

Dr. Lynn McPherson:

This is Dr. Lynn McPherson and welcome to Palliative Care Chat. The podcast series brought to you by the online master 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 Futurist in Palliative Care. A series I have recorded with Connie Dahlin, the support coursework in PHD in palliative care offered by the University of Maryland, Baltimore.

Connie Dahlin:

Good afternoon, everyone. My name is Connie Dahlin and I'm one of the faculty for the University of Maryland PhD program and this is our PhD podcast series and I'm joined today by Dr. Lynn McPherson who is the executive director at the University of Maryland, Palliative Care program. Today, we are delighted to have Marian Grant, Dr. Marian Grant with us. Marian is the senior regulatory advisor for the Coalition to Transform Advanced Care, C-TAC. She's a consultant for the center to advance palliative care and she is part of the University of Washington's Message Lab, serious illness messaging project and she'll be able to tell you more about that. I think what's important is I know Marian, and I think she brings some breadth to our field.

As you've heard from some of our speakers they may have started in a different field before they came to palliative care, which is really important to think about because Marian started her career in marketing, in Procter & Gamble and then moved into nursing and so, she has been in critical care. She earned her Doctorate of Nursing Practice and she has been at the University of Maryland Medical Center. She's also been adjunct faculty at the University of Maryland and Johns Hopkins Schools of Nursing. So, the other expertise that Marian brings to this is sort of this nursing perspective and this policy perspective, is in 2014, she was selected as a Robert Wood Johnson Health policy fellow, working on Capitol Hill and at the center for Medicare and Medicaid innovation, really important entities for both palliative care to have a presence and sort of have a nursing presence.

She's also served on the board of The Hospice and Palliative Nurses Association and the Carolinas Center and also has been a faculty for the end of life nursing education consortium. Marian is very widely known for a number of things. So, Marian, we're excited to have you here today.

Dr. Marian Grant:

I am excited to be with you. Sorry, I can't be there in person.

Connie Dahlin:

Well, it's going to be interesting how we all fall out about doing this in the future, but I think, tell us a little bit about yourself and your passion because I think it's really helpful for our students to understand the different ways that people come in to this.

Dr. Marian Grant:

I had a long term career at Procter & Gamble in marketing and media. I work on ... my last assignments were on the global CoverGirl and Max Factor Cosmetics businesses. I was spending my days trying to introduce a new lipstick technology, a lip color technology to the world and I kind of accidentally became a hospice volunteer at an AIDS hospice in the early 90s. That was just a huge, profound experience, back then everyone died and yet I was with this group of people regularly who were talking about death and planning funerals. It was just amazing and I had a midlife crisis, kind of an early midlife

crisis and I didn't leave my husband and I didn't buy a sports car, but I left my corporate job to go to nursing school.

When people asked me about it, I said, "I don't think the lipstick thing is going to get me through the pearly gates." I think I need to do something more valuable. So, I mean, I have ... it's been a terrific change. Not everyone could do that, not everyone would want to but for me, it's been a terrific change and I've been a passionate second career nurse for the past 20 plus years.

Connie Dahlin:

You've already told us some fun things, so tell us something that most people in palliative care wouldn't know about you.

Dr. Marian Grant:

No, this is getting tricky. I don't know. I have become very interested in Buddhist philosophy. The whole last year of uncertainty about the political future of this country and the alarming headlines every day, I thought, "You know what, I need to chill out," and so I'm engaged in a year long course, at the Upaya Center in Santa Fe. They do a terrific program called Being With Dying for palliative care clinicians. I did that a few years ago and now, it's a program on socially engaged Buddhism and I am considering a project working with ... helping to train staff at one of the big penitentiaries, here in Maryland, helping them learn how to provide end of life care. We'll see where that goes.

Connie Dahlin:

Well, those are great things, I think of the different things that we're all moving into. Tell us a little bit about what you're doing right now palliative care clinically, and also kind of policy advocacy wise.

Dr. Marian Grant:

Yeah, I have the good fortune to have a variety of roles and I love variety. When I was a new nurse, I was an ER nurse. I think it's one of the reasons why I like palliative care. I like the variety of patient populations, and the range of issues that people can have. A couple times a month, I'm practicing as a nurse practitioner on the palliative care team at the University of Maryland Medical Center. That keeps me really grounded for the other work that I do, because when you are working with real patients, and real colleagues, you see how it is, when you're writing notes in the EHR or you're reading notes in the EHR. So, it was my clinical work that drove me into policy because I keep running into the same issues, right?

I couldn't persuade patients to give up things like, "Oh, palliative chemo," to get hospice. Why wouldn't palliative chemo be covered by hospice, but it's not typically. So, that motivated me to get into the policy world. So, some of the time I'm a clinician. Most of the time, I'm working for C-TAC as their senior regulatory advisor. Well, what does that mean? I review regulations and it's actually a wonderful opportunity for advocacy, because the federal government has to put out any proposed regulations for comment. They give you 60 days to slog through 1900 page rules. I gladly do that using word search and other things to figure out, "Okay, is there something in this rule that has to do with serious illness? Is there something in this rule about advanced care planning or hospice or palliative care or should there be something in this rule?"

Then, I draft the comments for C-TAC. I help ... when CAPC submitted their own comments, I would help them with that. I am involved with developing Alternative Payment Models working with the Medicare Center for Innovation and with CMS. C-TAC had experience developing its own model a few

years ago, that got all the way through the vetting process that was available, and then the Medicare Innovation Center said, "Oh, well, we can't take it as is but can you modify it?" So C-TAC worked with AAHPM to come up with a model that turned into the chassis of the primary care first serious illness population model, which is unfortunately on hold. Then, because of this marketing thing, it's so funny, I was out of marketing for many years and people in the palliative care world started to say, "Hey, you know something about marketing, right?" I was like, "Yeah, a little bit."

So, I'm working with Tony Bach, Dr. Tony Bach, on a project where we've developed messaging principles for palliative care organizations to use advanced care planning organizations, hospice organizations on how to talk about these things to the public. So, like I said, today, I had six meetings and they are on six entirely separate topics.

Connie Dahlin:

I think what's interesting is that you have this breadth of experience, and you can bring it and so I mean, I think one of the things we're wanting our students to know is that they're coming into this, they're adults, they probably have some sort of experience to grow. So, as everybody finds a role to lead, there's not going to be the same journey for everybody. It might depend on where things are at and I think that's really important. I also think, it's important for people to understand... I was chuckling when you ... I was going to ask you how you got through 1900 pages, but the fact that you're using word search makes me feel better because I was thinking-

Dr. Marian Grant:

I don't read all 1900 pages, I will tell you.

Connie Dahlin:

I was going to say, she must be a speed reader, but I think this sense of being aware, so it also means that you're kind of ... you must have your ears constantly kind of paying attention to what's the chatter, what are people talking about? What are states talking about?

Dr. Marian Grant:

Exactly. I must spend ... I think it's at least a half an hour but close to an hour, most days, reading industry news, policy alerts, things from the Hill, Politico, Kaiser Family Foundation, Modern Health, Home Health, Hospice News, I am scanning all of those things. Then, I get all these alerts from CMS and HHS and the Innovation Center. So I have a lot of stuff coming in, because I'm constantly trying to be up on ... so what's going on? What's the latest issue? Now, we have a new administration. I mean, for the first 100 days, there were things like every day, from the Biden administration. So, even though those are wish lists, because they're not real, the way legislation or regulation is, but they're driving the conversation.

All of this is set against the backdrop from a policies perspective of trying to turn the battleship away from the fee for service world where we get paid for doing stuff to getting paid in value based payments, getting paid for outcomes, and reforming health care. Then, there was the whole COVID thing, which was challenging, both personally as a clinician, because I picked up extra shifts during the pandemic, but then also because Medicare just changed policy overnight. They were waving things and changing regulations on a temporary basis. It was quite remarkable and very exciting.

Connie Dahlin:

So, a couple things on that. I mean, I think we've heard from a couple of our other experts, this conversation about the need to move from incentive based to value based, and I think in palliative care, we've had that conversation that we don't want to make the case, we want to show the value, but we have a challenge with ... that we're never going to be an extreme moneymaker. I think the other thing is this pathway of thinking about innovation as they happen. So, I wonder, since you brought up the COVID part, do you feel like there are policies that ... or things that happen that are going to help us perhaps move palliative care forward. We didn't expect, none of us knew how the pandemic was going to happen. We didn't know what Medicare was going to do.

So, there are the policies that we sort of need to take advantage of, and that the students would need to know like, when this happens, you can't wait. You got to kind of step into the moment.

Dr. Marian Grant:

Well, I think the things that come most to mind for healthcare in general but also for Palliative care is telehealth. Telehealth had been around forever, it was quite restricted because of concerns for fraud, the patient had to take themselves to a qualified health center and only there could they connect via telehealth through somebody who was in their state, and only a few things can be done via telehealth and telehealth did not pay as much as a virtual encounter. All of that went out the window during the pandemic because you know what, could be wrong with a fee for service system, if patients don't come in to see their providers, right? We didn't have PPE, clinics didn't. A lot of private practices didn't.

Patients didn't want to come in. We didn't want them coming in, but there was still care that people needed to get. So it was fascinating. That was one of the fastest things that got waved. They could be at home. They didn't even have to use video, they could do just the phone. We did advanced care planning over the phone with people. I mean, those are things that you could not get reimbursed for in the previous world. Now, the changes are temporary, they're only through the end of the pandemic, which I think at the moment is only through the end of this calendar year. So now the question is, what are we going to change permanently, and that has to be changed by legislation, so there are a lot of bills pending in Congress to do that.

I think the other thing that became obvious was, again, fee for service not a great system, when it required you to do interventions that you could get billed for, as opposed to providing counseling or other information that could help people manage their health when they couldn't come in, in person. So I think it was another shot in the arm for Value Based Payment, that we really should be focusing on outcomes, not the stuff we knew. Finally, I think home as the ideal setting for many people with serious illness, just why are we dragging people who are seriously ill into offices, hospitals, ERs if they don't have to be there or they don't want to be there. I mean, we could provide care and there are models in brief parts of the country where people are doing this either virtually or in person at home and they are effective.

I mean Sharp HealthCare out in San Diego, they have panels of people with serious illness who never go to the hospital in the last two years of life. They are able to get services to them at home and then, by anticipating symptom management issues, keep the crisis from happening. So, it can be done, and now, the question is, we have this huge infrastructure in the hospital and everything, I love the hospital, but how are we going to dismantle that and start shifting things to the home?

Connie Dahlin:

So, we know that it was back in the 60s that we moved healthcare from the community to the hospital for incentive based care. Here we are 50, 60 years later, it hasn't necessarily worked or it's actually

promoted different outcomes. I think, the other part of that is thinking about ... and I'll be curious, what you think about this is, we keep saying, "Okay, the system is broken, we need to change," and yet, when you talk about changing a system, particularly in academic medical center, you can just feel people pull back and say, "No, this is the way we've done it, and this is how we get paid." So, where do you think that that's going to go or your thoughts about that?

Dr. Marian Grant:

I mean, it's not just an academic medical centers, inertia is a factor in all businesses, right? People spend time and money to establish businesses, and then if the ground rules change, that's very frustrating, it's very distressing. I think, I'm not really sure I was going to say that part of me is hopeful, because we had this pandemic, we had this reset. We did things differently and it worked out. I mean, like, we let nurse practitioners have much more responsibility in places that they typically hadn't had before and that wasn't a bad thing, right? It kind of was a weird test of a bunch of things, we've always hoped to test and we did telehealth, and that wasn't a disaster. In fact, it looks like we might want to do more of that. So part of me is hopeful and then part of me is not so sure that anything is going to change substantially.

I think that's a concern many of us have about equity. People are much more focused on it but then what? How do you really change lives so that people from disadvantaged communities are no longer from disadvantaged communities? So, I don't have a crystal ball, I have actually stopped reading ... here's a tip, I have stopped reading people's projections about the future because I just decided during the election last year, and during the pandemic, no one has any idea what's going to happen next and I'm okay with that.

Connie Dahlin:

So, this is interesting because you're scanning, though. I mean, I'm thinking that you must spend a couple hours trying to read all the things. So you're keeping informed-

Dr. Marian Grant:

Of what's going on currently, but people who are saying, what will happen in 2023, with health care. I don't waste my time anymore because I don't think they have any way of knowing.

Connie Dahlin:

So if you're thinking of our students, so they're future leaders, and we're wanting them to think about policy, what are some of the challenges that you can see that they would ... might have about kind of stepping into that?

Dr. Marian Grant:

Well, there was a question that you were going to ask me about, what are the things for ... somebody starting in the palliative care fields. I'll go to them now, my recommendations are, they should know something about business. They should know something about finances, because this is a business. I mean, whether you're not for profit or for profit or a volunteer group, it's about resources, and you have to understand how that works. Healthcare is paid in this country via various different payers, and they have needs and they set the agenda for how things go. So I think you need to know about that, and I think you don't need to know about policy because we are not in a highly regulated area but healthcare is regulated in the United States.

What I can do as a nurse practitioner is dependent on regulations in my state. What I can bill for are dependent on federal regulations, and how do we change that? We change that through laws or tweaking the regulations we already have. So I think it's important to be aware of what's going on with these things. When I say what I do, and then, I'm a positive person, I have colleagues in the hospital who just put their hands up, like, "I can't be bothered with that." I'm like, "Oh, really." So, what you can build for as a provider is dependent on policy. So if you don't care, fine but it does matter to us. It's not just like a nice to know, it's like, undergirds the care we can deliver and our institutions can get paid for, which at the end of the day is kind of the bread and butter of how this operates.

So I'm not saying you need to slog through regs like I do, but you need to at least be aware of what's going on, in the conversations in Washington, the conversations in your state because it's going to ... and some of those conversations end up being very positive. So some states have changed the regulations. California several years ago, just required that all managed Medicaid programs had to offer palliative care, home based Palliative care as a benefit. Boom, just a law passed, and it was done. Then there have to be palliative care at all, with 52 counties in California. Hawaii is looking at that now. Other states are looking at that. So I mean, if you want ... I love being a palliative care provider, but I would like to be in a situation where my program gets paid and I get to be part of the full interdisciplinary team.

That's not going to happen under fee for service. So these are some of the creative things that I think we all need to be aware of, if you're a clinician or you're administrator, to figure out how to make some of this stuff happen because if you're waiting for somebody in Washington to just decide there needs to be a palliative care benefit, I don't think that's going to happen this year. Even if they decided they would need legislation to do that, and that's not going to happen. Not much is happening on the Hill in Washington, right? You read daily about the challenges that the two parties have, with getting stuff done. They got things done for the pandemic, but once that's passed, we go back to gridlock, deadlock.

So not that we shouldn't be working on bills, because that's the only way to make some changes, but sometimes you have more flexibility on the state level than you do on the federal level.

Connie Dahlin:

So tell our students some of the things that they should do on a state level. I mean, should they be participating and just getting to know key people? Should they be meeting with insurers? What are some of the things that are important for kind of a policy skill set?

Dr. Marian Grant:

I think that's a great question. I'm often asked, "Well, okay, how do I get into this?" I think the easiest way to get into policy on the state level is to be part of a professional association. So I got into policy as a member of my state, Nurse Practitioner Association, because we didn't have independent practice and we were trying to change that. So I was part of the association. They asked me to lobby my state representatives, I did that. I wrote letters. I was aware of that going on. I mean, it was a long slog, but we finally got independent practice in Maryland which was amazing. So I already had a sense for what that was like. The Palliative Care Associations, HPNA has chapters.

They might be in a city. They might be in a state. They might be in a region. AAHPM has a similar structure. I think associations are ... or maybe you're not just a palliative care person, but you're interested in your discipline, so you're part of a social work group or you're part of a physician group. Those are ways to get involved on the state level with policy because as an average citizen, I mean, you can write to your representatives, and you can write to the local ... state regulatory agencies, but I don't

know that that's going to be an effective use of your time. I don't know that that will change anything. Then, the national associations are all working on policy. So your membership dollars contribute to that.

Those associations are always looking for members who are interested. So if you're interested in policy, and you're a member of HPNA, you should let HPNA know that. So I'm the state ambassador, one of the state ambassadors for Maryland for HPNA. That's the volunteer thing, but I keep them posted on what's happening in my state, which gives me a reason to kind of pay attention to what's happening in my state, with legislation and regulations. Then that's how I learned about what's happening in other states.

Connie Dahlin:

Well, it sounds like that's kind of also a way to kind of learn about the field of how to do that. Because, I think-

Dr. Marian Grant:

Yeah, I mean, you're not going to go out on Capitol Hill in Washington and meet with Nancy Pelosi, as a new person. That's just not going to happen, right?

Connie Dahlin:

Only if you're Marian.

Dr. Marian Grant:

I worked for Nancy Pelosi but I was there as a fellow, yeah.

Connie Dahlin:

For our students to know, Marian get to work in Nancy Pelosi's office. It's a pretty exciting time. So-

Dr. Lynn McPherson:

Awesome. That's very good. Can I ask a question Connie?

Connie Dahlin:

Sure. Yes.

Dr. Lynn McPherson:

So, if it was the world according to Marian Grant, what policy changes would you put in place for the future of your hospice and palliative care?

Dr. Marian Grant:

So I think the key thing is we need a better payment structure than fee for service. Fee for service doesn't pay for half of what we do. So I can get paid for symptom management, but I don't get paid for family education or counseling. I don't get paid for assessing spiritual distress. The chaplain on my team doesn't get paid for any of that either, right? He gets paid or she gets paid by the hospital, but not through the reimbursement mechanisms. So Value Based Payment arrangements would pay for a fuller interdisciplinary team, and they would pay for the additional things that Medicare, fee for service

doesn't pay for, that are important in palliative care, like providing emotional support or spiritual support or family caregiver information.

Dr. Lynn McPherson:

What are your thoughts about CMS putting all the responsibility for procurement of the medications on the hospice, even if some of those medications are medically futile?

Dr. Marian Grant:

Well, this is where it gets tricky. I think it's nice to be able to tell patients when I see them clinically, that if they opt for hospice, that all of their medications will be covered. Then it's the tricky part of were they on the right medications to begin with? To de-prescribe people off of non-helpful anti-dementia medication, I try to do that regularly. It is not easy to do, right? People are clinging to those things like, "No, no, no, she'll become demented. If we stop them." I'm like, "She already is and it's ..." So I am not focused specifically on hospice regulations. C-TAC is a very broad coalition, so I am aware of hospice regulations, but we are not in the weeds the way NHPCO would be in some of those nuances.

Payment is ... and then, the other thing that's related to policy is metrics. So, if you're going to pay for value, you have to agree on what ... how you will determine what is value, what are the outcomes you will measure. The easy one to measure, easiest ones to measure our claims based outcomes, hospitalizations, utilization, ER visits. Palliative care is much more holistic than that. We don't have a lot of measures. So, even if the world tomorrow said, "You know what, we're shifting entirely," and the government forces everybody into Value Based Payment arrangements, which would involve them taking financial risk both upside and downside, which is what scares providers and I totally get that.

For palliative care, the challenge would be, we have like 20 measures, maybe 23 now. Not quite enough to get a robust sense for what it is we do, but getting measures through the development and vetting process is a multi-year process as well. So there's nothing fast in federal policy.

Connie Dahlin:

We should say, for the students, Marian is on the National Quality Forum, Geriatric and Palliative Care Group, and I actually served on the National Quality for ... Clinician Workgroup and Post Acute Care, long term care group, which were mandated by the Affordable Care Act in terms of thinking about quality. Again, to have a measure be reviewed, as Marian reminded me the other day, it's expensive. You really have to have a team and it will be picked apart several times before it's finally approved, so you have to be persistent and really have the financial support to do that. So as we think about some of this, though? What is it that keeps you up at night in terms of policy?

Dr. Marian Grant:

Well. I mean, Diane Meyer persuaded me that we all should be worried about anybody right now saying that they provide palliative care services because there are regs. You can't just say I'm a hospice. There are Medicare federal regulations, which Lynn is quite familiar with. Anyone who works in hospice knows ... I mean, you've got conditions of participation, you've got like 400 specific things you have to do, to be able to get paid by Medicare for hospice. Now, somebody else might pay you and you run Joe's hospice, and you don't do those things but that's pretty unusual. So, we don't have regulations that force people to be certified in palliative care. That's something we're working with payers to try to have them require.

I don't think we're quite ready tomorrow to decide what those regulations would look like. Hospice took many years, was a demonstration project, an experiment and only over time did regulations get written. So it's going to take palliative care a little while longer.

Connie Dahlin:

Well, I think, it's interesting that you said that because I mean, one, when we talk to Steve Connor and Judy, lead person. There's a lot of mixed feelings about whether the hospice Medicare benefit was good or bad, right?

Dr. Marian Grant:

Exactly.

Connie Dahlin:

Because there's kind of this minimum criteria, and I think we do have a national consensus project for quality palliative care, clinical practice guidelines, which are high aspirations and most programs don't need those. On the other hand, I mean, I think it's a start for us of a platform, but I think, that's the interesting part when you talk about that. When you think about insurers, then I think it's sort of saying, okay to them, how do we help them decide, are they doing it by ... it's programs specialty certifications, so whether it's hospital based community and we knew now with the different entities, it can be in the community hospice, home health practice, physician practice, community, whatever. So I think we have the ability for people to be creative, or is it by a percentage of the different disciplines to have certification?

So, for nursing medicine, but then the challenge is you might not have it in pharmacy? Social work has just started chaplaincy. Even that gets kind of interesting, so when I ... you talk about-

Dr. Marian Grant:

Well, I mean and do you certify the program? Do you just certify the clinicians in the program? Those are two separate things, and you might need to do a combination of both.

Connie Dahlin:

Right. Yeah and that's what I think the interesting part is, and then there's a whole cost part, right, because then when you look at equitably, some of these smaller programs can't afford to do the ongoing part of that.

Dr. Marian Grant:

I mean, there's not a lot of great evidence that certification ensures quality either, by the way. So I mean, there are a number of papers about the Joint Commission in hospitals, that that is not necessarily guarantee that you get quality care just because they're Joint Commission certified. So I mean, I ... This is, again, where being a clinician is such an interesting thing, as a policy person, I am at my hospital, when we jumped through the hoops when the Joint Commission comes, right? We have people scrubbing with toothbrushes, at the corner of the hallways and I'm thinking, "Okay, that looks really good today, but that is not the way this hallway normally looks." Maybe it doesn't have to be clean like that, but Joint Commission, you know. So the drills are a little bit ... they're a little bit wacky.

Connie Dahlin:

I think the one thing ... I mean, I do think there is some evidence that discipline specific certification does improve practice, right? So we do know that part, but I think you're right. I mean, I think there's a whole financial piece to it and it's a challenge because, I think we're trying to look at something as a measure of something-

Dr. Marian Grant:

Anything, anything. I think the other challenge is, there are never going to be enough palliative care people to meet all the needs. So we say, "Okay, so then we'll focus on primary palliative care," right, which is where you try to persuade oncologists and cardiology people and Nephrologists that they should incorporate these skills. I have to say, just between us, that's always struck me as being a little crazy because, I mean, how do you go into a cardiologist and say, "Oh, you've been a cardiologist for 20 years, but I need to show you something you don't do, that your patients need." It's true, but as a marketing person, I'm like, "I just don't know how you effectively persuade people in these other specialties that they have needed skills."

Now, the pandemic helped a little bit because then, all of a sudden, everyone was like, "Oh, my God, I don't know how to manage breathlessness if I can't put everyone on a ventilator, or I don't know how to have a goal to care conversation and I don't have room in my ER for everybody, so we have to ..." So there was a recognition of that, but now that the prices is ebbing, I'm not sure that there'll be an ongoing recognition, that they have the opportunity to pick up new skills.

Connie Dahlin:

Interesting. Lynn, do you have a comment?

Dr. Lynn McPherson:

No. I'm a big fan of primary palliative care skills in every professional school.

Connie Dahlin:

Right. Well, and I think maybe what Marian is saying is that it's easier if we start it?

Dr. Lynn McPherson:

Yes.

Connie Dahlin:

For the new people, it's harder when people are mid career.

Dr. Lynn McPherson:

I agree. Yeah.

Connie Dahlin:

You're right, getting people to sort of understand that it's actually part of good care, that that's the impetus rather than, "Oh my god, you're making me do one more thing," right?

Dr. Marian Grant:

I mean, I do see that in my hospital, as a teaching center and people who've had palliative care as medical students or as residents now come in as fellows, they're like, "Of course, I'm calling you guys," right? They work with attendings and section heads who are like, no. I mean, it's going to take a long time to work ... new people with that perspective through the system. I think what will help though is just the focus on, this is not working for anybody and I think even oncologists and cardiologists would say they don't feel great about the care they're providing either, and how do we get this to be better? Yeah.

Connie Dahlin:

I mean, I think it also goes back to this expectation, and I think in terms of clinics right now, whether it's an outpatient, ambulatory or really in the community, how we book patients right now is we're saying, you get 10 or 15 minutes, right? Well, if you have a 15 minute appointment, the first five is running through blah, blah, blah.

Dr. Marian Grant:

Exactly.

Connie Dahlin:

Get somebody's attention. I mean, I don't know about you but I use those opportunities sometimes when I'm a patient, to kind of say, "Okay, let me sit in the seat about what does it feel like," right? I have lovely caregivers, and noticing how much time they're actually talking to me versus filling in that questionnaire, versus what's being triggered by what I haven't done that they have to do that. So my problem becomes ... and it's not a very satisfying experience. I mean, I'm a health care provider, but it's like, I don't sort of feel the need, unless it's an emergency because I don't feel like there's that much that I glean from it, right? It makes me think about my own practice, and this might just be showing my philosophy, I sort of refuse to go as a quality measure into a patient with any sort of electronic advice.

I'm still [crosstalk 00:36:16] where I'm talking to that patient and family. If I have to do a medication part, I will sort of be honest about it and that's when I might have a computer and say, let's talk about this. Otherwise, I'm taking notes so that they know that I'm really paying attention. Now the onus is on me, which is why we had somebody talk about, they didn't like charting, on the other hand, I like templates, because I know, I've done a lot and the template will help me fill it in because I haven't done it well, I've done it-

Dr. Marian Grant:

Well, and I'll tell you, I mean, I just had this realization the other day, so now our notes are available to patients.

Connie Dahlin:

Right.

Dr. Marian Grant:

I think that is going to be ... I saw a patient recently I did a consult, there were three notes from the ER about this person, and in each note, he had a different kind of metastatic cancer. It varied from prostate, to lung, to pancreatic. It was prostate actually, and I thought, "Oh my God, if the family asks for the chart, and sees what I just saw, we look like idiots," right?

Connie Dahlin:

Right.

Dr. Marian Grant:

So I mean, I wonder if the note thing is going to weirdly get itself worked out when people really start scanning what we're actually saying and saying this is garbage. What are you guys talking about? Well, a separate issue. That was a policy change.

Connie Dahlin:

Right, that's what I was going to say. It could be another policy part that we decided that we're going to have access. So I'm just thinking, are there any other ... So these are students, we want them to be leading the future, they are going to be leading the future, they've made this investment. Any other thoughts or comments you would have to them in either policy or anything else that you think would be important for them to know as a leader?

Dr. Marian Grant:

Well, I try ... I am passionate about the work that I do. I believe this is important. This is the kind of care I went to nursing school to do, palliative care. So you have to be persistent, you have to be effective, you can't just be morally righteous. You have to persuade people. So, advocacy isn't just about you transmitting, you have to be in the receiving mode at the same time, but I am not easily daunted and I think that is an important thing, and I know that neither of you are easily daunted either, and that is the only way you make it through a long career where you start to be effective, because nothing can be done quickly and nothing can be done just by yourself. You have to be able to work and persuade and motivate and cajole others, to get things done and work as a group to get things done.

That's my hope is that these young leaders are not on their own, that they're part of associations and institutions and collaborations that are getting things done as a group because that is the only way we affect change, certainly on the policy sphere. If, you try to persuade Congress of something, you have to be a unified front. If four people come to the office and talk about a bill four different ways and have four different points of view, their lives are complicated. They're just going to say, "Forget this one."

Connie Dahlin:

Well, that's important. I mean, I think, it speaks to a collaboration that we may disagree, but we do need to put forth a united front, even with the patients, right?

Dr. Marian Grant:

Yeah, yeah.

Connie Dahlin:

We've got to have that one voice, and I think persistence is kind of what you've said and I think that that's ... I think it's always important to remember those common themes. So Lynn, anything else you want to add or make a comment about?

Dr. Lynn McPherson:

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No, that's great advice, Dr. Grant. I appreciate it very much.

Dr. Marian Grant:

Well, thank you for asking me and look students, best wishes to you onward and I am available if you have questions or comments or want to more about policy. I'm always happy to talk to people about that because I don't plan to do this forever. So, we will need young recruits or new recruits.

Connie Dahlin:

To take care of us, and we're all right.

Dr. Lynn McPherson:

Thank you so much.

Connie Dahlin:

Thank you so much. Yes.

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 Futurist in Palliative Care." I'd also like to thank you for listening to the palliative care chat podcast. This is Dr. Lyn 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 request regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.