Dr. Lynn McPherson:

This is Dr. Lynn McPherson and 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 in the PhD in palliative care, offered by the University of Maryland Baltimore.

Connie Dahlin:

Hello, everyone. Welcome to our PhD for the University of Maryland program. My name is Connie Dahlin and I am one of your faculty. And today we are joined by Tom Gualtieri-Reed. Tom is a really mover and a shaker in the current space of hospice and palliative care. He works with Spragens & Gualtieri-Reed Consulting. He has 30 years of healthcare experience of working in business operations, strategic development, analytics, and has really doing a lot of work with both providers and payers and brings this really wonderful mix of helping us interpret some of this clinical work to a business frame in a language that we can understand. He really has looked at a lot of other things outside of palliative care, which in terms of aging population and serious health, which also brings him back into this. He is also a consultant to the Center to Advance Palliative Care and faculty on numerous of their educational activities and has really written a lot of their business and program development tools and resources.

He's also worked with a lot of hospitals and clinics and home-based settings to really help them think about the care they want to deliver and thinking about developing palliative care. And prior to that, he was working in Blue Cross and Blue Shield of North Carolina and at Duke University Health Systems, Kaiser Permanente of North Carolina and the University of Massachusetts Medical Center. And he has his MBA from Duke School of Business School and his BA in economics from College of Holy Cross. So I think Tom really brings into this real important part for us about it's not optional for us to not understand business principles, we have to understand them. So we are so pleased to have you today, Tom.

Dr. Lynn McPherson:

And if I could also say... I'm Lynn McPherson, Tom is also faculty in our Master of Science in Palliative Care.

Tom Gualtieri-Reed:

Great. Thank you. Welcome. Excited to be here.

Connie Dahlin:

So Tom we're going to after my introduction for you, let you kind of underpin some more about yourself with a focus on what you think is important in what you're bringing to our PhD students.

Tom Gualtieri-Reed:

Sure. Just a little bit of background from me personally, as Connie just mentioned, my journey in healthcare has brought me through all different settings and all different perspectives of payer world, provider world, economic centers, et cetera. So I hopefully bring a lot of that. Personally over the years as you evolve in your own career and develop you, you start to get a finer point about what's important and why you're doing the work you're doing. And for me my family is very important, knowing the generation ahead of me and the generation behind me is important. And so a lot of what I've found

myself focused in on is thinking about our healthcare system and how do we make it better at a time when people need it the most. And we can go into more detail as we go forward, but I think that's really what drives me when I think about the field of palliative care and the work that I do and why I do it.

Connie Dahlin:

So we have to ask, because we've asked everybody that we've interviewed. What is the most entertaining fact about you that I don't know?

Tom Gualtieri-Reed:

I think I'm kind of a straight on, my entertaining fact is I absolutely love to spend time with my kids and my wife. Just last week we were at my daughter's graduation and had all of their friends in a safe way together. And so I can say that that is the most critical foundation to me. It may not sound exciting and entertaining but it is genuinely who I am and what I believe. So for some people hanging out with our kids is not something that they would say they love to do, and I love it. So that's my little nugget for you.

Connie Dahlin:

Well, that's great. I mean, I think people need to think about what are the other things that bring them joy and also help them to have other interests in this. So you've talked a little bit about what you love, but in terms of moving into palliative care what is it that you feel like you're currently doing to move the future and kind of what's your passion about it?

Tom Gualtieri-Reed:

Yeah, I mean, there's a couple of things about it. First of all, we've talked for many, many years about population health as a term and we've used it for years and yet our system gets very siloed. So we get very fixated in one area. And so I think one of the things that I absolutely love to do, and I do this when I'm out doing the discovery work, when I'm starting off a consulting engagement or learning about an organization is the discovery interviews and talking to different people about the perspective that they have about the population that they're caring for. And it could be an emergency clinician, it could be an ICU clinician, it could be a home-based primary care provider or a nurse and hearing from them what they're seeing in the system.

And then the magic of figuring out ways to connect the dots where I think that in this field of palliative care the clinicians in our field and clinicians in hospice are so magical at that same process that they do with patients and families. And so what energizes me is to think about the skills that we have in the field of palliative care and hospice as clinicians, and how do we take those same skills and apply it to understanding the business side of healthcare and to figuring out that continuity of care and really understanding, "How do we make the different parts of our system work better together?" And so that's what drives and energizes me when I think about again, going out and do that discovery, learning what's going on, and just starting to put a couple pieces together that start to shape a better team, a better program, a better plan, a better way to identify patients then was there before I got there. So I think that's a lot of where the field is trying to go to.

Connie Dahlin:

I think you also kind of hit something and I know you and I have talked about this, but I think the flip side is true, right? Palliative care is not so insular, we are not so unique. And I think one of our other things we need to be doing, but I think I know you're really good at is saying, "Look, there's been a lot of things

that have been tried in the business world and other models that we need to bring in that we don't recreate the wheel and that we acknowledge that other people have expertise in other areas." Does that make sense with you?

Tom Gualtieri-Reed:

Yeah, absolutely. And again, I'm going to think about what makes the field unique. And I would say what makes the field unique is that the clinicians in the field know this population often better than many others. And to your point, though, we can't walk in with the perspective that we know it all. We've got to walk in with a spirit of curiosity, a spirit of understanding and learning. And again, one parallel I always think about for clinicians who are doing leadership work, I do a lot of work with clinical leaders is the skill that you have in running a complex family meeting, of learning about the patient and their family caregivers, understanding that capability that you have is powerful in the business and planning side of the house, because you're going in with curiosity, you're trying to connect the dots between. And to your point Connie, there's a lot of resources that are around a palliative care team, if they're in whatever setting they're in.

And so part of the magic of this is finding what the skills are and the people that are around you that know their business very well, know to serve as well. And how do you tap into that and how do you help work with them? And then from a strategy perspective, how do you have them become an advocate for what you're trying to solve for, and how do you start to do things together? I often say to people, the most powerful person that can sometimes express what you need in a palliative care service, if you're doing planning or in hospice service, if you're trying to sift through how to grow referrals, is the others. Others around you, other referring providers coming forward and saying, "Oh, we need that thing. We need that." And so how do you build those relationships in a way that make it more of others talking about the value of your service sometimes more than you? So there's an example.

Connie Dahlin:

I think also you bring up this interesting point suddenly that you're doing. And I think that in the way that hospice and palliative care was formed, it was very much out of this clinician lens. And that, that lens now has to have many facets to it because it has to be clinical, it has to be business, it has to be a technology. It can't be to be successful anymore. And I think in my mind and I'm kind of speaking very generally and probably over generalizing, but I think there's still a lot of clinicians who hold so tightly to that clinical piece and are not willing to kind of pull in some of those other parts and it kind of limits their practice and limits their scope.

I think of it like when you're building, if you were to take some rubber bands and you wanted to make a little rubber ball, if you have one rubber band, you do nothing. But when you start adding the other bands of the other disciplines you pull together, and then you have something that can be more than just a rubber band. What does that say to you or does that resonate with you?

Tom Gualtieri-Reed:

Yeah, it does. And I think about the fact that what you are building, and maybe I can shift a little bit into kind of what's the challenges that you face in this field. And I mean, certainly one is the fact that engaging people in hospice in particular in a topic that people don't want to talk about often, and don't want to admit to. And I think about that is when I think about late referrals and you talk to a clinician from an oncology practice, they'll often say, "Well, how do I open up a conversation about anything other than hope?" Right? So you start realizing that from that perspective of that clinician,

understanding that's where they're coming from, becomes an opportunity for you to figure out how to engage with them in a way that gives them permission to talk about something such as palliative care or such as hospice.

So there's an example where you know about rubber bands and patching things together. It's also about building very constructive relationships with the folks and again, being an extension of their service in some ways, a part of their care pathway, integrating into their workflow, et cetera. Those kinds of things becomes a way that you're not this standalone piece of this tool over here, but you're a tool in a toolbox, you're something broader. So that's kind of one challenge. I think the other challenge that we face in this work is we sit on a fee for service chassis in the payment world. And so the model of getting resources is often driven by, "How much additional revenue or money will you bring into our system?" And we are, we have to be pragmatic about it. Healthcare is run as a business. It is the reality, there are business elements to it.

So the question becomes is how do you think about shifting from a fee for service mentality, where a lot of your resources come through a value based channel, and how do you measure that? And again, back to your point about rubber bands and cobbling things together, if you can be part of a broader strategy to grow a program more efficiently, again integrating into a cancer practice that is sitting on a fee for service chassis, they want to see more patients running through their system. Well, how do you jump in and help them more efficiently see patients through their system? You're adding value to them, but you're still working in a fee for service environment.

So I don't know if that connects all the dots Connie, but I was trying to think about that thread of... I loved your image of kind of rubber bands and the magic of what we're trying to figure out, given the challenges that are out there of how do you become part of the bloodstream of a healthcare system? How do you become not a bolt-on, but an integral part of a mechanism that's improving the population's care specific to this population.

Connie Dahlin:

So you said something that I think is really important for our students to think about and really get comfortable with this whole concept of value-based care. Do you want to talk a little bit about why that specific terminology is important now and for the future of palliative care particularly as we kind of think about reimbursement and business models?

Tom Gualtieri-Reed:

Yeah. So there's a thread of information that comes through this. I mean Becky and I've been in healthcare for 30 years. And so I'm going to go back to 1988 in a hospital setting diagnosis related groupings, DRGs were starting to come to shape as the payment model for hospitals. And the shift in the hospital setting was before Medicare and others paid based upon the charges that came out of the hospital. And they moved to what were called DRG payment, which was per episode of care within a hospital, a hospital got paid a certain amount. When that happened, and the hospital I was in, we started shaping and forming teams, looking at patients coming in with heart failure, "How many x-rays do they need? How many different tests do they need? What should happen on day three, which had happened on day four, what should happened on day five?"

So there was a whole re look at how certain patients were working through the hospital with a goal of, from a reimbursement perspective being as efficient and effective as you could be for your DRG payment that you were getting. That same concept is what's trying to happen across populations. So how do we think about a payment that you get for not every single procedure you do, but for the

outcome of the episode of care that someone might be having that cuts across hospital, outpatient, home-based, all those different settings. So I like to go back to that as an example, because it's not anything new in our delivery system. What is new is we're trying to take that concept and bring it across all the different silos of our healthcare system. And it's very, very hard to do. So that's one example. And I just want to go back again just to kind of frame up that fee for service and what the challenges in our delivery system for particularly, I'm going to focus on palliative care services for a minute.

Is that in a fee for service world, you're getting paid for the services that a billable provider can deliver. And a billable provider is a physician or an advanced practice provider, a PA, a advanced practice nurse, and there are codes and all sorts of logic that goes into what you can or can't get paid. And there's relative value units that drive the payment. But my point is oftentimes we find ourselves talking about, "Well, how many are we use, or how much revenue did a person generate on a palliative care team." But what we know is palliative care is a team sport. So in our fee for service world, we're getting paid for a piece of the service that we're providing for the billable providers, but we have a social worker, we have pharmacists, we have a wonderful chaplaincy service, that's all part of the care model. And that is one of the tensions and challenges we have in our fee for service world, within the palliative care services, where you're not able to fully cover the cost of the entire team.

And I think that's one of the fundamental challenges in our fee for service model today. And the other is you are also competing up against a lot of other services where their revenue is adequately covering the cost of their services. And so you're working with services where they're making more resources than you because they're generating enough revenue to cover their costs. And so in a fee for service world, you're competing up against that. And the last piece of it is, is that in a fee for service world more gets paid, so more gets done. And so you're swimming upstream a little bit when you stop and say, "Does aunt Julie want to continue the care that she's getting with her wonderful oncologist?" Can be a great service. And it's hard to kind of slow the train and have the conversation because in the fee for service world, the more different services they're getting done elsewhere, the more revenue they're making. And it sounds very crass, but that's the mechanism that we do have and that we're sitting on. And so anyway, there was a couple of points that I wanted to...

Connie Dahlin:

I think those are great. I mean, I think that, that's the part that we want people to think about. It's like, this thought process isn't going away. It's been with us for a long time, it will continue in the future. The question is, how does it sort of play out? I was really intrigued last week, the National Academy of Science, Engineering and Medicine released the Future of Nursing 2020 to 2030 Report, and very deliberate about bringing care back into the community for health equity, and very deliberate about saying it's healthcare in which their medical services and social services to pick up the whole social determinants of health piece. And so it was just fascinating for me to sort of think about in that realm of what we're struggling with, exactly what we're saying in palliative care of this duality, if you will survival and picking up the revenue and working within the guidelines and then thinking about our philosophical base and how does that kind of work. And then knowing that we need the business experts to be helping guide us, right? That's a very interesting part.

Dr. Lynn McPherson:

Connie, one question?

Connie Dahlin:

Sure.

Dr. Lynn McPherson:

So speaking as a pharmacist, who's non-billable [inaudible 00:20:27] value and it just kills me when I hear a palliative care team talk about, "Well, the pharmacist could go see Mrs. Smith, but the nurse practitioner can bill." I mean, it's so frustrating. What are your thoughts on that?

Tom Gualtieri-Reed:

Yeah, Lynn, I think there's a couple things on that. I think number one, that there's often times when we'll be working with a program and we'll be recommending that they need to add a non-billable provider, so they need to add a triage nurse. They need to add a pharmacist. And what we're able to start to think about is the most effective use of each of the team members. And in that case, we might say having a really good nurse triage person on a team will help prioritize which patients might be most effective for the physician to go to versus the APP versus the social worker. And the logic starts to become, "How do you free up, right? The most if it's billable with a billable service provider to make sure that they're seeing the next new patient which might get paid higher, but more importantly brings another volume into the team?"

And so you can start having this conversation about how the additional addition of certain providers on the team, clinicians on the team make the rest of the team more productive, more efficient, more effective. So that is one way to put it in. Another way is to really look at that data and think about the number of in this case, it's pharmacy or medication issues that are going on and talking about those in terms of cost or utilization factors. So if you can find five cases where it took five days for the meds to be figured out, well, that was, if you're in a hospital setting, that's two or three extra days in the hospital. So thinking about throughput as another example of how you can think about that. And I would always say we, we tend to go to the business side and we find ourselves feeding the frenzy of it.

And I know my lessons have continued to be that everyone's best intentions need to be understood and let's assume best intentions on administrators and others. They are absolutely under the gun for certain pressures of financial efficiency. They need to be able to talk to their colleagues and rationalize why they think that something is good. So the more data that you have that shows good use of a team that you have, that shows case examples where patients went through the cycle and they could have been dealt with better. The more data you have, the more business strategy you're using. And it's not all about the next revenue it's about that overall effective use of the team. And just don't feed into the frenzy. My guidance is don't feed into the frenzy of revenue.

Think about the data that tells the story about how effectively you're using different members of the team and each of those members of the team is resulting in better outcomes. And don't ever apologize for the fact that you had really good patient outcomes that you reduce suffering, because that is part of the value equation. And if we aren't talking about it, others are not going to talk about it. So keeping the patient value proposition in this is I think, a really important role of our field. Does that help Lynn?

Dr. Lynn McPherson:

It does, but it's hard sometimes to show, I think, to demonstrate that increased efficiency by having the non-billable practitioner in the loop, don't you think?

Tom Gualtieri-Reed:

Oh gosh, it's hard because the other part of it, and this goes back into the kind of population health challenge we've got here, which is we're trying to articulate the value of a service that helped make

something more efficient, which means that helped not have other things happen. And so the question is always, "How do you quantify something that never occurred, right?" So in pharmacy you're trying to articulate how you avoided so many medication errors using that as an example, or how you avoided overdosing someone or under dosing someone or et cetera. So my experience has continued to be that number one, be tracking whatever data that you can because that shows good business discipline. It shows that you are staying attuned and thinking about where you are spending your time. And I think the second thing is patient stories and finding the two or three that you went through and those two together can often be very helpful.

A third one, which I often recommend to folks is if you've got someone who is challenging what you're doing and has a lot of questions, invite them to a team meeting, invite them to do rounds with you, invite them to see what you see. And that's not to, again, over promote to say, "Hey, we're the experts of the most complex and we know it all. Come learn from us." Just let them observe and listen and watch the team. And many times the epiphany starts to click off for people and they realize, "Ah, now I get it. Now I get the connection points," and they see, and they hear it in a very different way. That's another way to do it. So if you can't quantify it, find a way to emotionally connect to it.

Connie Dahlin:

Well, and I would also say Tom, I think there's a sense that only clinical people can follow us even into patient visits. I've had business people be a visitor with me for the day. Now they had nothing to say. They were truly an observer, but it was so eyeopening for them when they heard the complexity of the conversations, because even in rounds or something like that, it's second or third hand. When they're having to see what you have to bring up in that emotional moment and God forbid you say the word death and dying, and they're like having their own internal reaction to it, it's so powerful, right? And so I think this other part Lynn talks a lot about transdisciplinary, well, that goes across from business to IT, to clinician, right? Of how do we kind of think about that. So I think that's also really important for our learners to think about.

Tom Gualtieri-Reed:

Yeah. And I think just a quick story, but even my wonderful business partner, Lynn Spragens, who's been doing this work for so many years. When I first started working on this with her we would go and we would make sure that we attended a team meeting. So if we're doing a consulting project, we go in and we meet with the team and we just observed the team. And we're not clinicians, but we quickly start to get a feel for what is going on, on the team, what are the dynamics on the team? How are people communicating? How are they triaging their patients? Same thing can happen with an administrative person in your area. And I'm always a huge fan, if you're a clinician, find an administrative dyad partner, find someone in finance.

And even if someone finances to help you pull some reports together, many, many will be very interested in coming over and just learning and joining one of your team meetings. It's just a way to engage and engage with the people that are trying to make these very difficult decisions. One other comment, and this is just a perspective that I have, which is unfortunately you're not number one in everyone else's priority list, right? Leaders and administrators and decision makers and folks that are running these systems and programs and home-based and clinic, they have a lot going on. Helping them understand you and what you're trying to solve for in some way helps them get more context when you're coming in and talking about services that you need, growth that you're seeing, opportunities you have to integrate, how you want to partner with others to improve some things. The more they know

about you, the more they'll be able to review susceptive to different ideas about what you're trying to solve for.

Connie Dahlin:

That's great. So Tom, like what keeps you up at night right now about the future of palliative care?

Tom Gualtieri-Reed:

I have more excitement than I have worries.

Connie Dahlin:

Okay, that is good.

Tom Gualtieri-Reed:

Yeah, I do. My excitement is that palliative care and hospice has been on for a long time, but all the nuances of the two, but there is growing recognition of the importance of this service as part of broader care systems. I think whether it's through public, where people are starting to realize and are asking for it, they're seeing articles about palliative care. And so you've got patients asking for it, whether it's because of the standards and recommendations coming out through the NCP Consensus Project Release of Addition for 2018, which gave some press and some more meat for people to hang onto to say, "How do we integrate palliative care?" Whether it's ASCO and others who are recommending it be part of cancer care, all these different strategies and tactics are starting to happen, which is making it more of an expectation, more of a standard of care.

And so that's where my excitement is. I don't know if they're worries, but where I hope we can continue to do is to not apologize for what we're trying to do. To come in with a little bit more of a less defensive, "Let me defend what I need," and more of an assumptive of, "This is standard of care, we've got patients cycling through, our systems look like this." To Lynn's point, "We've got patients that are suffering through unnecessary pain. We are here to help work and collaborate with you to figure out how to integrate with services that are already being built in some ways." So that's where I hope we can go. So maybe it's more of a hope that we really change how we position what we're doing and how we're approaching things.

And again, I think at a very pragmatic level, it's we can go in and fight or we can go in and collaborate and partner. And the more we go collaborate and partner, we bring information that shows how it's becoming standard of care. It shows how others are doing it. That's a lovely strategy too. We come in with examples of where we're trying to help partner and integrate. I often think of the great opportunities, for example, of case managers and others who are starting to see more and more of a need of population health across settings. How do we sit down and review cases with you? Let's learn together, those different strategies I hope is where we go because I think that's how we'll be more part of the fabric of the system and less of a bolt-on and less of a, "Okay, when we're ready for them."

My hope is that we really find ways to shift earlier into the disease trajectory. And again, the very pragmatic level that means rounding with people earlier in their disease, communicating with the referring providers, very consistently. Being part of an extension sometimes of someone else's team in again, a good way are ways to do that. So those are my more optimistic and hopeful than I am worried that we're going to fall apart.

Connie Dahlin:

The other thing that you've made me think of Tom is that it also means we have to pull the palliative care field to say that what we have done in the past is not where we're going in the future. Healthcare has changed, business models are changing, finances are changing. And so what we have done is very important for us to learn, but we have to grow with it. I think what you were saying about where does it fit in the cancer trajectory? It's not just at the end of life, where does it fit in heart failure? It's not just in D, C and D where we already know they have problems, but it's upstream in heart failure. Where does it fit in ALS? Where does it fit even in renal disease where we're talking to people before they start dialysis, right?

So it's not like waiting till people are so sick. And so I think to your point, that that means it's a very forward-thinking and then we also have to have our clinicians change because I still find some of my colleagues themselves are stuck in doing just end of life care. And that's a problem in my mind. And it's a challenge a little bit, because I think with COVID palliative care rightly was partnering and helping our clinicians. And these were really sick people, a lot of them at the end of life. So the challenge of, we got pushed back a little bit with COVID and so making sure that we found back and go forward again, I think is really important. Any thoughts about that kind of even just as a business frame?

Tom Gualtieri-Reed:

Yeah. And I think having a vision, right? If I want to go to kind of business planning or however you want to frame it up, right? So you've got to understand where the world is today. You can't ignore it. You have to meet the world where it is today and understand where it is today, but then having a little bit of a vision about where you think it can go. Even mentally going into it with a growth mentality, right? That we think about where we can go. But again, you've got to go back and meet people where they are. So if you come in and say, "Here's the latest and greatest we're better than everybody else," but look you typically shut people off. So I'm thinking the strategy of have that vision of where you want to go, all the things you just said how do we reposition to think about growth and we're here to really integrate with, but then you do have to think about a staged way to get there.

And so how do you pause and say, "Okay, well, we are very focused today on end of life and that's where we're getting a lot of referrals. What can we do to move upstream a little bit?" So if I'm in a clinic based setting, how can I join the rounds that are going on in the heart team to review the most complex cases? If I am working in a home-based setting, how do I connect up with and build some strategic community relationships with other programs in the area who are also seeing complex patients and seeing if we can do some things and pilot some things together to get a little bit earlier referrals to go a little bit earlier upstream? So sometimes we come in and we try to build the Taj Mahal, we try to build just the one solution and I'm just a big believer in, if you want to have a vision of where you want to go, want to have a mentality of wanting to grow, but starting and working kind of in a stage way forward, picking the things that move you that way and not trying to do it all at once.

So I think that's a lot and I would say for the field, historically again, I've been involved in the field for eight, nine years now, I've seen the transition and the shift happen and it's happening sometimes with, or without us. There are more times that I go out to systems where someone has been trained at a place that had quality palliative care, and they're turning to their colleagues in neurology, their cardiology, and they're describing to them what they experienced. And I think those are examples where we should hold onto those, let others speak for the quality and they become advocates for what we want is one of the other shifts.

Connie Dahlin:

So as we think about we have students who are going to be the next leaders by taking this PhD program. It's really exciting. So what advice would you give to them kind of going forward in terms of they're just starting, maybe in the field because we might have some people who have not been in palliative care, or we might have people who have not been in it for very long. What would be your advice for them in terms of kind of taking this next steps and starting out?

Tom Gualtieri-Reed:

I'd say three. If you're newer to the field or even newer at the level that you're trying to move into, whatever it might be, whatever your next stage is taking that moment to do the discovery, taking that moment to go in and really understand if you're newer to the field, understand the field, understand what we are trying to solve for. But most importantly, understand the population that we're trying to take care of. I think that is fundamental to discovery of really understanding this population while so many people come in and they might say, "Oh, we can put a really good transition program in place, that'll solve it." No, these patients have a lot of needs at different times. That's part of the solution, but how do you create a broader one? So really understanding the patients and the population and understanding the field and what it's trying and how it fits.

I think the second is data. Is thinking about how to gather and collect data. It can be qualitative or quantitative. It certainly is number of admissions or a number of home visits or number of patients being readmitted, those things. But it's also stories. And it's also information that's specific to what the problems are that your funders are trying to solve for, the problems that your stakeholders need, like what data and information is important to them. But having that data is important. And the third is relationships. Building strategic relationships with clinical, programmatic, administrative colleagues. If you are the clinician side of the house, build a relationship with someone in finance, if you are in a home-based setting and you're a community-based practice, build a relationship with the clinician lead at the hospital.

Building relationships, understanding what others need is where I have seen the most success. Having people recognize that you're part of the solution, you're not here to threaten. You're not here to take away business, you're here to be part of in grow. I think just having those relationships, building that with them, learning about them, learning about what data's important to them is I think a big part of this magic.

Connie Dahlin:

Wow. Well, those are really great words because they're very specific and I think people can learn with that. Lynn, do you have any other last minute comments or questions?

Dr. Lynn McPherson:

No, I think that was a great overview. Thank you, Tom.

Connie Dahlin:

Well, Tom, thank you very much. I know that the students will really find this helpful because you really offered some good insights and some real practical ones for them to go forward. So thank you very much for being with us today and we look forward to working with you more in the future.

Tom Gualtieri-Reed:

Great. Thanks for the opportunity.

Connie Dahlin:

Thank you.

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.