

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:

Welcome everyone. My name is Connie Dahlin. I'm one of the faculty with the University of Maryland PhD program, and we are having another one of our PhD program podcast. And I'm joined today by Dr. Lynn McPherson who is the director of the palliative care program at the University of Maryland. And we are joined today by one of my dear colleagues, Jeanne Twohig. Jeanne has been in healthcare for many years and also in hospice and palliative care. She has a master's in public administration. She started out with working somewhat in federally qualified health centers and then also then joined in with Ira Byock in working in the Promoting Excellence time period where Robert Wood Johnson Foundation was offering a lot of money for us to push palliative care forward. And she can talk about that.

And then she was at the Duke University and looking at spiritual care and working with Dr. Richard Payne on that. And then in the last number of years, she's been working with CAPC, the Center to Advance Palliative Care, on community-based palliative care. And so I'm just delighted because I know Jeanne has such a range of experience and really knows some of the creativity that was going on of people working within a framework and how people interpreted that. So welcome Jeanne.

Jeanne Twohig:

Thank you, Connie. It's nice to be with you and Lynn.

Connie Dahlin:

So, do you want to talk a little bit more about what you have been doing in palliative care and your role in its evolution or what you think is important for people to understand about your background coming into it as well?

Jeanne Twohig:

Oh, I'd be happy to. It's interesting when you contacted me about this and I started thinking back, I realized it's been 25 years, really, since I've been working in palliative care and how much has changed since then. Would you like me to talk about that early experience or?

Connie Dahlin:

Yes. That would be great.

Jeanne Twohig:

I first got involved at the national level around 1996 when Robert Wood Johnson Foundation was funding to a vast degree improvement in how Americans died. And that was an outgrowth of a study that they had done called the support that you know well, Connie, and you too I'm sure, Lynn, that looked at I think American's preferences and prognosis around end of life. And realized what an abysmal

environment it is for dying people in America. And that prompted the foundation to really pour a lot of resources into improving how Americans die.

And in those days, we weren't really even using the word palliative care. That initiative that I was deputy director of with Robert Wood Johnson Foundation was called Promoting Excellence in End-of-Life Care. And I think now probably we would have been calling it Promoting Excellence in palliative care, but then even that terminology wasn't as accessible to us. And the purpose of that program was to, or the language that we used at that time was take the best of hospice and move it upstream. And we wanted to take a look at how to diminish what we call the terrible choice of when someone who needed this kind of support that hospice gave, but wasn't yet ready to either have their physician sign off that they were actively dying or they themselves were not in that place.

So it put folks in the position of they had to give up curative treatment in order to get hospice. So the movement at the time that has now become the palliative care movement is the how to think about and demonstrate the ability to provide concurrently the best of what hospice had to offer for folks who were not ready or appropriate for hospice. So that goes back 25 years. At this point, it was a little shocking to me when I did the math last night when I was thinking about our podcast and thought, "Well, where did those years ago?"

So at any rate we, we learned a lot than those were demonstration projects that Robert Wood Johnson was funding for Promoting Excellence. And the demonstration projects were testing models of delivering care. And they were in everything from academic medical centers, cancer centers to truly push frontier Alaska and all points in between, looking at either special populations or certain diseases or certain venues of care prisons. For example, another project was with the seriously and persistently mentally ill. So, a complete patchwork of types of patients but all with that one intent of how do we get the needed care, right care at the right time to these folks? So, that's for me where it started, my work with looking nationally.

Connie Dahlin:

No, and I think though it was so formative Jeanne because I ... So I realized that my own library is like an archive because I have all the reports, the originals that came out of Promoting Excellence. So for our students to know that there was something on ALS, there was something on kidney disease. I think the work that was done on mental illness I think was with Dr. Fody here in Massachusetts and nothing has been done since then, right, it was so important. And really thinking about what does it mean. We take for granted that we've moved into different populations, but I think what you're speaking to is that the model was so cancer based that Promoting Excellence was really saying, "We've got to move a different way with that."

Jeanne Twohig:

That's exactly right. What we spend at 22 projects to demonstrate in, as I said, a variety of venues, a variety of geographic areas, et cetera, and then we did in addition to that, that were specific to ICU's. That was around the first time I met you-

Connie Dahlin:

Yes.

Jeanne Twohig:

... when you were with Mass General. And then we also did several pediatric projects. Then we also did eight different work groups. And that's what you were alluding to, AIDS, end-stage renal disease, a whole variety of surgery, American college of surgeons. And what those work groups did was pulled together leaders in that particular segment of healthcare and had them chart a course forward. And it resulted in tremendous policy change and just a new vision for what can happen outside or beyond the scope of just what how cancer patients could benefit. And I think that what happened then was all of those demonstration projects were written up in individual articles in this big series in Journal of Palliative Medicine, and that helped get word out to the field. And again, it started to create this vision of something can be done and with at least a framework of what program design could look like. And here we are all these years later still working on a community-based palliative care program design and what makes for sustainable programs. So it's been a journey.

Connie Dahlin:

And so for our students, Jeanne and I actually have worked together on helping programs start this. And I think the elements of program design, whether it's inpatient or community have really come together with what you've heard various speakers talk about, that you can have the passion, which is really important and you can have the clinical expertise, but you've got to have in place a business model for sustainability. And so you have to have the heart and the dollar sign together to do this. And so Jeanne has really been really helpful in helping programs understand that if you don't do that, you won't survive, or if you skip the needs assessment, it will come back to haunt you because you will still have to do it. So I think that those are things that for our students wherever you go, and you're going to start an initiative, the principals of a needs assessment, you have to do, whether it's a palliative care program per se or whether it's starting some sort of education project or whatever. Because if you miss that step, it really decreases the probability that you will be successful.

Jeanne Twohig:

The other thing that as I think back about it, that Promoting Excellence in end of life care did as a national opposite of the Robert Wood Johnson Foundation. And at that time, and we can talk more about the context of what was happening in the late 90s, but at the time, RWJ also funded three other national offices. One was located at the Midwest bioethics center in Kansas city. It's called the Community-State Partnership to Improve-End-of-Life Care. And that pulled together coalitions to think about community and how communities and state policy could come together. Another one was called Last Acts, and that was more communication oriented, like how can we as a country think about how we communicate around this thing that nobody wants to talk about, death and dying? And White people shy away from when they hear the word hospice, how do people even understand what the word palliative care means? And so at any rate, Last Acts was a communication effort. That was extremely successful. And then the fourth national office that RWJ had at the time was the Center to Advance Palliative Care, where you and I continue on as consultants.

But one of the things that my office did and I would intend that each of those national program offices learned in these early days was the importance of cultivating leadership. At the time, the field of palliative care was so young that almost everybody was an emerging leader. And now some of those folks that were emerging then with support from philanthropy and also support with tribe building, folks were able to come together, share knowledge, gain momentum, gain traction, and grow a field by virtue of how they learned to lead. And I think this whole idea of palliative care leadership is something that is as important today as it was then as the field has grown.

Connie Dahlin:

And that's what we think that a lot of our students, they are going to be leaders. They're stepping into this. This is a PhD. Just by coming into this, you're stepping into something new, right, and so you have to be brave and taking a risk to step into a new program. But we know that we want them to be leaders, but we also know that they were adults. And so they have to think about where they want to lead, right, what's the interest they're going to have the passion about? I think that's all really important.

So I think it was interesting because all of us ... I remember being of that and working on the palliative care in the critical care unit. And that was a really interesting time. I think now we take it for granted, particularly with COVID, about how much palliative care has been in the ICU, but that it was a big shift of getting that attention. So when I think about when the Robert Wood Johnson shifted their focus from palliative care, I think that was hard for a lot of us because it had been so successful and it was really a way of bringing together the community. What are your thoughts about when that shifted and then what you decided to do next, did you sort of feel like the field had enough groundwork from Promoting Excellence that there was places for people to grow or what were your thoughts at that time?

Jeanne Twohig:

Well, it's interesting because I had to learn that foundations have lifespans for their initiatives. And surely we all would have wished that that level of support would have continued longer. But RWJ invested many years and many, many, many millions of dollars in a very profound strategy to improve end of life. And at some point, because the issues throughout healthcare are so many, any foundation needs to turn its attention to other issues. And so their idea was they had well seeded the landscape and then it's time for what will grow to grow. Because sustainability and proving the value to other stakeholders beyond a foundation is critically important. So I think for all of us at that time, there was that, holy smoke, RWJ is coming to the end of its philanthropy in end of life care, will the field crumble?

Well, no, it didn't. And I think because of a lot of reasons. One was all the work that had been done over that maybe 10, 12 year span of time, but also because of this whole idea about creating leaders and those leaders could carry forth. And also because part of RWJ strategy involved research and so there was good data to draw upon, which helped with sustainability of programs or helped to give programs a way to show their value to their stakeholders. So there was research. The other thing that had happened in the course of time was there was a tremendous effort to change how medical schools were teaching about end of life. And remarkable changes had been made in medical schools, nursing schools, fellowship programs, in all of this. And so there was a greater knowledge base, a more broad knowledge base and a greater awareness to carry the movement forward. And other funders did step in as well.

So I think that it was validating to see that things didn't crumble then. And some of the things that really were impressive that happened over time that built this into a sustainable movement were things like palliative care becoming a medical sub-specialty. That's huge, absolutely huge. Other things that happened in the course of those years was the creation of the American Academy of Hospice and Palliative Medicine. That started as just a small cluster of leaders. Now, I don't even know the number of how many members that has. And each national hospice organization formed and then expanded into an HPCO, National Hospice and Palliative Care Organization. The Institute of Medicine came out with Approaching Death which was an expose in some ways about how Americans were dying. So, a lot happened. Another main thing that happened in that period was the release of the first national consensus project on quality guidelines for palliative care in 2004. Do I have that right, Connie?

Connie Dahlin:

Yes, you do. You know the exact date.

Jeanne Twohig:

But things like that that were establishing standards and making this amorphous thing called palliative care into a reality as real as being a medical sub-specialty, as real as having national guidelines, as real as having professional organizations that are advancing the cause. So yes, it was difficult when RWJ lessened their philanthropic support, but the field was primed.

Connie Dahlin:

Well, I think you gave several lessons to the students. One is, if you're going to be in palliative care, you need to understand funders. So it could be insurers who are going to pay, but also philanthropy and understanding foundations. And that when you're going to approach foundations, that it's going to be time limited. They're wanting you to get something solid so that you have a basis to continue, right, so I think there's that. And then I think you're right. There were so many pieces to that of the different organizations. I can speak to working on the consensus guidelines, and in my own experience of even, since I did the references for the first edition, what we had as evidence. I was pulling from all types of stuff because we didn't have anything really in palliative care. And by the third edition which I edited, I could take from all of the palliative care because in over the course of those 10 years, we'd developed a base.

So you speak to the different parts about growing up as an entity. And I think people understanding that hospices 60 years old or so, it depends on whether you decide the 70s or the 80s when the benefit. And palliative care as a recognition of a specialty has really only been in the last 10 or 15, 20 years. And so unlike other specialties ... Well, I guess there are ... Addiction medicine is probably coming into its own. So there are specialties, but those take a while to get established, right, and palliative care has moved into that.

What are some of the other things like ... So, you Promoting Excellence closed, you did a great job of tying up all that. I remember all the reports that came out of the summaries and things like that. I'm sure that that was interesting because you've gotten to work with Dr. Byock who everybody knows had been quite a leader and coming out of emergency medicine, but doing all that. And then you jumped into a different space. And so what was that like for you? Because you saw this change. And then as a leader in palliative care, you were having to choose about where you were going to support next from this administrative place.

Jeanne Twohig:

Yeah. Well, life is such a serendipitous thing. I first met Ira Byock when I ran the community health center in Missoula where I live, Montana. We had a lot of community physicians who served as volunteers and would do different clinic hours for us. And Ira was one of those. And that's how I first got to know him, in a completely different capacity and actually before he was such a national figure in all of this. And then he was really starting to devote his professional career to understanding and serving Americans at the end of life. And he had a real strong community focus. In fact, he started this thing called the Missoula Demonstration Project, which is another important piece of the history of all of this. And MDP as we called it, it later became known as the Life Center Institute, but that looked at the community, in this case, Missoula, Montana as a laboratory for how a community can think about end of

life issues, whether it's legally or in the school systems or in our art, et cetera. So MDP was a very vibrant part of community oriented attention to palliative care, end of life care.

So at any rate, I got to know Ira through the community health centers. And then when he was asked to work for Robert Wood Johnson to lead Promoting Excellence, he asked if I would join him on that. Well, serendipitous life, Richard Payne was one of the members of Promoting Excellence as advisory board. And I had become just a huge fan of him and the work that he was doing as a cancer doc neurology, a real leader there and also with a real strong understanding of community, particularly African-American communities, and how to take a look at racial disparities. And so he became the head of the Duke Institute on care at the end of life, and asked me, because my work at Promoting Excellence was winding up, to join him there at Duke.

What was attractive to me about that is the Duke Institute was housed in the divinity school. And the reason for that were various, but it was the only end of life Institute at an academic center that was in a divinity school. And it really gave us license to take a look at the whole person. In fact, there was a saying there at the time that death is a spiritual experience with medical implications as opposed to a medical experience with some spiritual implications. So we were able to take a look at that as well as ... And so my work in program design then was fortified by this enhanced vision of the whole person nature, the what goes on inside the person.

And from a context period, there was a lot of people thinking about that at that time. Christine Puchalski at Georgetown, I'm sorry, George Washington Institute of Spirituality and Health, that was formed to them. And there was a big national meeting probably maybe in around, I don't know, 2007, 2008, where leaders from around the country came together just to try to define what you even mean by spirituality at the end of what language are we going to use, what standards should there be around that? So again, it just shows how the field in that time period was grappling with a lot of issues that have formed the foundation of how we think about things now. So, we did a lot of work with chaplains and chaplain organizations and thinking about how to expand their clinical work as partners with other palliative care team members, et cetera.

Connie Dahlin:

So you've finished those two projects and you're there. Where do you feel like we are now, given all of those routes that you've been involved in, where do you think in terms of where we are in hospice and palliative care? Solid place, are we still moving towards something, are we missing something?

Lynn McPherson:

Would you do anything differently?

Jeanne Twohig:

Gosh, there's a lot in that question. I think one thing that I've learned is that movements take time. And this has been a movement. It's a huge cultural shift that has been in process over the last 25, 30 years. Because at the heart of it is that cultural aspect of how do we as Americans think about our own mortality and learn to talk about it and have dialogue with our providers as partners in these discussions and decisions. And so I view it as a movement. I think for me, it's been eye-opening to realize that there's tipping points all along the way that help push a movement forward. But it takes time to make cultural change. And so the impatient part of me is wanting to be farther along than we are now.

And that said, the last year has I think shown all of us how far palliative care has come. The reason I say in the last year, I think the pandemic has elevated awareness of palliative care. And the field

was able to respond. The field is so positioned that it really was in a good place to not just attend to the palliative care needs of seriously ill patients but also to step up and in new and more powerful ways support colleagues who were attending to the needs of folks impacted by COVID. So, I think that the inpatient part of me says, "Geez, how can we still be trying to define what palliative care means and how can there still be resistance on the part of some clinicians and administrators and funders to what palliative care offers?" But that's only when I fail to stop and look back and see really how much is in place.

And when you think of things like ... I'm not sure in 2021 what the exact percentage is but I remember around 2020, it was a full 95% of hospitals, over 300 beds, have palliative care programs. Holy smoke, that's a huge benchmark. So there's been tremendous change. And then CAPC's mapping project which sought to map where there's community-based programs shows an amazing, if you envision pins in a map of the United States, there's pins everywhere. So, yes, we want palliative care everywhere. We want it to be easily accessible for patients to have high quality palliative care. And it is happening.

So I think that my prediction for the future is that increased awareness that we've been able to more concretely see in the last year is just knowing it can continue. I think both patients and families are increasingly aware and familiar with how to ask for palliative care. I think there's been a tremendous expansion of what we would call primary palliative care where physicians with other specialties, primary care and other specialties have an increasing understanding of palliative care and bring that as a first line to patients who need it.

And I think that we're learning through the work you and I are doing, Connie, with CAPC and the work of many others around the country, we're learning with more precision what high quality palliative care programs look like. And we can define it better. And the better we can define it, the more sustainably those programs can be crafted. So, I'm hopeful for the future. I think that we need to continue to expand access post geographically and demographically. We still have a lack of equity in terms of who has access to palliative care because of race or ethnicity or geography or sexual preference, the whole gamut of whatever causes folks to be more marginalized and underserved by our health system. I think we've got great work still to be done in that realm.

And I think all of this expansion of palliative care that would be my dream is going to be dependent upon progressive financing and more innovation in terms of how palliative care is funded. And so we need to continue the policy work and the work with insurers to better understand what palliative care is and how it benefits and therefore how and why the value that it brings is worthy of significant funding. So, work to do. But I think spring boarding from a very, very solid foundation.

Lynn McPherson:

Can I add a couple of things?

Connie Dahlin:

Sure. Go ahead.

Lynn McPherson:

So, I think we would agree that when you look at internal medicine as a practice that's been around 4,000 years and palliative care has been around, what, 35, 40 years, So I think we would both agree, all three of us would agree, that we've made tremendous strides. And you've mentioned primary palliative care a couple of times now. You've mentioned physicians both times. Do you think we're doing an

adequate job in our schools of nursing, pharmacy, social work, medicine, chaplaincy, in teaching these young providers about the principles of palliative care?

Jeanne Twohig:

I think, Lynn, that that has certainly changed from when I first started. Again, there's been tremendous work that's done, but is it sufficient? No, I don't think it is. I think there's so many ways in all the professional schools. And I can say going back to my work at Duke, it was a subset of those students in Duke Divinity School who were ... They had to be pretty self-motivated at the time to learn about end of life care and palliative care as we would wish. I think there's tremendous work that needs to be done. And also too, post training. You think of all the clinicians that would benefit from ongoing education, ongoing awareness of the principles of palliative care. The reason why that is so important is because there's too few specialists in palliative care, and we need to be able to reserve those specialists for those patients who need specialty palliative care. There's so many patients who need good palliative care at the onset the same way they need good cardiology care or good internal medicine. So, to answer your question, no, there's more work that needs to be done.

Lynn McPherson:

And how do you think we're doing in terms of transitions in care from palliative care and acute care institution to either community-based palliative care or to hospice?

Jeanne Twohig:

I'm so glad you mentioned that because when I was thinking about what the future holds, to me, one of the most important parts is exactly that. I think as our healthcare system as a whole, beyond even palliative care, one place where our health system, it breaks down as a system is in care management and adequate transitions of care. And I think palliative care is focused holistically in those ways and understands that the interrelationship that happens among disciplines as patients transition throughout the system, but more work needs to be done there. I think that there's uneven boundaries between palliative care and hospice where that territory can get confusing and dicey for patients as well as for the clinician serving those patients. Same is true with nursing home long-term care settings.

And to me, it's that good management of transitions and good management of care that translates to quality, especially when I think about the patient and family experience. Well, I know when I talk to patients and families around the country and listen to their gripes, at the heart of it is this sense of feeling very alone with a lot coming at them and nobody helping them navigate.

Lynn McPherson:

Yeah. I think sometimes people on both sides of that fence aren't even terribly knowledgeable about where the patient's coming from or going to. I know several years ago, I was preparing a talk on transitions in care from hospital palliative care to home-based hospice care from a medication management perspective with my bestie. And I thought, "Oh, this is going to be easy peasy." It was almost the end of our friendship because I was from a hospice perspective saying, "Why didn't you take care of this when they were in the hospital from the palliative care team, why didn't you stop these drugs that are medically futile?" And then she had the same misperceptions about, "Well, why don't you do this in the hospice?" So, it was really, really going on in hammer and tongs. So, I think people needed to be better educated. And I think people don't have that safety patience, don't have that safety net of knowing that where you're coming from has talked to where you're going to.

Jeanne Twohig:

Yeah. I love that example because if you think about you and your colleague having different opinions about what should have been done, imagine the patient and family and [crosstalk 00:36:19]. They're the victim of that confusion.

Connie Dahlin:

I would say, one of the things that's interesting in just my perspective is being one of the people who had been in hospice and then went to palliative care, I was very knowledgeable about how hospice worked, the payment model, all of that, right, so I think when I went into the hospital, I was a better palliative care provider because I knew what was going on in the community. I knew that benefit upside and down. And I also knew that you knew what you need to be with community care, right, I think there is a challenge right now because we have, with few exceptions, our training for palliative care is very much from an academic medical model. People get community experiences, right, but they're not doing that.

I'm trying to work on helping, at least with APRNs, by the nature of practice, don't get me started. It's insane. But before APRNs now go into their nursing masters, they have to declare whether they're going to be inpatient or community. Okay, that's insane, right, because you haven't even had that experience, but that's the way that it's done. And here we are, we have these people we're going to be in the community, but they aren't getting trained in the community, right, and so it's a craziness.

And so one of the things that I have often thought about and really tried to encourage, and in fact, Jeanne when we had our grant for the critical care part was to do this cross training because I have people who still ask me, "Well, don't you need a special license to be a hospice nurse?" It's like, "No, it's still the same license. It's just focusing on that." And I think people don't understand, and I think we haven't done enough for people to go see what it's like from the other perspective, right, and then, Lynn, to your point, I confess. One of my tasks that I hate is when I have to do medication reconciliation, particularly when I have one from what was the clinic to what was the home to what was now? And I'm like going, "I don't even know which one to start with," right, do I pick the one at home or am I assuming that stuff when they are in the hospital will get discharged because we're just doing it now. But you know better than both of us, the things that get started in the hospital [inaudible 00:38:42] are crazy, right?

Lynn McPherson:

Proton pump inhibitors, perfect example.

Connie Dahlin:

Or a three parts of a bowel regimen or all the other vitamins. And in my mind, I'm like, "Okay, that's \$10 a pill, that's \$6 a pill," right?

Lynn McPherson:

Even if palliative care knew the formulary that a hospice was likely to have, we are not going to pay for Oxycontin unless there is an enormous need to use a branded product. We're going to use generic long-acting morphine or methadone. So showing some sensitivity to what's coming down the pike. And one of our other interviewees just said, "I love being able to tell the patient going to hospice, hospice will pay for all your medications." I know that CMS would like us to cover pretty much anything that is appropriate and relevant to the tremolo diagnosis or any illness affecting that terminal diagnosis, but we

don't actually, quote, pay, and I hate when nurses use that word, we will or won't pay for that. It's far more discerning than that.

Connie Dahlin:

Yeah. So I think that, Jeanne, you bring up all these interesting points that you were talking about where we have been and the Medicare benefit. It's hard sometimes, right, because it's making us make these decisions. And then what happens. And I think for our students to understand that Jeannie and I really like people to think about their community, not just of who the clinical providers are, but who are the service providers, who's doing nutrition, who's doing transportation, who's doing legal services, who's doing translation, who's does respite care? And that's going to differ from every community. And if you don't know your community resources, then that's a problem. And it won't be the same because all communities are different.

And so I think when I think about some of the work that you've done with Robert Wood Johnson and then also working with Duke, it's really about thinking about where are these patients and meeting them and how do we get the resources to meet what they need, which in my mind, and I started off in hospice, so I feel like I can say this, hospice may not be right for some patients. I think that we have this sense that for, A, that we should make all patients goals of care be comfort care, and that may not be what they want. And then we say they have to have hospice, but that's could be not in sync.

And I think about in my own practice with the Temel study, and as you both know, 45% of those patients were mine, I had young people who told me, "I am not going to hospice. I have young children. I want my story to be that I fought with them till the very end that I did not want to die and I did not want to leave you." And I had conversations, but I also knew that when all was said and done, hospice wasn't right for them. And how do we think about that?

Jeanne Twohig:

I love that. You just brought it full circle as I think about the support study that RWJ funded, and that was multi multi-million dollar study in I guess the mid-90s.

Connie Dahlin:

Right. 1995.

Jeanne Twohig:

Yeah. And what was it about? It was about prognosis and preferences. And the one thing that we learned was that we didn't have adequate ways to even ask patients and families what it was that they wanted much less to honor what it was that they said. And here we are, the conversation still is asking, listening, believing, supporting. It's if we don't develop that way of knowing what patients and families want and really believing it. And then helping them choose the right plan of care to meet their desires. At the heart of it, that's what it is about.

Connie Dahlin:

So Jeanne, in that sense of you've been around and you've seen so many, much, what would be your indicator or a marker that says we've made it?

Jeanne Twohig:

I would love to see high quality palliative care available to everyone who needs it. At first I was going to say in every town. Well, that may not be necessary. But, that everyone has access to it in a way that translates to quality. I think telehealth is going to help us a lot with that. Again, the pandemic has been a great boost for acceptance and increased sophistication with telehealth. But to me, it's anyone who needs access to palliative care has it. And when I say that, I want to challenge us all to think about broadening who that who is. I think that there's certain folks demographically in our country that are the recipients of palliative care or hospice care and/or hospice care. And I challenge all of those as providers to take a look at who's in their service area and ask themselves the question, does our patient population reflect the demographics of our service area? And think harder and better about how to get the care to folks that traditionally have not received it. So, I would love to see a broadened new vision of the who and just increased accessibility.

Another thing I want to say, and this is inspired by what you were saying, Lynn, part of my vision I think would be a stronger involvement of pharmacists in all of this. In my experience, the pharmacist is an important colleague who's sort of one step removed oftentimes, and yet they are so central to the quality of care that the patient receives. To really beef up the involvement of pharmacists on palliative care teams I think would be a tremendous benefit to patients-

Lynn McPherson:

And extending into the community. So if the inpatient palliative care team would just call the community pharmacist and say, "Look, Mrs. Smith is coming back home 90 miles away from the university, and she's on a pretty high dose of an opiate, but this is what works for her. So we just want to call and loop you in and make sure that you knew this was correct and this is what does the job for her." So the pharmacist doesn't, say, holy moly, make a patient feel badly and maybe they don't [crosstalk 00:45:40]. So, I think I agree with you. Of course, I agree with you.

Connie Dahlin:

So, Jeanne, any other things that you would want our students who will be leaders to think about as they are going forth and becoming leaders in palliative care?

Jeanne Twohig:

Gosh, a lot comes to mind with that leadership topic. One, I guess, is finding mentors, learning from each other and sharing with each other. It's how we all learn. And there's so much wisdom out there to grab onto. And the other is to really think holistically. Your discipline might be clinical or your discipline might be administrative. It might be research. But, we need all of that. And so a leader needs to not necessarily be subject matter expert in all of that, but develop the relationships with others so that as a leader, the vision is a holistic one. Because like any movement, like any strategy, it's multifaceted and each piece of that strategic pie is important. The financial piece is important, the clinical piece, the research piece, the communication piece, the marketing piece, all of it's important. And as a leader, if you can have colleagues that you can call upon to make sure that your vision as you lead is comprehensive, I think that's to the good of the movement.

Lynn McPherson:

Yeah. That's great. Even though I think we probably do that already better than any other disciplines. I think there's still room for improvement too.

Jeanne Twohig:

Yeah, yeah. Yeah. I think we do it well among clinical disciplines. In palliative care and hospice, nursing's represented, spiritual care is represented, medicine's represented, et cetera, social work, but I don't know that we always think more broadly about the nonclinical parts of it. And it's vitally important.

Connie Dahlin:

Well, Jeanne, this has been a delight.

Jeanne Twohig:

For me too.

Connie Dahlin:

I knew that there was so much for people to understand some of the history. And as you know, I feel strongly that people need to understand that this just didn't start in the last 10 years, that there's been so much that's been built upon and different people have had such a big role. And you did have such a big role with RWJ and with the Duke, and you still have a big role, but I think with that funding part was so important. So, we're so grateful that you joined us today.

Lynn McPherson:

Thank you so much.

Jeanne Twohig:

Yeah. Truly the pleasure has been mine. I had a very enjoyable time. Just thinking back, as I was thinking about today's talk, and it was very interesting for me to put it all into a certain perspective. So thank you for that opportunity.

Lynn McPherson:

Absolutely. Thank you again.

Jeanne Twohig:

Yeah.

Lynn McPherson:

I'd like to thank our guests 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 cast 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.