Dr. Lynn McPherson:

This is Dr. Lynn McPherson, welcome to Palliative Care Chat, the podcast series brought to you by the online Master of Science, PhD and graduate certificate program in palliative care at the University of Maryland. I am delighted to welcome you to our podcast series titled Founders, Leaders and Futurists in palliative care. A series I have recorded with Connie Dahlin, to support coursework and the PhD in palliative care offered by the University of Maryland Baltimore.

Connie Dahlin:

Good afternoon, everybody. Welcome to our University of Maryland PhD program podcast. My name is Connie Dahlin, one of your faculty. And our focus of this set of podcasts is called, what comes next? The future of palliative care. And I am so excited to have Allison Silvers with us. Allison is the vice president for payment and policy at the Center to Advance Palliative Care. And Allison has a broad range of experience. She's been really involved in educating payers and policymakers who sometimes think they have a better understanding of palliative care than they really do. And helping work with key strategists to think about access to palliative care and quality. And also really thinking about educating palliative care programs on value of their program. Rather than justifying it, showing the value. Which I think is a different way of looking at it.

And so she has done so much in the last few years, one of her biggest projects was creating a payment accelerator program, which was a workshop, to help people think about payment opportunities and operating efficiently under payment models. She's also co-lead the Serious Illness Quality Alignment Hub, which looks at convening experts from the public and private sectors to define high impact feasible requirements and incentives for access to high quality palliative care. She also created a toolkit to help healthcare purchasers to improve the care of their individuals in their plans who have serious illness.

She has created and led three Learning Communities for health care plans for ACOs and PACE programs, and then also really thinking about how to combine these events and the tools to help people move forward. And she does a lot with the National Coalition for Hospice and Palliative Care Coalition. So I think understanding of a different framework for hospice and palliative care under that, and using all of her experience, and I'm going to let Allison introduce herself more as we get started. So Allison, welcome. And our first question for you is letting you introduce yourself, and then we'll ask you the follow up question of what's the most entertaining thing about you that not many people know?

Allison Silvers:

Thank you, Connie. As Connie said, I'm Allison Silvers VP for payment and policy at CAPC. And I have been working in healthcare for generations at this point, I can safely say. Often very frustrated with how our healthcare system works or doesn't work. So coming to CAPC and trying to advance palliative care and really the right way to care for people with serious illness is just a dream of mine. And as I'll talk about, I think the move to population health is the wind in our sails. We can only make sure that both sides of the fence understand the opportunities and what needs to be done.

In terms of something about me that people don't know, in the before times, when we used to go to in-person classes, I was studying improv. And actually if I can say so myself, I really wasn't too bad at it. It's a great way to just be comfortable on your own skin and to have fun and of course, to just let your brain go. So that's something about me.

Connie Dahlin:

So we'll see you improv during our interview.

Allison Silvers:

Exactly.

Connie Dahlin:

So you actually have a very interesting view of palliative care and what you've been able to do just, I mean, it's been so much when you think about it's only been five years. I mean, that's a short time for what you've done. So tell us more specifically what you're doing in palliative care and what is it, the joy that it brings to you.

Allison Silvers:

Yeah. So the way I describe what I do, I call it a three-legged stool because there's three audiences that need to understand value and opportunity and strategies, they all come together. The first as you alluded to, we do a lot educating policymakers, both at the federal and the state level. Federal, yes, a lot of focus on Medicare and what Medicare is paying for, how Medicare is paying, how Medicare puts in the rules of the game are things that CAPC is trying to pay attention to, can we somehow improve the rules of the game so that people with serious illness don't have to suffer as often as they do?

Then payers. As you may know, the world of healthcare, even for Medicare and Medicaid is increasingly in the hands of private payers. Their incentives to improve care for serious illness are just naturally there. So making them understand the value that palliative care can bring to them. And then helping them actually implement different ways to improve care for their seriously ill members.

And lastly, palliative care programs. And we'll probably talk about this a little bit more. But in talking with payers and health plans especially, the field of palliative care hasn't always been the best partner. Hasn't always quite understood how to deliver care, how to be responsive, how to be a good financial partner in a way that perhaps some other parts of the healthcare spectrum have been able to do. So CAPC jumped in and said, "You know what, palliative care? These are teachable skills, we're going to try to get that information out there as well," especially on operating efficiently, billing optimally and creating long-term relationships with the folks who hold the purse strings.

And as you can probably tell, it's nuanced. But all those three audiences come together. And when everybody recognizes the value, knows what to do to get patients with serious illness to palliative care early and then deliver palliative care efficiently and effectively, you've got a much better health system.

Connie Dahlin:

Can I just ask a follow up question, because you said something very interesting. When you were saying that we haven't played along, what do you mean by that? That we, because we're a newer specialty, we didn't understand that there are some things that people have been doing a long time that we needed to grow up to, or is it that we see ourselves somehow as different and then that is our own enemy? I think that would be a really good explanation, particularly because students who are watching this are leaders and they need to hear you give that distinction.

Allison Silvers:

So my sense of it is it's not the newness of the specialty, it more is that palliative care views its sources different. And don't forget palliative care, a lot of the folks who are delivering it are coming out of hospices. And the Medicare hospice benefit is pretty generous. I know there's people on hospice that would not agree with that, but compared to a lot else is what is being paid for out there, the hospice benefit is really quite generous. And it's a daily rate. So it's constant. And that way of getting paid isn't how other parts of the healthcare system that are having to rationalize who gets what when is probably where palliative care could use additional guidance.

I think it's, again, going from the hospice model to a much thinner payment stream, you can make it work, you could focus more intensive resources on higher needs while you dial down lower needs. You can know when people should be transitioned to different parts of the healthcare system, how to monitor instead of maybe intensively coming in. I've even heard, in hospitals, hospital based palliative care, demand is now exceeding supply which is fantastic. That's a good problem to have, but it is a problem.

So knowing when somebody could come off service, you do your consults, you stabilize them, and then they come off service. So things like that, that's where I think palliative care... It's coming from a great place, we want to help. Of course, you're never going to leave someone in perfect shape, it's just not our population. So you want to jump in and you want to be there for them, and you want to make sure everything's okay. Just to be blunt about it, the resources aren't there for that level of support. So knowing how to use the resources you have to give the support where it can be most impactful.

Connie Dahlin:

Well, and I think you bring up a couple of things, and I think that this is actually really good for the students to hear. We do hear a lot about the hospice benefit is not enough. And I think many of us who, and I know you would share this, it's been a political quagmire for the last few years, because you don't want to bring it up because you don't want it to be taken away, right? Because you can imagine it would bring up a whole can of worms of how people would interpret it. And yet you are bringing up something that because it is a benefit is guaranteed. Has it kept up with the market? That's a whole other philosophical discussion. But I think what you're also saying is, we should be grateful that in fact, it still exists. And it has that per diem model when a lot of other things have been taken away. And I do think-

Allison Silvers:

Yes.

Connie Dahlin:

... I agree with you of... And I've been in this field my whole career. Started in hospice [inaudible 00:11:40] so I feel like I can say this is that I do feel like we are in an interesting part business wise, which is why some of these things that you've said are so important. Those of us who were starting this and remember leaving hospice to do palliative care, we did feel like we're special. But I think if we keep thinking that we're special and nobody else can do that, that doesn't necessarily engender a camaraderie of we are in this together. Because I can imagine primary care people think that they have great relationships and do a lot of stuff. We have ED people who do a lot. And so we have to be careful that we don't make ourselves so special that we alienate other people.

Allison Silvers:

That's a great point. And I don't know if the students might have heard, there's a term called the medical neighborhood. You probably heard of the medical home where there's a particular clinician, that's your guy or your girl and that's who's taking care of you. But in reality, and especially for people with serious illness, it's more like a neighborhood, a medical neighborhood or it takes a village and you've got the baker and the butcher and everything. And that's how a lot of other clinicians operate, that we're in this together and we're going to do what we need to do.

Also, very cognizant of the resource constraints. Obviously that varies market to market and provider to provider. But being cognizant of those resource constraints. You probably hear mostly in primary care, you've got the 10 minutes, maybe 15, if you're lucky. So what can you do? And then, of course, other team members and other folks in the medical neighborhood chip in to make sure that patients and families get what they need, and are they doing a great job? Maybe, maybe not, maybe for some. But the idea of that playing in the sandbox, understanding where everybody is coming from and what their constraints are. And I'm not saying palliative care doesn't do that, I just think, again, back to the hospice benefit, it's a richer way to look at things than others might be coming from.

Connie Dahlin:

So it sounds like some of your joys also is bringing some of this language together and commonality and understanding. Sometimes maybe not being sure where it's going to lead everybody, right?

Allison Silvers:

Well, right. And actually the other joy is, so back to the three-legged stool. There's also the payers and the ACOs and the population health people. And really educating them about palliative care. And I always talk about that there's a lot of solutions out there, that these folks are being presented with. A lot of tech stuff, an app for this, a new program for that. And I really do think palliative care is really one of the very few that could improve quality of life while reducing unnecessary utilization. And it's got the evidence base, and it really is, again, one of the few where you get both sides of the coin.

So to be able to introduce that to folks who can do something with it and also to be able to explain to them, "And here's what you can do." I get a lot of joy out of that. We just finished, you mentioned the Learning Communities, some 43 Medicare Advantage plans and Medicare ACOs. And just about out of all of them, they may progress on what they were doing to help their members or patients with serious illness. Some to a bigger degree than others, but still, I think just about everybody reported progress, which is exciting.

Connie Dahlin:

Yeah. So tell us a little bit, because we talked about in the beginning, the concept of population health. Why is that important, do you think in palliative care? And in terms of moving to the future, how does that gain a bigger role?

Allison Silvers:

Yeah. So I will say for the future, everybody keeps guessing, is value here to stay? Will value accelerate? Is this look at populations something that's going to last or not? I'm very optimistic, maybe because I don't think America has a choice. I know there's a lot of people who wouldn't agree with me. But nonetheless, if you take the view that getting value, which really means ensuring optimal quality in a cost effective way, not wasting resources and making sure that patient experience and patient quality of life is front and center. That's really what population health is trying to achieve. So the opportunity that palliative care offers is pretty apparent, the incentives really are aligned.

I think what could be getting in the way, as I said, all of the other ideas that people in population health roles are facing, I call it solution noise. As a matter of fact, there was... I was going to talk about this about what keeps me up at night. But there was a meeting I was in-

Connie Dahlin:

You can go there. Feel free to go there.

Allison Silvers:

Okay. It was several years ago, I was in a meeting with some pretty important leaders in American healthcare. And we were talking about what should be the standards for patient experience. And of course, I brought up that doctors, nurses, all clinicians really should have basic communication skills. Knowing how to understand what a patient values and then how to use that to impact the treatment plan. And by and large, the rest of the room is like, "Well, that's only for people who are dying. All the rest of us, what we really need is a good app so we can schedule appointments. That's what people really want. And that's what will make the good patient experience." And I mean, to be fair, yes, having an easier time scheduling, yes. It's not that something you can dismiss out of hand, but I think what palliative care offers just has so much more of a meaningful role. And I think ultimately, that's really what patients want. When you're sick is when you're interacting with the healthcare system. And when you're sick you need that empathy, you need that opportunity to have it be about you.

So I think people are getting it, it's a lot slower than I would expect. To me the logic of it is like this hammer hitting you over the head and it's not going as fast as I would like. But I'm sorry, I forgot your original question.

Connie Dahlin:

That's okay.

Allison Silvers:

But my point is that there's opportunity there.

Connie Dahlin:

So well, here's the question though Allison, when I think about population health, I wonder... There's two parts to this question. If there's a group that you feel like we haven't done a good job with. And then my second part, though is, given... Well, we're still in the COVID pandemic. But last year things were different. And so palliative care, if you think about population health, COVID got associated with palliative care.

Allison Silvers:

Right.

Connie Dahlin:

So just thinking about two parts of, okay, is their a population we should be doing that? And then what do you think with what's happened as a population health for palliative care COVID?

Allison Silvers:

Oh, yes. And thank you, I'm glad you're asking that because one of the things that I really would want your students to take away, if you take nothing else from this, take away that population health is really data driven. And what palliative care folks need to do better at embrace and I know this gets very political in organizations, but proactively identifying the population who would most benefit from palliative care. Back to that medical neighborhood, working with your colleagues, working with the oncologists and the cardiologists and the critical care stuff to try to figure out as a systematic way, who are the folks that should be getting palliative care consults, getting admitted into home based palliative care programs, etc. I think that that speaks the language of population health people, that we're going to stratify the population and figure out the language of matching the patient's needs to the services, right service, right time, right place. I think palliative care could be an enormous team player there.

Clinician referral is important and it doesn't always work. Most often what I hear is that you get the referrals too late, you get not always the right patients. So to be able to do it systematically and bring your services to the right patient population on the whole, better than otherwise using data you can also then therefore have a greater impact. And then that could be self-sustaining too.

So with COVID what I was hearing about was the organizations that were are using data, okay, here's the 20,000 people today in this emergency room, who's going to get palliative care? So they implemented just these simple protocols to help the ED staff manage that. And then some places got sophisticated teaching the ED staff, "Okay, here are some basic communication scripts that you can use with patients and our families. And here's the triggers that this might be getting too complicated. And here's when to call palliative care." So it worked pretty well in those intensive surges of COVID. And if we can keep that up when the situations aren't so dire, I think that would be a win for the field.

Dr. Lynn McPherson:

[inaudible 00:23:29] with a couple of questions?

Allison Silvers:

Of course.

Connie Dahlin:

Sure.

Dr. Lynn McPherson:

I know-

Connie Dahlin:

I can see, she's been getting excited. She's trying to figure out that blank.

Dr. Lynn McPherson:

[crosstalk 00:23:36]. So I must have missed a memo, because this just seems so intuitively obvious to me that the healthcare plan's best interest to see the enormous value that palliative care brings to the table in terms of quality for patients and reducing costs. And I would think that populations of people would be happy to mount a grassroots effort to push for this too. And then when I think about the for-profit community based palliative care companies that are out there, that have developed these algorithms that they run against the healthcare plan's database-

Allison Silvers:

Right.

Dr. Lynn McPherson:

... should we be doing this systemically? I mean, did I miss something here? Why is this just not happening?

Allison Silvers:

Oh, my God. Mary Lynn, I love where you're going. I always say the same thing. I'm like, "What are we missing? This is so obvious." I will say that when you talk to payers, and where I see the hesitancy is yes, there's published literature and when you said, "Yeah, we know this, better quality, lower cost, done. What's your problem?" There's just skepticism. And back to that concept of solution noise, figure 20 people a day knocking on your door or zooming into your living room saying the same thing, "We know exactly how to increase quality and lower cost. And it's this app or it's this care coordination model." Or, "What you really need is..." I don't know. Again, a scheduling app and everything will be better.

So when all of that comes at you at once and palliative care becomes yet another thing that's saying that, I think it is hard for us to break through and CAPC is trying to figure out how to break away from the pack. The Learning Communities did help, and I think we took organizations through and showed them where they can start.

And then the other thing about the grassroots, I really like that you're going into, if I'm understanding you, going into the idea of the public and maybe public demand. CAPC is working on that as well. As you know we have a public relations issue of being associated with death, and just the association has a public relations problem. So I think that gets complicated too. So I hear you, it should be so straightforward. But there's so much communication and hitting messaging that gets in the way.

The other thing that I'll also mention is there have been a lot of instances where palliative care leaders knock on the door of whatever, their chief population officer or medical director in health plan, whoever it might be, and they'll show the literature. And the response is, "Oh, well, that won't work with our population." Or, "Oh, of course, that worked because it was in Iowa, but that's never going to work in Boston." Things like that. And there are ways to respond to that. My favorite from Shawn Morrison is counter and say, "Okay, fine. They got a 30% savings. What if we cut it down and make our expectations half? What if we improve 15? Are you willing to give this a try?" So there are ways to respond to that. But there is also a lot of skepticism. We in the field know this is almost a magic bullet. Certainly on quality of life. I don't think anybody could debate that. But outside of the field, there is indeed debate about it.

Dr. Lynn McPherson:

Well, granted, I do suffer from a pretty bad case of everyone's entitled to my opinion. But it sounds like winning the war is going to be one healthcare plan CEO's mother at a time, if you know what I mean.

Allison Silvers:

And actually some of the early adopters were exactly that. And the time is on our side. So Connie, you were saying when we started, is it because we're an early field? More and more people are just experiencing palliative care and seeing the difference that it makes. And yes, more and more of those people wind up being health plan CEOs or chief medical officers in the health system. So yes, that is helpful.

But I also think there's things that palliative care leaders can put forward to folks to not only convince them that palliative care is the best thing since sliced bread, but really to give it a try. Let us try with a population, again, back to the data, who are the patients that are keeping you up at night? Is it those oncology patients that are going to the ED too often? All right, let's give a try there. And then let's see what happens and we move from there.

Connie Dahlin:

I think the other part that it makes me think of is it's not only the CEOs that need to have that. I think all of us as palliative care providers or team members, however we want to say this, we're having these encounters when we try to get our own families involved. And it's not a positive one, right? I think one of the things that I always try to do, for better or for worse is get out of my clinical mode, right? So when I'm going to get that mammogram experiencing as a patient and going, "Oh, my God." Okay, this is what a patient is experiencing. And how much do they tell them. Or you're at the front desk and they're asking you about your insurance. And you're having to explain something. And even, I have a card, I have whatever, but I have to insert the card and they're like, "Well, why didn't you do that sooner?" And I'm thinking, "Man, if I were somebody who didn't feel empowered in this world or didn't have health literacy, I'd just want to shrink back down and leave because I'd be mortified." Right?

Allison Silvers:

Right.

Connie Dahlin:

And so I think some of this, and it's so interesting because I was [inaudible 00:30:22] app, is that a generational thing? And yet, I don't think so. Because that's about the scheduling. But when you're in the room with the patient, right? Which is when the rubber meets the road, all of us know what it's like. And we want that person to be connecting with you and not paying attention to the computer. We had computers that were called cows, computers on wheels. So first of all we had to stop calling them that because patients got insulted. Because-

Allison Silvers:

Oh.

Connie Dahlin:

... they thought [inaudible 00:30:50]. And second of all, I made it my... I mean, when I see a patient, I don't have a computer, I have a notepad and I'm connecting, right? So it means sometimes I'm taking the... Sometimes I'm like, "Gosh, I wish I had some other things, but I'm taking these notes so that I am with them." Right? But there's no computer. Now the challenge for me means that when I come out of that room... That's why I love electronic health records, because it prompts me for the things that I went over, right? Because I may not have done them in that order. But I did go over them. And so then I'm with the patient, it takes me longer to chart because I haven't done half the note in the room. But I would much rather have that experience from my own provider, right? Than them paying attention to that.

And that's become true to me when... I still work clinically. And it's a very interesting part. Because I'm covering for the team, I'm in a community that's not well resourced. So when I'm on, I'm by myself. And I went in to see a patient and she's in her 80s and she has a husband who's demented, who's caring for her and there's family members and just lovely, right? And they're trying to be nice for him. And at one point, she said, "Okay, dearie, you go with the girls and I'm just going to talk." And when they left the room, and I was sitting there and I had just in order... She started crying. And she said, "Thank you for just sitting with me. Nobody's asked me those questions." Breaking my heart, right? Because I'm sitting there thinking in my mind, "I'm a fraud. I haven't done anything." Right? I haven't fixed that. But it was so clear that her experience was we were treating her as an object-

Allison Silvers:

Right.

Connie Dahlin:

... and not as a person. And so that's the part that I think of when all is said and done, and when you think about populations, to each of our encounter and I'm thinking about culturally competent care, whatever, that we are present. And how do we really sell that experience to some of these payers, right?

Allison Silvers:

And I think the sale is that the system does work for anybody, I keep repeating that. But every day, I'm just like, "Oh, my God, how did we get here?" The system doesn't work for anybody, but the system just is completely inappropriate for people with serious illness. And I think showing the payers exactly where that goes wrong and what palliative care can do to make meaningful improvements really does work.

Connie Dahlin:

So what keeps you up at night for this work? We are, at this moment palliative care.

Allison Silvers:

Yeah. So again, I think the pace of change is keeping me exactly Mary Lynn, what you were saying earlier, like, duh. Why is this not everywhere all the time, starting from 20 years ago? So I think that pace of change is frustrating. I'm going to go somewhere which may be a little controversial, but I think the other thing that is starting to worry me is an emphasis on advanced care planning and filling out advanced directives. And let me preface by saying, yes, that's extremely valuable and can make a difference. But I'm starting to see some payers' population organizations focusing on completion of an advanced care plan and completion of advanced directives. And it's measurable. You know you can be successful if you have 100 encounters and 89% of them filled out the post at the end. So I think there's an appeal there. And I think there's an appeal that it's very tangible.

But I'm concerned that that's where the buck would stop. That we've got a population with serious illness, let's make sure they have advanced care plans, let's make sure they have advanced directives and we're done. And I really am trying to be out there, CAPC is trying to be out there as well teaching that it's a musket of interventions that folks need. And advanced care planning could be a valuable piece of it, but there needs to be other things as well.

So I think if your students interact with these population health leaders who are like, "Oh, great, we want advanced care planning," it's a foot in the door, what is it? The camel's nose under the tent, whatever you might call it, but that the work still needs to be done that in addition we're going to find out, let's assess for symptom burden, caregiver burden, areas of distress and let's address that. Not only what happens in the future if I face this distress, but what distress I might be facing at this moment and how to get that addressed. So that's my improv thing. It's a yes and yes advanced care planning, happy to help, I'm going to dive in. And let me make sure that sources of suffering that are currently present get address.

Connie Dahlin:

That's great. I mean, I think that's... I think I would agree with you. And I think that's been in my mind also about a little bit about the NCP guidelines, right? It doesn't say an advanced care planning program as a specialty palliative care program, right? That's a component and helping people guide back to that. So what do you think, we have these students who are going to get their PhD in palliative care and we want them to be leaders. So how do we help them guide into the future of the things that we need to make better?

Allison Silvers:

So I alluded to this earlier and I'll put a little more meat on the bones. And it's the business of running a palliative care program. Being a good partner, as much as I was just saying about making the value case if they push or if they come to you with ACP making sure that you could show value for a broader range of services. But I think the other piece of that is really being able to operate your program efficiently. And I, again, caution controversy. I don't know if this is distasteful, I have an MBA. So that's, I guess, the way I look at the world, but in reality there are limited resources and in reality patient and family needs are just so enormous to what we can really ever hope to help with. So I think the work of palliative care leaders is figuring out how to deploy your team, how to deploy the time and attention that is a limited resource to the right patients at the right time.

I'll tell a story, it was not palliative care, but I ran a community case management program for isolated older adults. And there was a nurse who I heard about from... So somebody had a scheduled visit with another nurse and they came in and one of the other nurses was there making scrambled eggs for the patient. And I'm not saying that making scrambled eggs is wrong and I'm sure the patient was hungry and needed and talk about an expression of love. I mean, there was nothing bad about it, but could that nurse, while she was making scrambled eggs for that patient have maybe used her skills at the top of her license helping somebody else? And those are the choices that palliative care leaders are going to have to make all the time. Maybe not scrambled eggs hopefully there are some boundaries already there, but how do you have an impact on patients and families, but still make sure that you're available to serve the gazillion other patients and families that are there?

Back to being a good partner, when I was saying earlier that payers didn't always see palliative care as playing ball as well as some others, wait lists. So palliative care programs would be like, "Okay, I have a three month wait list. Isn't that great, my program is so popular?" But that means that all those people who can't wait three months are less suffering. So I know this isn't easy, and I know this is a problem that will continually have to be solved, but just I would suggest as a leader, keeping your eye on, I'll call efficiency key. Just making sure that your resources are going where they can have the most good and it does mean dialing it back from where the marginal benefit might not be as high.

Connie Dahlin:

Well, I mean, it's funny, Allison, knowing you, but also just thinking. So my mind is racing, because I thought you were going to go two places. One is I mean, I think what is seen as the clinical part is only part of it, right? There's a whole support team behind it. And I think in a business frame of making sure that the right people are doing the right job. [crosstalk 00:41:39].

Allison Silvers:

Yes, I left that out. Yes.

Connie Dahlin:

But to remember that, when I'm seeing that clinical person who's behind me supporting my ability to do that, right? So that has to be structured really well. And I think, you do get into these clinicians who say, "Well, I just want to do it." Well, my feeling is once you do something, once you're setting precedent, and if you haven't talked to your team about it, it's really unfair to them. Because you know once, "Oh, well, you did it for them," right. And the second place, I thought you were going to go, that I thought was interesting is this whole part about we have moved in the sense that none of this work can be only about my compassion, right? Because what you're really speaking to is this financial sustainability that you have to have the dollar sign and the heart next to each other. And well, you said you're an MBA people might go, "Oh..." No, we need that perspective. And it can't just be the clinical part and recognizing all of our parts to come together of creating.

And so I'm just reinterpreting a little bit, because I think you were trying to be gentle, but I think that that's how we've risen, of understanding that we can be the most compassionate, empathetic people, but our program will fail if we don't have that work. And you and I have seen that where you have somebody who started something, never had the support of the hospital, didn't even know who their business person was. Comes up for a budget and the person's like, "We didn't know you existed and you can't show anything." And they're really surprised. And it's like, "Who were you working with?" So I think that that's really important. Lynn, did you have a question about that or were you just taking that in?

Dr. Lynn McPherson:

I'm taking it in, but my two observations are, I think that we as individual practitioners and palliative care teams as a whole need to continue to strive to show we're not revenue generator so much, we may save money, but the value and the quality aspect. And also to encourage not only people be super well trained here, but towards transdisciplinary extent, so that were not practicing in a siloed environment.

Allison Silvers:

Right. No, and thank you for mentioning that. Using the team wisely is another core skill of this. And I think in terms of that point about revenue, we're not revenue generating. One, the field has room for improvement there too. I do think on the whole we're leaving money on the table and that's sophistication that maybe will come in time, but if we could expedite that, that would help.

But the only thing about that, I'll name it, it's unfair. A cardiologist doesn't have to worry about proving their value. Forget about orthopedics. But most of healthcare doesn't have to worry about proving their value and I'm sure palliative care folks feel beat up. Why do we always have to prove our value? We're contributing to patient and family quality of life, that should be enough.

But I think too, to be fair because we're not pulling in the revenue, it just means we have to be good financial stewards of the resources that we do have. I started my career in healthcare, it's not on my bio, in transplant. And the money that the transplant program brought in was just astounding. I think we were able to... The excess revenue just really, I don't know, yachts and things like that. And palliative care is not going to do that. And there's no need to, not everybody needs a yacht. But on the other hand, recognizing that because we're not doing that, you also can't have a program that doesn't deliver in volume and outcomes.

Connie Dahlin:

Yeah. So our last question is... So we're going to have, again, these future leaders who are doing this PhD. What advice do you have for them starting out in palliative care and their career maybe or are starting a new career?

Allison Silvers:

Yeah. I'm looking at the notes that I prepared. I'll end with this idea about palliative care being a partner to population health. I hope out of this conversation it's pretty apparent that the goals of population health and the goals of palliative care are really exquisitely aligned. So what's needed is to have the confidence and the capabilities to have conversations to point out those alignments. And then as, again, has been pretty apparent from this conversation, delivering a program in a cost effective way that delivers on where that alignment is. I really think PhDs are the leaders of the leaders. So really showing how to make that happen and being successful there would drive success elsewhere.

Dr. Lynn McPherson:

We need a Dr. Fauci in palliative care.

Allison Silvers:

Yeah. Well, Dr. Meier-

Dr. Lynn McPherson:

[crosstalk 00:47:41].

Allison Silvers:

... Dr. Bayuk, we've got them.

Dr. Lynn McPherson:

Yes, we do. We do. Thank you so much.

Connie Dahlin:

Great. Well, thank you, Alison.

Allison Silvers:

Thank you.

Connie Dahlin:

We are really excited for our students to listen to this. Any last minute comments, Lynn?

Dr. Lynn McPherson:

No, I think this was awesome. I think it's almost an uphill battle. I mean, I know as a pharmacist I spent much of my career justifying my existence and it's hard to quantify. Okay, if I recommend stopping a drug, they may feel better and we saved a boatload of money. Is that enough? So I think your points are so well taken. Thank you.

Allison Silvers:

Yeah.

Connie Dahlin:

I would just say I think it's really important for our students to be thinking about these business strategies and some of the outcomes and the quality because that is us growing into what healthcare is. And we are a part of it and we are going to be compared. And so really thinking about some of these things.

Dr. Lynn McPherson:

Definitely.

Connie Dahlin:

So thank you again, Allison. We are so appreciative.

Allison Silvers:

Thank you. Oh, I'm sorry. One last comment, data. Use the data to find the patients and you're already in a better place. Okay, now I'll shut up.

Connie Dahlin:

No, that was helpful, data support. Great.

Dr. Lynn McPherson:

Thank you again.

Allison Silvers:

Okay, thanks.

Dr. Lynn McPherson:

I'd like to thank our guest today and Connie Dahlin for the continuing journey in our podcast series titled Founders, Leaders and Futurists in Palliative Care. I'd also like to thank you for listening to the Palliative Care Chat podcast. This is Dr. Lynn McPherson and this presentation is copyright 2021 University of Maryland. For more information on our completely online Master of science, PhD and graduate certificate program in palliative care or for permission requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.