recognizing that partnering with outside vendors for services is a much more effective way to manage patient satisfaction and ultimately outcomes.

John Marchica:

So, Paul, this goes back to part of my quote. Is it still the case that the patient is given a menu of options, and they have to pick one or, I'm like, how do you execute an effective partnership if the home health provider is effectively kind of a random selection on the back end? From my understanding, there was some law that related to that. So, how do you effectively partner? And what is the discharge planning process actually like?

Paul VerHoeve:

Yeah. So, patient choice obviously is always there on the home health side where patients ultimately have the ability to pick from the various providers that are in the community that they have. I think, for us, what we've recognized is having deeper relationships with the hospital is really important, and whether that's joint quality meetings, whether it's finding some way to make sure that there's constant communication going back and forth, ultimately leads to better patient care.

Paul VerHoeve:

So, I think what you're finding is that the number of providers is no longer like the old days where case manager would give you a list of 30 names, and they'd say, "Here, pick one," which puts the patient and the family in a discharge situation really in a bad spot because-

John Marchica:

Of course.

Paul VerHoeve:

... they're left up to having to do all the research where the hospitals really know who they've had great experiences with, who they have alignment with. So, I think most hospitals have gotten away from the 30-page list. It's now a handful of providers that they know are going to ultimately meet the patient's needs, and that they can feel comfortable in making those referrals to. So, I think it's a little bit more guided than maybe in years past, but you're right. You have to still address patient choice and any anti-STAAR clause as well.

John Marchica:

It just seems to me, if you ask your average patient or ask a family member of that patient to name a home health care company that they're familiar with, most people wouldn't be able to do that.

Paul VerHoeve:

Well said.

John Marchica:

And so, to me, it doesn't make sense.

Paul VerHoeve:

[crosstalk 00:29:56] When you think about it, I mean these are folks that are our average age of one of our patients is 73 years old. So, add that on top of it, right? This is not somebody who's probably going to get in front of a computer or use their cell phone to start Googling things. This is somebody who's really dependent upon their healthcare providers to really try to provide some guidance. So, that adds a whole other level of complexity versus maybe if you and I were being referred, we have some abilities to do our own research with the population we care for. They're much less limited in how they can access information.

John Marchica:

Right. Right. So, there's a little bit longer quote. So, I'm going to read fast, but I want to get your reactions just toward the end of the piece. As an industry, I used to think that home healthcare needed a rebrand. It could use a fresh coat of paint, I would say. It needed a new marketing strategy. I was wrong. Home healthcare doesn't need rebranding. A fresh logo and an awareness campaign won't solve the problem that all home care companies face.

John Marchica:

How care will be delivered and paid for in the future is at odds with how they do business today. Home health isn't the only health care sector with this problem right now, but it may have the most to lose. In my view... This is where sort of maybe the controversy comes in. In my view, the successful home health enterprise of the future will resemble companies like the Visiting Physicians Association, but will offer much more.

John Marchica:

They'll employ primary care docs and nurse practitioners that will make house calls as well as licensed in-home caregivers from skilled nursing to private duty care. They'll offer full-service coordination of post-acute care and will manage challenging populations with chronic comorbid conditions. They will integrate telemedicine by caring for patients in novel ways. They will deploy preventive technologies that keep patients safe and out of the hospital.

John Marchica:

They may even provide ancillary services like in-home diagnostic testing, prescription management, and clinical lab services. Thriving home health provider will align with ACOs, hospitals, and health systems for bundled services and risk-based contracts based on patient type. And they will be fully accountable for the quality of care delivered, and will put their payment at risk if quality suffers. Your thoughts.

Paul VerHoeve:

The first thing I have to do is I have to ask you when was that quote written before I comment.

John Marchica:

August 2015.

Paul VerHoeve:

Okay. So, we're talking about six years ago, and I would have agreed with you then that that's where things were going. Just now are we really starting to see exactly what you said, and I couldn't agree more with the quote. I think if you just look at even Mission Health are here in San Diego, we started off as one location with one service line which was home health.

Paul VerHoeve:

Now, we have 14 locations that have both home health, hospice, and we've added palliative care in to really make exactly the movement that you were talking about, because the ability to provide multiple services in the home allows you to really manage that patient through the continuum from whether it be home health to palliative care, to hospice care. And when you do all three, you really can manage "risk" for the health plan or for Medicare because you have more ability to be able to maneuver a patient who changes in condition whether they get better or whether they get worse while they're still in the home.

Paul VerHoeve:

So, I couldn't agree more with that. I think it's very much the strategy that we're employing today. I almost felt like you may have looked at my three to five-year strategy plan because it mimics absolutely everything that you said. And I think out in the west too, there are some uniqueness to managed care really was what was bred in Southern California. And though it wasn't the first place it started, it's probably where it gained the most traction the fastest. And you'll see some of the most managed care lives being managed in the state of California, particularly Southern California.

Paul VerHoeve:

And I think that they've really been on that trail for much longer than other parts of the country. So, providers who are out here, I've found, are much more in tune with managing risk or trying to get better outcomes with maybe less, where in other places where it may be strictly Medicare and they've been kind of on a fee-for-service basis or being paid episodically may not have had some of those experiences. But I very much think that home health companies will be in value-based care arrangements. They'll be taking on shared risk arrangements, and they'll be asked to do more in the home whether it's from them directly or through providers that they ultimately coordinate so that there's better continuity from anything that a patient may need in the home.

John Marchica:

Great. Great. Paul, so, I mentioned at the onset I wanted to ask you about your secret sauce. Obviously, your organization has been tremendously successful in its growth assuming financially you've been doing okay as well. So, what is behind the success because it is a tough business?

Paul VerHoeve:

It is, and I don't want to sound too cheesy here. But it really is the simple things that, at the end of the day, we think make the biggest difference. And when you think about, you talked about it earlier, trying to find the number of clinicians that are required to provide this service is, by far, the largest challenge that any provider has in the marketplace today.

Paul VerHoeve:

It's not about the need of the patient. Those are there, and you're going to have plenty of opportunities. It's really around having the right clinicians who have the right skill set, the right mentality to care for these patients in the home environment. And we believe that we take a different approach than a lot of other health care companies.

Paul VerHoeve:

And it may be sound a little silly, but we put the employee before the patient, and I know that sounds almost blasphemous in healthcare because everyone says, "Patient first." But our thought is that if we take really good care of the employees, and they feel like they're a part of something that they're a part of a family where they really have purpose and meaning, it's a very mission-driven business that our clinicians participate in, and they need the environment to feel that.

Paul VerHoeve:

And we've really spent a lot of time, energy and money on trying to build that culture. And in turn, there's so many studies out there that have talked about when clinicians feel really good, patient satisfaction goes up. So, our belief is that if we take good care of people and we have good retention, and we're not having to retrain employees, and they can continue to build on the skills that they have, we'll be able to deliver much, much better care in the home, probably higher level of acuity of care in the home.

Paul VerHoeve:

And just by doing that, that's how we've grown. Like I said before, we started with one location. And it just became where you'd get the next referral in the city that you just didn't go to at the time. And then,

little by little by little, we found ourselves being all throughout Southern California and now in Northern California with exactly that mentality. It's all just happened organically. And we've been recognized by a number of different groups from the outside who've surveyed our employees as to what has made them happy.

Paul VerHoeve:

And they really do express their feelings about the people that they work for, and we think that that's a special sauce. It's not some great marketing campaign or some great sales campaign or some incredible relationship that we have with health systems. Though we have all of those things, and those are still a part of what we do, it really comes down to the clinician. And that's what we've done, and we've stuck to it year after year. We veer off every once in a while.

Paul VerHoeve:

Obviously, working through the pandemic was a challenge in that area as clinicians weren't making changes. And as a growing company, the need to find really good clinicians who feel comfortable in the home is not the easiest thing because they're working in an autonomous environment. They're not being supervised directly like you would be in a hospital, or in a nursing home, or in some other setting that was brick and mortar. And you also have to feel really good about going into the poorest of the poorest neighborhood, as well as the wealthiest of the wealthiest where you may have no resources with that patient.

Paul VerHoeve:

You may have a ton of resources with that patient. And that takes a special skill set to where somebody can, from visit to visit, really change how they're going to care for a patient. It really is just about focusing on the culture of the organization. And I think trying to be creative as well too is something that's important. Must like you just mentioned in your piece six years ago, some of the intuition that you had six years ago is what is starting to happen today.

Paul VerHoeve:

Not unlike health care, there's always a lot of really smart people that can see what's going to happen 10 years from now. But folks end up living in the moment and never really evolving quick enough to really make the change. And I think one of the things we've seen is, a lot of times, if you evolve faster than the system evolves, that's not a really good thing for an organization. It's never easy to sell uphill. You want somebody to want what you offer as an organization, and that's worked really well for us. So, it's simple blocking and tackling at the end of the day, and we're going to continue to keep doing the exact same thing. And hopefully, it'll continue to show a lot of great success with patients who really enjoy the care that we provide.

John Marchica:

I have a similar philosophy that you have, and that is really focusing on the employees. We just had our Q2 off-site meeting where we talked a lot about our goals, our ambitions, our values. And for me, and this is the second venture that I've had and that I've led, it's always been about the people And I mean they're the ones that, in our case, that produce the research or go out and sell, to bring money in the door.

John Marchica:

And I try to spend all of my focus on, in addition to my other responsibilities, but really focus on am I challenging people? Is it a healthy environment? Do I see smiles when I come in the door, that kind of thing? Is it worthwhile work? It's so much easier to retain somebody than it is to have churn and be hiring new people all the time. It just makes sense. Companies that burn through employees, I don't understand it.

John Marchica:

And then, ultimately, that ends up in putting out a bad service or a bad product. It seems to me to be common sense. So, I'm going to [inaudible 00:41:41] you on one last quick question. Not sure if you have a say on it, but I wanted to know what's your read on Humana's strategy ? I mean the acquisition of Kindred, their Enclara Hospice PBM acquisition, that was in 2019, $100 million stake in a house call company. Their acquisition or investment in Concentra occupation. What are these guys doing? I'm trying to figure out especially the big push in that joint purchase or investment in Kindred.

Paul VerHoeve:

Yeah. So, I was a an executive with Kindred at Home for a number of years before I joined a Mission. I spent eight years with Gentiva who ultimately got acquired and ran the West Coast for them. And Humana ultimately bought them when I was there. I think their strategy is as they look to try to manage patients, is having as many of those services under their umbrella as possible to be able to manage the right place at the right time, is really how I see them looking at it.

Paul VerHoeve:

And for an insurance company, it's quite a bit different because they may look at very similar to what a health system does, like we talked about earlier, where a health system may look at its ancillary services as way to manage expense and keeping patients out of the hospital. I think the insurers are trying to do a lot of the same things where if they can manage patients in settings outside of the acute care environment, that's one of the most cost-effective ways to be able to provide care.

Paul VerHoeve:

I think that's very much something that you're seeing a lot of insurance companies, health systems all striving towards as cares is being pushed further and further away from the brick and mortar healthcare that many of us grew up in and now, trying to find more creative ways to provide those services in other environments.

John Marchica:

I wonder if they're going to be making the same mistake. I mean I get it, they're an insurance company. But if they're maybe making the same mistake of a hospital or health system. Assuming that they know how to run home health, what they're really good at is acute care.

John Marchica:

And if I'm an insurance company, what I'm really good at is managing risk. And maybe, they view these as independent entities that they let them leave them alone to run their businesses, and that just

ultimately that they're able to manage risk, I guess, in a different way. I just think it's fascinating. And just going through and looking at all that they're doing in the last few years is pretty interesting.

Paul VerHoeve:

Yeah. Kindred at Home is the largest home health provider in the country. So, they cover the most geography. I think a lot of their locations overlap where Humana covered lives are. So, I think for them to have an organization of that size and have the talent and the expertise to be able to really provide really good home health care where it's the focus of that unit is different than a hospital hiring a branch director to run a home health business all by themselves.

Paul VerHoeve:

When I think about even our organization, when I think about the person who's running the local office, the layers above them and around them to support them is pretty immense. And in health systems, you'll find that those resources just aren't in great abundance whereas I think with Humana and Kindred, Kindred is a very, very large multi-billion dollar company that has a large infrastructure and great technology, and folks who've really been highly skilled in the industry running that business.

Paul VerHoeve:

So, I think they'll have a lot of success with care delivery, and that may change over the course of time as folks once again try to manage risk versus maybe looking at it as a top line. It may be more about it being a cost center. I've thought about that a lot with insurance companies in particular where it may generate revenue, but that won't be how it's measured on success. It'll be more measured on how did the overall organization do on managing risk. And did we have patients that were in the right setting of care at the right time, I think, is probably how insurance companies... They've always been looking at it that way. But now, owning their own services, I think, makes accessibility a lot easier for that.

John Marchica:

Yeah. It makes sense. Well, Paul, thank you so much. It was great getting to know you a little bit better and talking about a topic that I'm actually pretty passionate about. I'm a firm believer in home healthcare, and it was one of the first areas that we dove into at Darwin Research Group. So, thank you again. I hope we keep in touch.

Paul VerHoeve:

Yet bet.

John Marchica:

And maybe, we'll have you back in a subsequent season to see how things are going.

Paul VerHoeve:

That sounds good, John. Hey, listen, thanks for the time and appreciate you bringing some light to the home health industry. Really important.

John Marchica:

Great. Thanks again.

Paul VerHoeve:

Take care.

John Marchica:

Take care.

Kim Asciutto:

From all of us at Darwin Research Group, thanks for listening. Health Care Rounds is produced and engineered by me, Kim Asciutto. Theme music by John Marchica. Darwin Research Group provides advanced market intelligence and in-depth customer insights to healthcare executives. Our strategic focus is on healthcare delivery systems and the global shift toward value-based care. Find us at darwinresearch.com. See you next round!