HUSCH BLACKWELL

Hospice Insights: The Law and Beyond

Episode 15 – Innovators Series – A Conversation with Carla Davis, CEO of Heart of Hospice LLC

July 8, 2020

Speaker	Statement
Introduction	Hello, welcome to Hospice Insights, The Law and Beyond, where we connect you to what matters in the ever-changing world of hospice and palliative care. Join my conversation with Carla Davis, CEO of Heart of Hospice, where we discuss her path to hospice and her vision for the future of end-of-life care. We explore the question of what leadership looks like in good and bad times, and what remains constant in times of change. Carla shares her insights on how being open to the unplanned and unbudgeted opportunities that cross our paths can be defining moments for organizations. Carla is an engaging leader who has her finger on the pulse of where we are and where we are going. Enjoy the conversation.
Meg Pekarske	Carla Davis, thank you so much for joining me in this conversation. It's wonderful to share this time with you, so thank you.
Carla Davis	Thanks, Meg, I'm looking forward to it.
Meg Pekarske	I always like to – you and I have known each other for a long time, but even though I've always known you as a hospice person, but you did not begin as a hospice person. So I want to take us back a bit in terms of – and I'm going to take us way back to the beginning of Carla, which is – so where did you grow up, Carla? And sort of what were your beginnings like?
Carla Davis	I grew up in Atlanta, Georgia. And I actually think I have been a hospice person since the beginning. I didn't know hospice existed, but if I kind of think back on it, I was one of those people who volunteered in nursing homes in middle school. I volunteered at the VA, maybe even in elementary school but definitely in middle

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	school and high school. I just – I loved the elderly. That's where I gravitated to. I never pictured myself in health care. I just loved, you know, being of service.
Meg Pekarske	That's interesting that you say you're a hospice person from the beginning, because I sort of feel that way. Even like I will say hospice people are my people. I didn't know that, right? But it's just like you end up meeting other hospice people and you're like, these are my people. These are people I connect with and being very – use the word of service and mission and values. Those are words that resonate with me and I think are the foundation of everything we do. So you're in health care from the beginning. You can't explain why you're attracted to it, because it's just part of you. So you didn't go in the sort of provider angle, though, right? So did you think of being a nurse or doctor?
Carla Davis	I thought about it. I felt called to health care and I started exploring it in college. I took this class called Rationing Medical Care. And this was 1990, so this is right when Bill is running for president, and Hillary, and people are starting to talk about this impending health care crisis. And so I took this class. It was a 12-person symposium at Davidson College, and learned that we were spending basically, at that time, a third of our Medicare dollars in the last year of life, most of that in the last couple months of life, and that people were dying isolated behind curtains in hospitals. And so I actually came at hospice from more of an economic perspective. I was just like 'I know the answer!' You know, it has to be 'Bill, Bill, call on me!' You know? This has to be part of the answer to our American health care crisis is we have to fix end-of-life care. And so again, I didn't even know hospice existed yet, but I decided that that was going to be my angle, end-of-life care, on my end of semester paper. And so I remember typing into the card catalog-ie thing, which there wasn't Google or the Internet or all of that at that time, and I type in 'terminally ill' and things like that, end-of-life care, and out pops on the paper with the holes on the side, you know, on the printer, all of these articles about hospice. And I remember checking out these books and these journal articles and everything and taking it home for Thanksgiving break that year. I literally can remember sitting on my bed, I'm 19, and reading about hospice. And I just knew at that time – you can call it whatever you want to call it, I believe it's a calling – that this is what I wanted to do for the rest of my life, is help advocate for people at the end of theirs. There's been a lot of my life, personally, that hasn't been so set, but on this I'm forever grateful that that's what I knew I wanted to do. I never would have pictured the path that God had had me on at all, ever, even this last couple of months. But always, I knew that I wanted to be in end-of-life care. And so I ended up creating my own major at Davidson College. They had a Center for Interdisciplinary Studies and they allowed students to propose to the Board, if there wasn't a major that met your needs, you could create your own. You had to submit a proposal and all that. So I created my own major in medical ethics and I focused specifically on the care for the terminally ill and I ended up writing a thesis on how hospice should change to better incorporate – well, how the American health care system should change to better incorporate the hospice philosophy. So that was really nerdy because I was in college. Now, I'm still a friendly, fun-loving person! But, you know, if you went in my dorm room, you'd see death and dying, pain and suffering, all of these books. But I'm a pretty happy person, so it was funny.

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	So I could have ended up really messing myself up for my future, because was major basically is hospice, but that's what I've ended up doing and I have loved every single minute of it.
Meg Pekarske	Wow! That is remarkable. Who knew? I didn't know it went that far back. Wow! And so your path to – as I think we all know, the longer you live the more things make sense. I know I've talked about this in the podcast before. Like things sort of make sense in the rearview mirror. Even though when you're living it, it doesn't really make sense but it's like – and we're recording this during the COVID pandemic and so I think, you know, one of the things we're going to get to is the opportunities you saw here to serve right now. But it's like all of these things you've built your whole life, it's like for this moment. And it's like if you didn't take the circuitous path, you never would be where sort of you are, because you've done a lot of different things – you've worked at Palmetto and you've worked at other health care companies. And so tell me a little bit – so you do this thesis on hospice and it's sort of like my mentor, Mary Michael, who started at the firm about the same time I did in 2000, and it's like why do hospices need lawyers? That's crazy, you know? And then here we are 20 years later and I've been a hospice lawyer for 20 years and I'm really, really busy. And so – but it is, to me, it's been really connection to the people and being part of something that really matters deeply to me. So tell me – I pigeon-holed myself into hospice law, you pigeon-holed yourself at least into something bigger than just hospice law, but hospice. So what was your first job out of school with your death and dying resume?
Carla Davis	So Palmetto GBA was my first job and that was not my dream job going into it. I applied at all different kinds of places. I thought I'd be more on the provider side, but this 21-year old chick who, you know, other than volunteering and having good intentions, you know, didn't have a lot of experience. But Palmetto saw hospice on my resume and they were looking for an education consultant and this is – I was hired and started in January of 1994. And so the fortuitous thing about that, although I didn't see it at the time, you may remember that it was that year, maybe even the December prior to that, that CMS wrote this memo about fraud and abuse in the hospice industry, particularly in Puerto Rico and – at that time, which is funny looking back on it. And so Palmetto took the lead and started editing hospices and it was really the first (*inaudible – 10:18*) at that time to do that. And so that gave me a lot of experience, but also exposure to providers at a very, very young age. So my job was to go educate hospice providers about the regulations. And so while I wasn't looking forward to this angle on the hospice world now, looking back on it, it was completely invaluable, because I learned the regulations in a way that, you know, no one normally does, from the ground up. That was my job to teach them. And I do think that sometimes people use the regulations to keep people *out* of getting care instead of to help them get care. So now on the provider side, I'm able to be conservative from a regulatory perspective, but also progressive from an access to care perspective and I think just being confident in the regulations was important. But going through the medical review at that time and for the providers out there that were around in 1994 and '95 and '96, it was pretty hard core. And, you know,

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	I'm still friends with some of the providers that were on the other side at that time. I remember Gretchen Brown from Hospice …
Meg Pekarske	Sure.
Carla Davis	… yeah, you know, she would do the provider side and I would do – we did several public speaking events and I would do what Medicare says and she'd be like, you know, what the provider said. But I think we all learned a lot through that process about how we should – we should have to make sure the patient is eligible for the benefit. We should have to document that. We are collecting Medicare dollars and we have a responsibility to be good stewards of those dollars and to be able to support the patient's eligibility for the benefit and that obviously we've gone in multiple paths over the last 25 years around that, but, you know, I think just suffice it to say that I do consider that experience and the friendships that I made during that time, including Judy (*inaudible – 12:25*), completely invaluable.
Meg Pekarske	And as you and I were working on the TPE issues with Palmetto, issues of today, you know, I think your insight into, you know, when people work for the government or a contractor, you just have a different perspective that you can never have despite working on the outside for decades. It's just different. I mean, you just understand the mindset and how things work. So obviously very good training and who knew that – obviously you knew you were going to be in hospice, but so how long were you at Palmetto?
Carla Davis	Two and half years.
Meg Pekarske	Okay.
Carla Davis	Yeah. Two and a half years and then I was recruited by Vencor – which changed names to Vencare and then back to Vencor and now it's Kindred – and recruited by them to start hospice organizations for them. I had never done that before. I think I was 24 at the time, but I knew the regulations, so I wasn't that scared. So I opened up hospices for them literally all over the country. It's sort of ironic because I opened up these hospices for Vencor, who then sold them to VistaCare, who then sold them to Odyssey, who then sold them to Gentiva, and then sold them *back* to Kindred.
Meg Pekarske	Oh, funny!
Carla Davis	Twenty years later, yeah, which is sort of funny. I don't think there's anybody there that remembers all that. So my job was to open up new hospice programs and by the end of my time at Vencor, which is just a couple years, three years, I was running one of those programs that I had started in Greenville, South Carolina. And then VistaCare purchased Vencor. And I was 25, 26, as an administrator in Greenville, South Carolina, and through that process, I was immediately promoted to a regional director of operations over the southeast. And then that just grew and then I had the whole east coast and then eventually, I think at age 30, I was promoted to the Chief Operating Officer for VistaCare. And we ended up taking VistaCare public, which was a whole other experience. But never in my

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	wildest dreams would I ever have imagined me on Wall Street. That wasn't what I was oriented to at all. Again, I knew hospice. I knew how to talk about hospice. But at that time, back in 2000 or so, we were the second company to go public after – Odyssey, I think, went public first – and so the analysts didn't really know that much about hospice. And I found that experience really enlightening, because they know business and they obviously know things I don't know. And they would ask questions using words and getting me to think about the business differently than I had thought about it before, so I think I really grew from that experience. So then after that, I left VistaCare – VistaCare was preparing to sell – and joined HCR ManorCare as their VP of Sales and Marketing for home health hospice and home infusion. I'm very grateful for that experience as well. I was in Toledo, Ohio for nine years, closer to you, and I learned a lot from HCR ManorCare, but particularly for discipline and structure and tight management practices. I also learned how to navigate a large organization and get things done in a – you could call it a bureaucracy – but a large organization where there are a lot of matrix things and so I am very, very grateful for that experience. It's also where I met my husband.
Meg Pekarske	Love at the office! Love in the bureaucracy!
Carla Davis	Yes, exactly. Exactly. But I'm excited to be doing my own thing now. So in October of 2014, I joined Evening Post Industries, which is a family-owned, privately-held company based in Charleston, South Carolina. I chose them because, as opposed to more traditional private equity, they really had a long view and, you know, starting my own hospice, I wanted to build something that would leave a legacy. I wanted to build something that I was proud of and I wanted, you know, I didn't want to flip it in three to five years, which is probably what most of the private equity organizations would do. And Evening Post Industries has been in business, the same family owning it since the late 1800s. And I think that you don't stay in business that long unless you do the right thing by your employees and do the right thing by your communities. And that was really our common ethic. Because I do have a philosophy that if you take great care of the employees, they'll take great care of your customers and everything else, growth and profitability come from that. But if you don't take great care of your employees, then they're not going to be as inclined to take great care of your customers and results come from that, too. So I could not happier with that decision in every single way. In little ways and in big ways, they've supported us through success and they've supported us through failures and not meeting goals. But in every single way, they have been even better of a parent organization than I could have imagined.
Meg Pekarske	Wow! So you said you've been there, did you say three years? Four years?
Carla Davis	No, five and half years. Since October of 2014.
Meg Pekarske	So I guess in terms of – so you came in as CEO and at the time you came in, was it just one hospice they had? I mean, I know you've had a growth strategy, but …

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Carla Davis	They didn't have a hospice. They didn't have a health care. They were a media company. So they were looking to diversify and we were sort of their first major diversification effort. And I came in with the acquisition of our company called Heart of Hospice. It had three locations at that time, 265 patients. And so we selected Heart of Hospice as our foundational hospice because it had some regional density and some size, but obviously some opportunity for growth, some infrastructure, but some more opportunity to put some structure in place. And primarily because they were solid from compliance, quality, reputation in the community, they were at the top in every one of the markets that they were in. And so I think if you're going to build something on a foundation, you need a solid foundation. And so every time I got to learn something more about them, I'd continue to be impressed. And I'm very grateful that they were our first hospice because we have several of the – many of the leaders in our organization are leaders that we acquired when we acquired them. So basically, I came to Evening Post and Heart of Hospice came to Evening Post all at the same time.
Meg Pekarske	Okay. So you had three hospices. And then how many do you have now?
Carla Davis	So we have sixteen in five states, and we're serving about 1,700 patients a day. We've completed ten separate transactions to acquire those either licenses or provider numbers and we've done a combination of kind of new site startups, as well as acquisition. But now I'm proud to say that we're serving 1,700 people.
Meg Pekarske	Wow, that's amazing! So I guess in terms of – and we're talking about the traditional hospice business, I guess – because one of the things that I want to get to is sort of, as I said in our opening about the future of end-of-life care and where things are going. The challenge is that the six-month bucket that we get stuck in has so much gray and uncertainty and all the things we fight about. I mean, the amount of my life that's spent fighting about six-month prognosis is, you know – what happens if we didn't have to talk about that and we were just applying our skills and our model of care to patients who need that. And so I guess where in your business plan does, for lack of a better word, non-hospice palliative care and some of the demonstration projects going on, where does that fit in and do you see that? Where do you see it on your balance sheet? Where do you see it in your business plan of getting out of the hospice bucket, per se?
Carla Davis	Right. Well, first of all, I think that there is a lot more we can do in the hospice bucket in terms of enhanced care delivery models and serving people that are not traditional but are dying. And we are trying, first and foremost, to do that within the sidelines and end zones that the regulations require. But I do think …
Meg Pekarske	Tell me about – who is that? Who is that? So tell me more.
Carla Davis	Well, I mean, I think it's a little bit of everything. I think that we try to figure out who is eligible, as currently defined as eligible, which of course is six months or less and people who want to elect for palliative care versus curative care. And that really is as simple as we keep it. And we try to serve people that want help and are dying but might not fit in a box. And that might be patients who still have hope. That might be patients who haven't signed a DNR. That might be – we serve this little remote island off of New Orleans that nobody else will go to because you have to go to it on a boat. That might be a patient who's still getting palliative radiation and you know, who still needs the palliative radiation. That

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	might be a patient who's got TPN because the daughter, you know, is afraid to starve her mom to death. It looks like a lot of different things. It might look like a patient that's very expensive or a patient who is actively dying in the hospital, or a patient who lives in a section of town that nobody wants to go into, or the patients themselves. Like we took a patient that was in Angola for 30 years for murder, and we're finding ways to serve those people too. So I think that it looks like a lot of things, but before we go into the future of the hospice benefit, I just want to say to everybody, I think there is a lot we can do today, within the rules, to find ways to serve people who are dying in the current regulatory environment, current reimbursement environment. And it's not always ideal and it's definitely not easy. But I think that's what we're called to do.
Meg Pekarske	That's incredibly important. I'm glad that we paused there, because I do think there are people that are not being served that can be served. And when we talk about COVID in particular and what is the role that hospice can play in the current pandemic that we're dealing with, obviously that's a question you've thought about and you were saying, how can we be of service and you came up with something, which I'll get to in a second – but so I think you're absolutely right, that there are a lot of patients everywhere that are dying and not dying good deaths, and that we have a lot of value that we can add. Because you always go back to – I mean, I don't know if there is any other health care provider who the outcome is death. And like we have the highest ratings in terms of satisfaction and the value – and changing people's lives. I mean, I know some of the stories that you've shared with me that I've repeated that are very moving, is just how, you know, a good death and giving those opportunities to say goodbye changes the lives of the living. And that that is, I mean, is there a greater work than that? And I do think, when you said that you're a happy person, which you very much are, and enthusiastic and passionate and all these things, and I think that hospice people are those people, right? Because if you read death and dying books, it's all about what death teaches you about living, right? Which is living now and being present and how can I be of service and all that stuff. So I think they go hand in hand. Being happy and optimistic goes with being close to death and think about it often, because we don't have forever and what not. So I'm glad that you bring up that there is a lot of work to do in terms of meeting the needs of our community. And you are on the NHPCO board as well, and obviously NHPCO has its veterans program and a lot of things about how can we better serve people who may be underserved. But as we also think to the future, is – because I just feel that we have so many skills that could be very useful and helpful to others. Because we look at things differently and I think that the skills that hospice nurses have go a long way in serving other patient populations. I think our ability to be present with what is and ask good questions and deal with the whole person and not just treat someone like, okay, I have 15 minutes and then I've got to go, you know? So tell me a little bit about what you see the future to be. You're building your hospice business and so that's still going, but all of these demonstrations going on and the serious illness project and all that stuff.
Carla Davis	Right. I mean, I think that, back to the comment about those six months or less, I think that, you know, in the future, I would imagine that that line of demarcation will not be so solid and that, perhaps we are able to care for people with serious illnesses, advanced stages of illness, however that is defined and however the

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	reimbursement structure needs to change to accommodate that. Certainly – and so we do know that we need to gain access to these people earlier to be able to ensure that they do get the end-of-life care experience that they want, that they can fully live in this last phase of their life. And so we are piloting a palliative care program. It looks different in several different markets. We're doing more facility-based in one market, talking to hospitals in one market, and we're doing more home-based in another market. We're really trying to kind of learn from that experience and figure out what the infrastructure needs to be. I would imagine that we're a little bit behind a lot of other hospice providers who have been doing palliative care for a while, but we've been growing quickly, so I'm starting to work on that. I have been for the last year. We hired a Chief Medical Officer, Dr. Sonali Wilborn, who is helping lead up that project for us. And then the CMI is launching the Serious Illness Program set in January of 2021. And, at least to date – and I'm not sure if we're going to see an announcement in the near future that changes this – but to date they've selected markets and selected states that are eligible to participate. Unfortunately, three of our five states are in the zone of the demo, and so we have applied for all of our locations to participate in the Serious Illness Program. So we haven't made the absolute decision that we are going to do it in all of those locations, but I imagine we'll do it in many of them. And so I think that substantial experiment of helping manage people, all of whom are hospice eligible or will be in the next 6 to 12 months, but many of whom I think probably are hospice eligible. In using the skillset, like you said, that is case management, interdisciplinary in nature, understand how to take care of very acutely ill people in their home and keep them there, which is where they want to be with the people that they love. I think overcoming issues as access to care and helping assess with the social determinacy of care and figuring out what those missing pieces are and helping to get those things to them, whether it's good nutrition or financial support in another way – just any of that connectivity with the greater communities. I think those are things that we do. We do that in process all day long every day, and why would we not leverage that skillset upstream and help those people. But, also, my hope is that we help those people gain access to hospice when they're eligible for it instead of when someone else realizes there's no other choice or when they're ready for it, if they understand and have a relationship with a provider along the way. Then, hopefully, more people get access to hospice period, and hopefully they get it for the benefit they're entitled to receive, not just the last few days of life. That's our hope. I don't know that we know all the answers to that, because we really don't have a palliative care benefit today. That's another thing that I really hope comes out of all of the learning that we've done through COVID, but also just through these discussions, is that with the Medicare Advantage carbon, we do end up with some defined palliative care benefits so people know what it is that they're eligible to receive and they can access, but they also get a certain level of care as a minimum. Right now, there's all different kinds of things being delivered and being called palliative care, and there's really no consistent definition. I don't want to stifle innovation, because I do think a lot of goodness from playing with the model and trying different things. If anything, the last two months have definitely taught us that. But I do think there needs to be some understanding of what it is and definition around that and at least a minimum of standard of what is delivered and what the outcome should come be.
Meg Pekarske	Exactly, and I think we forget how defined. Hospice is what Medicare's defined it as, you know, and because there's no one source for palliative care, it lacks

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	definition. When someone reaches out to me about a non-hospice palliative care program, the very first question is well, what can you get paid to do? What you can get paid to do is what you can do. You have the kickback issues, beneficiary inducement and all of that stuff, and so I agree with you that the fluidity there exists because we're trying to piece together while we have this part fee thing and then you might get a payor onboard to cover things. I mean, I do think that 10 years ago I feel we were doing a lot of non-hospice palliative care. At least initial discussions then would sort of fizzle hospitals and whatnot, and then people closed their programs, and now you see a resurgence. I do that that it's becoming more mainstream, just like hospice got mainstreamed from cancer to now what percentage of Medicare deaths are covered under hospice. I mean, it's pretty remarkable. It's fantastic the model care that we deliver and people love it, because as you said, we're meeting people where they're at, which is at home, and your helping them define what it is that they want, as opposed to the wall this is what there is to deliver to you and one size fits all. I mean, you are creating an individualized care plan, so I do think that as we deal with all this chronic illness, we do really have this opportunity where payors are seeing that this really makes sense to do. It's not only the right thing to do and aligned with what people what, but it's also getting back to where you started. Back in college from an economic standpoint, it makes a lot more sense, so absolutely. I'm hopeful that in five years there is something that we get paid to do that really meets people where they are, because right now I think that there's a gap that, as you said, is underserved and they're just getting whatever healthcare there is but not be exactly what they want. I think something that connects us is just I want to be of service. You and I were planning on doing this conversation quite some time ago, and then COVID happened. Then you suddenly were super busy because you sort of saw an opportunity to serve and then stepped into the fold and did a whole lot of stuff that when we're talking about your pathway to hospice and all of the skills you gain through that path to get what you did done is – I think all of those skills came to bear on that. So you opened up this inpatient unit in New Orleans to serve COVID patients. I know the outcome, but I don't' really know how you saw the opportunity. How did you get this done. I mean, why don't you tell me a little bit about how this came to be.
Carla Davis	Okay. Well, first of all, New Orleans was becoming a hot spot. We were starting to learn that there were a lot of case in New Orleans, and this is primarily, I think, believed to be because of Marti Gras, and we weren't aware of the COVID illness. So we started to see just the cases going up and going up. First of all, there is no question that we would serve COVID patients and that we would have enough personal protective equipment of take care of our employees while we did that. So I think that was an important thing before we even get into the inpatient unit, because I know a lot of people really struggle with both of those things – whether or not they should, whether or not that's the role for hospice, should these people be let out into the community. We were just very declared from day one, this is our mission. We're absolutely going to serve them. We will do whatever it takes to make sure you're protected. I'm really proud of our team around that. I'll give you some shouts in just a minute in terms of the patients that we've served.

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	So at the very beginning of April, it was becoming apparent that New Orleans had a big problem on its hands and that we were going to end up with way more patients flooding the hospitals than the hospitals were prepared to take. They were putting beds in the convention center – 2,000 beds in the convention center. They had popped up tents in parks, and they were preparing for this onslaught of patients. Our Chief Medical Officer, Dr. Wilborn, was like we should open an inpatient you, and I'm like well, that's crazy. You don't open an inpatient unit overnight, you know. That takes a year or two of planning and negotiating finding space, getting the people employed, going through the regulatory approvals, all of these things. Then she said it again because she got a call from the hospital system in Michigan, which was really looking for help because they were also getting flooded. She just got thinking and was like no, Carla, I really think we should. I'm like well, okay. So I just organized the call. I'm like this probably is not possible, but let's just like run the lanes. That's kind of how we approach everything just in general, and I think that's one of the reasons for our success – that we don't really think linearly. We think okay, what would have to happen for this to actually happen? Well, you're going to have space. Okay, let's send a team on that. So you have to get regulatory approval. Well, let's send a team on that. You have to have staff, so let's start working on that. Well, you have to have equipment, you have to have enough PPE, you have to be able to get drugs in there, you have to have a contract with the pharmacy. Literally, we just all went down every single lane all from the beginning. I was on the phone with Enclara on that Saturday, and I was on the phone with (*inaudible – 40:19)* Express Company. We didn't know if it was going to happen. In fact, we thought it was a complete crazy longshot, but we went down it like it was possible. Two days later from that just initial crazy conversation, like go find space, we got a call from one of our folks on the ground in New Orleans, and she was like I have somebody who's interested. And it was an L-tech that had just closed down literally that week and just moved out of the space. We got on the phone immediately with the CLO of the hospital of the L-tech, and she's like absolutely we'd be interested in subleasing. She was like the concept is not horrible and I would consider it. Then we got on the phone with the State of Louisiana, and this all on that Friday. It was like Friday at 4 o'clock, and the State of Louisiana was completely responsive. I have to give them total credit because they knew that had a problem and they knew that they could do better by people facing the end of life. I think they were searching for a solution, and they also knew that if we could take the people who were facing the end of life then their resources could be focused on the people who had a chance of survival, and those resources are people, doctors, nurses, beds, all of that in the hospital. So we got literally on the phone with the head of hospice Friday afternoon, and she was like I think that my supervisors would like this idea. Why don't you put together a proposal and I will run it up the chain and let's see where it goes. Well, 20 minutes later we got a message back saying they want to talk to you Monday morning at 9 o'clock. So I put together – we had nothing at this point – but I put together a PowerPoint. Meanwhile, I got on the phone because we have an inpatient unit in Fort Smith, Arkansas, and we have an amazing director of that inpatient unit, Melissa Moody. I'm like it's Friday night and I have this crazy idea, but we're going maybe an inpatient unit in New Orleans. Any chance you want to be involved? It can look like whatever you want it to look like. She was like, "put me in, coach." Like, no joke.
Meg Pekarske	Wow.

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Carla Davis	Didn't talk to her husband – didn't do anything. She said I am in. She said I am an adrenaline junky. There is nothing going on in Arkansas. I want to go help on the front lines, literally.
Meg Pekarske	Wow.
Carla Davis	And I said can you bring more people? She said I will work on that. So this is like Friday, literally, the idea of this came. I won't bore you with all of the logistics, but the bottom line is the state approved our proposal of the idea early the next week. Literally, that happened on Monday, by the end of the day Monday. So then we started negotiated the lease. By the end of the day on Tuesday, we had verbal approval on the lease. We had not gotten the L-Techs in the hospital, and we hadn't gotten the hospital's approval yet, so then we started doing that. Meanwhile, again, we're running the different lanes on the other things. I sent out an email, I think it was actually the week before, for volunteers from all of the Heart of Hospice locations. We have about 750 employees, as I said, in five states. I said we may need help in New Orleans. If you're interested, please let me know. At that time, I didn't even know that we were going to do an inpatient unit, but I got people saying they wanted to help. So I sent out another message that said this crazy idea of an inpatient unit is possibly going to happen, so I really need your to raise your hands. All told, at this point, we had 60-something people who said they were in from all over, and that's the part that makes me emotional. Honestly, I get chill bumps because people knew that there was a need and they wanted to be a part of helping. They sacrificed their time with their families, their patients, their own safety, to go make a difference. So that's one of the coolest things that I think has happened about the whole thing is just people were working side by side from Mississippi and Arkansas and all over Louisiana. Anyway, I'm really really proud of the team. I will tell you that it's been a transformative experience, not only for the patients and families – and I'll share a little bit about that – but just for our organization, because people are all working together and feel even more like one family than we did going into it. The other thing that it taught me is just really we put these barriers up in front of us and think that something can't happen or think that you have to pilot it, and then you have to expand it out and take five years to do something – like, we did it in eight days – in eight days we were licensed and approved. We literally had beds and sheets. I had people going and buying sheets, and it all came together really fast. I had our medical supply vendor literally rent a truck to go to the warehouse to get supplies so that we could open this thing. We have served probably 58, 59 patients. We've been open four weeks exactly. Every time I think it's getting ready to slow down, the day before yesterday we got seven more referrals. It's continuing right this second. At some point we may pivot it to be more of a hybrid unit, but right now it's COVID-focused entirely. Most of these patients have not seen their family for certainly their entire hospitalization, but if they were in a nursing facility prior to getting COVID, those have been shut down since the beginning of March. So they've been so isolated from the people that they love and haven't seen their loved ones. Just this week, one of those referrals was a lady who is dying, and many of these people were dying and hospice-eligible prior to getting COVID. They weren't on hospice necessarily and COVID may be accelerating their death, but they were really hospice-eligible prior to COVID.

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	Another thing I will say is we have discharged some people from the unit. Not many, but we have discharged some people home with hospice because they lived through the COVID, which I think is sort of reassuring in some way for all of us if a hospice patient can live through it.
Meg Pekarske	Yes.
Carla Davis	One of the calls we got this week was for a lady and she's been in the hospital for I don't know how long, and her husband started crying on the phone when he found that we were going to take her. He was so excited he was going to get to see her again. Mostly, he was so excited that their son was going to get to see them again. I think it goes back to what you said before that healing isn't just for the patient. But I can't imagine being locked out of being able to see my mom or my dad and the repercussions of that emotionally for the rest of your life fighting with it. I'm very proud of the work that our whole team has down to be able to help connect people with their loved ones and help make sure that they're comfortable for their last days.
Meg Pekarski	I just find that so – like, that's the work of a lifetime. This is like these defining moments. It's not something that oh, I have this business plan and I'm going to – and not that we shouldn't be deliberate and thoughtful, but I think there are these opportunities. It's the difference between thinking all the reasons this won't work to like well, okay, what about this? What about this? I mean, it's to really make change and make a difference, whether that's optimism or whatever you call that. And the thing is – how many bad ideas have you abandoned. You thought it was really great and then it's like, um, this didn't really pan out? No shame in that, right? So I think what you said that this is a crazy idea but let's run with it and then see what happens – when you talk about defining when you're on your deathbed – this is probably going to be one of the most memorable things and impactful things you may have done in your life. It's just being called to serve, taking that opportunity. I'm sure the sleepless nights, all hours of work to get that done, all the uncompensated time and energy and all of those things, that's a lot to do in a very short period of time, and then your staff are stepping up and serving. I think there's a lot of heroes, but I think at the end of the day, I don't think people do it to be called a hero. It's like people who do this work are not thinking about it, like how am I going to perceived if I do this? Your inpatient director, she didn't even think because it's like of course. That I think is really admirable, because it's not about oh, my neighbors will think I'm heroic and wonderful – it's just like this is what you're called to do. I think it's so fitting, because what I love about hospice people is we lean into the things that pretty much everyone else finds the most difficult. It's just such care, and I think something that has challenged hospice nurses. The number one thing in talking to folks across the country is just fear and fear with their staff, and how do you overcome that. So I think a lot of education and PPE, because hospices nurses are used to dealing with infectious diseases on a daily basis. I also think that the barriers that we have to have physically, because I think we are connector and how do you connect to people when you have to wear essentially like a spacesuit to serve your clients. I guess I wanted to ask you that question. So you had people say sign me up, called to serve, and then obviously doing that and providing service to patients in normal times, and then inpatient works very different from what you had to do here – the handholding, the literal handholding

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	is different. So can you describe how you got staff comfortable with that the barriers that PPE and all those things bring.
Carla Davis	Yeah, I think again we had an initial group of people who raised their hands who were scared. I think their families ended up being more scared than they were, and so some dropped out and some came in. You think about it, like we're staffing a unit and we're only authorized for two and half months, so we only have license until June 30th. Just that – operationalizing something that's so temporary – is crazy. First, you don't have time to hire staff. Literally, we were taking a patient on the ninth day of the idea. What ended up happening is that people want to experience it, and you do feel safe -and I'll share my personal experience in just a second – and you get comfortable with it and you feel the amazing peace that that place is and you see the piece that people are experiencing and you know you're a part of helping change people's lives. Then the word started to spread, and then more people raised their hand. Then we started getting volunteers from outside of out hospice and people wanting to come from Nebraska and Texas.
Meg Pekarske	Ahh.
Carla Davis	That part is not what I anticipated at all. There've been some challenges trying to staff everything, but for the most part, we've really not had trouble, which is ironic because the reason the L-Tech closed the week we were able to secure it was staffing, which I think is interesting. In regards to the PPE, for those of you who don't know, I'm not a clinician, I'm not a nurse, so that was new for me. I wanted to go visit the unit and thank our volunteers and serve them and cook them dinner and all of these things. So I went, but I've never been more mindful of PPE. It was the first time I'd worn scrubs, which, by the way, are very comfortable. So they taught me how to do it and I felt very secure in the equipment. I think the more you do it, the better you are at it and the more secure you get around it. So I was able to see a patient. I wanted to experience what that was like, and I got to see precious little lady. You know, she could have been my mom was the feeling I had. She was barely communicative but communicative, and I was able to play with her hair and hold her hand. I mean, I had the Hazmat suit on, and gloves of course, but you still can find ways to connect even through that. We, of course, put the pictures outside of their gowns so they could see who was behind the mask. I asked her if there was anything that she wanted, anything that she needed, and she said "figs." But she said it very faintly, so I was like did you say figs? She said I want figs. Evidently, around New Orleans there's a lot of figs, and so people grow up eating figs. So we got her a jar of figs the next day, and she ate the entire jar. I thought that was awesome. For me, it will probably be Pinot (inaudible 56:27). She died three days later, but she got her figs. So I think to answer your question about the physical touch and what is at the heart is hospice – it is different. You can't say it's not different to have a mask on and have all this stuff on, but it's still the heart of hospice. We still can help people feel valued and supportive and loved in their last few days, and I think that's the magic of what we've been able to accomplish there. I would be remiss if I did not also say that we have cared for many COVID patients at home, as well. Probably at this point we're up to 130, 140 total patients between the unit and home, although it changes every single day – maybe even close to 150 at this point. Most of those are in Louisiana, but not all. It looks to be about 5 percent of the people who have died of COVID in Louisiana. So I'm very

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	proud of being able to take people home. I'm seeing in other markets that hospitals are keeping the COVID patients until they either pass or are negative, and I think that's unfortunate because people can go home and be safely cared for in their home with hospices that are willing to do that. And then there are home health agencies that are willing to do that too for patients who aren't eligible for hospice.
Meg Pekarske	I think that's a really important point. I have lots of thoughts on this question, but I want to know what you think. I think again, by sharing your story, these opportunities that come – and you probably have had no time to really reflect – but I guess in terms of leadership, I think being a leader in good times is easy. Yes, there are struggles, but it's in tough times you learn lots of stuff. I guess what do you think from a leadership standpoint are the skills that, as we're living through this really difficult time, have served you the most, and have those been sort of surprising to you? What is the thing that has helped you both rally your staff but also motivate yourself and whatnot?
Carla Davis	Well, I think this has definitely been the largest leadership challenge of my entire life, for sure – just the intensity of it, the fear of making the wrong decision, or ultimately the fear that my staff and my employees would be hurt making sure that we're doing the right thing by that. The constant pivot and change and lead the change – all of that in addition to the fact that we're all personally going through change and working out of different locations and working differently, kids underfoot, and all of the things that people are having to navigate. Definitely it's the hardest challenge that I've ever had, but I think that what has served me well is that I'm transparent and not afraid to be vulnerable in front of the people who I lead. I'm also optimistic, despite nature, so I absolute believe we would get through it and that we would be stronger on the backside. I didn't know what that meant or what that looked like. We started just immediately (*inaudible*-1:00) with all employees, and they have so appreciated that. In addition to written communication, every Thursday I broadcast from wherever I am, and I think we try to tell some of these stories and I try to highlight the patient care and thank people for the patient care. I had a mentor, David Reem, who you may remember back in the day. He said "in the absence of truth, people design their own." I think that's served me really well through this time, because I think that the communication of where we were and where we weren't and what we knew and what we didn't know and continuing to update that communication has served us well. I'm pretty aggressive and assertive, so I absolutely went out after the PPE. I didn't use traditional methods of that. I had lots of people going after it, so I was very quickly able to ensure that we were able to protect. And I say this humbly, because you never know. That's what this thing's taught us is that every time I feel confident, I'm also constantly worried. So I'm just trying to think through a (*inaudible*-1:02), which is, I guess, a strange combination of optimism and constantly looking at your worst case scenario. But I think that's what allows me to look optimistically. I think the worst case scenario we can handle, so let's handle it. I don't know if that answers your question.
Meg Pekarske	Well, it's the dichotomy because you started with vulnerability and then you said strength and assertiveness, and then it's optimism. I mean, for the worst case scenario, I think it's like these need to be in balance. If you're all I am is assertive and confident and I don't know what I don't know, I think that's what makes a

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	great leader. You are not falsely humble. You're grounded in both humility but also – humility doesn't mean that you're not going to go out and get stepped on – so that's why I think you're incredible because you have all of these different qualities, and I do think they're in balance. I think that his humanity – I mean, we're all humans, we're humans taking care of humans, and leaders are humans. This is why I think women in leadership is so important. I'm fortunate to work in hospice because I'm surrounding by amazing role models and women in leadership. I just think women are more willing to show their humanity and their vulnerability. Maybe culturally there's just more acceptance with women showing vulnerability in a way that men can't, but I think it's a unique opportunity for us. I think you're remarkable. When you and I were prepping for this, like you just do, right? I mean, you just do, and you throw out what doesn't work and keep going. You just keep going and you keep going. I mean, that's how you build a business, right? It doesn't mean that you're perfect and you make every right decision. You probably have to be forgiving of yourself. I know one of the things that we – I don't know about you – but I too struggle with is just expecting I need to be perfect and everyone needs to like me and all those other challenges we have, but being willing to step in. I think you are uniquely you, and that's what I think is the best kind of leadership. You're not hiding who you are and you're bringing your whole self to what you do. I think ultimately that's what connects you and motivates you. Anyway, I think you're remarkable, and it was so you that you did this inpatient unit and rallied the team to do that. It's a wonderful story, and I'm thankful that I know you and your story, which has been shared all over. But you and I were going to talk before all this stuff happened, but it was just a good culmination of your leadership and the team that you've created in meeting the challenge of today.
Carla Davis	Well, I think I would be remiss not to say something about the team, because that's the culture of our organization. It took a village to raise my view in eight days completely, and I'm just really grateful for them believing in it and then us too. It was all hands on deck, and it wasn't defined by your job title. I mean, Dr. Wilborn was negotiating the lease. I mean, we just did it, so I'm very proud of them.
Meg Pekarske	And you've made a difference in more lives than you probably even know. I just so have appreciated this time, and it's been a lot of fun. I learned knew things – that's what. Honestly, the leaders I talk to on this podcast, I know them, but then I always learn these different parts of them. It's like both surprising and it's like I totally get that. So I appreciate you sharing your story and how you got to where you are.
Carla Davis	Thank you.
Meg Pekarske	Well, that is it for today's episode of Hospice Insights, The Law and Beyond. Thank you for joining the conversation. To subscribe to our podcast, visit our website at huschblackwell.com or sign up wherever you get your podcasts. Until next time, may the wind be at your back.