

TRANSCRIPT: [The Future of Palliative Care: Who Will Lead, Who Will Pay, and What Comes Next? | Part Two](#)

[Leadership And Purpose Opener](#)

Melody King 0:00

Everything rises and falls on leadership. The ability to lead well is fueled by living your cause and purpose. This podcast will equip you with the tools to do just that. Live and lead with cause and purpose. And now, the author of the book, *The Anatomy of Leadership*, and our host, Chris Comeaux.

[Meet Bryn Bowman Of CAPC](#)

Chris Comeaux 0:22

Hello and welcome. I'm so excited today. We have with us Brynn Bowman, who's the Chief Executive Officer. We all know it is CAPC, the Center to Advance Palliative Care. She's also an assistant professor at Brookdale Department of Geriatrics and Palliative Medicine at the Icon School of Medicine in Mount Sinai. Welcome, Brynn. It's good to have you.

Brynn Bowman 0:41

Hi, Chris. It's so good to be here. Good to see you.

Chris Comeaux 0:44

Yeah, I've really been looking forward to this conversation. I know a lot of folks know you, but let me introduce you and read from your bio here. Brynn's the CEO of CAPC. She presides over the organizational and content strategy that serves more than 1,700 Cap C member health organizations, including over 70,000 clinicians and administrators. Ms. Bowman previously was CAPC's chief strategy officer, and she succeeded the legend, Diane Meyer. There's a lot of ways we call Diane. Many of our mentors a legend, just an incredible person. And so, I know Brynn probably looks back fondly in her time with Diane. Ms. Bowman is nationally recognized as a leader in scaling practice and culture change, health care delivery for people with serious illness. She's an expert in palliative care education. She specializes in healthcare leadership, palliative care business financing, palliative care program design, palliative care education for non-palliative care specialists, and palliative care delivery, especially during the COVID-19 pandemic. Her work has been instrumental in the development of clinical engagement and education strategies to equip the U.S. healthcare workforce with skills needed care for patients with serious illness

and their families. I could go on and on. Brynn's got a very illustrious background. Brynn, what did I leave out that maybe you want people to know about you?

Brynn Bowman 2:02

Nothing. That is absolutely plenty. Thank you.

[A Superpower Called Deep Curiosity](#)

Chris Comeaux 2:06

And I warned you I was going to ask you this question. It's a staple of the podcast. What is your superpower?

Brynn Bowman 2:11

Yeah, I'm ready. You did give me fair warning. You know, and what occurred to me is I think what has been a superpower over the years is I'm pretty deeply curious about everybody. I'm actually interested in understanding what makes the person I'm talking to tick. And that could be for a patient advocate or a palliative care leader or someone across the negotiating table or a difficult family member. And I think that has made it easier over the years to find common ground, even if it's somebody that I disagree with. And every once in a while that means that things can happen that didn't seem possible because there's just enough trust to keep the conversation going.

Chris Comeaux 2:52

I love that. That's an awesome superpower and such a timely superpower, especially for some of the things you're not going to talk about, because it's such an interesting time, well, in healthcare as a whole, it's an interesting time in multiple levels in our society going through a lot of change. But also think for powder care and really appreciate you saying yes, because really wanted to talk to you about some of the changes. So, if you're okay, you ready? We'll go ahead and dig in in the questions. Dive in, there's a lot to talk about.

[A Five-Year Vision For Access](#)

Chris Comeaux 3:18

So if we're having a conversation five years from now, which I hope we get to do, what would you hope is fundamentally different about palliative care in America? Who gets it? Where do they get it? And who pays for it?

Brynn Bowman 3:30

Great question. The first thing that comes to mind is my grandma Marion is 91 and she's living on a farm in rural Minnesota. And boy, does she plan on being around five years from now. Um, she would also tell you she plans on being around until there are more great grandchildren, but that is another story. Um But you know, in five years, I really hope that if she needs palliative care, she can get it, even where she is. And to get there, it would mean really significant transformation in where palliative care is available, potentially how it's delivered in a town with no specialists really of any kind, getting palliative care services. So, somebody like my grandma would take a combination of partnership and technology and education for sure. Um, but to me, that's the benchmark thinking about the future. Um, you know, I entered this field because it felt so obvious to me that palliative care is a big part of what good health care should look like when a person has a serious illness. And that means we don't have highest quality care unless we're reliably meeting people's needs wherever they are.

Chris Comeaux 4:36

Brynn, I love that vision. And you know, I kind of alluded to this in the beginning. Just I'm becoming more and more, I'll say, interested, concerned about substitution competitions. Palliative

Competitors And What Patients Need

Chris Comeaux 4:48

care is no longer just competing with other palliative care programs, primary care, home health, oncology, Medicare at Vantage plans, hospital-at-home programs, navigation companies, technology-enabled care models. Um, it kind of feels like the wild, wild west is this serious illness space. And many of these different solutions are addressing pieces and parts of this whole serious illness population. So, what do you see as the real competitors or substitutes for traditional palliative care?

Brynn Bowman 5:20

It's a great question. And, you know, the wild west that you're describing is real. There's a lot of solutions on offer out there. And I really think as a field, we need to be absolutely confident in our expertise and also pragmatic about how to get the best care to the most people. Um, we need the subspecialty. I am firmly convinced of that. Um, our teams in palliative care are expert at navigating complexity in service of what matters most to patients. And we all know that more patients have more complex needs, and that's continuing to grow over time. So if every oncology practice or home health agency or Medicare Advantage plan is doing a great job of symptom management and aligning care with goals and supporting caregivers for most all of their patients. That is totally the

world that I want to live in. Um, and I think we are still going to need specialty palliative care for patients whose needs are most complex. I uh it puts me in mind of what we what we saw and what we learned in the pandemic. Um, in my health system at Mount Sinai, palliative care leadership were part of the crisis response team that was called in to design solutions because they are expert at it. Um, you know, that was a time when um suddenly everyone was homebound, many people were seriously ill, goals of care had gotten really complicated, family caregivers were getting called on to do even more than normally. Um, symptoms were being managed at home, existential crises were really the norm. Um, and the health system badly needed palliative care expertise. So, while I certainly and obviously hope we're never in that situation again, we learned something from it. Um, CAPC worked during that time with an organization called Aquifer, and we surveyed medical students who were in school and seeing what was going on during the pandemic. Um, and the answer was they recognized they needed palliative care skills. They didn't have the confidence that they wanted having complicated conversations. They weren't sure how they themselves should absorb, digest the emotion of caring for people with serious illness. They felt unsure about complex symptom management. Um, you know, palliative care leaders during that time really were recognized in a lot of places as just health care leaders, period. Um, so I think looking into the future, you know, there are a lot of paths and they're all important. I think we always need specialty palliative care teams for patients who need that level of expertise. And our health system writ large needs palliative care leaders who are doing the teaching, designing services, solving population health problems, advancing the science of best care for people with serious illness and for their caregivers. And, you know, to your point about substitution competition, and it's a good, you know, frame to be thinking in, but uh we need to figure out how best that necessary palliative care services fit within the constellation of services, and that's going to depend on what's available in any given community to make sure that patients get what they need.

Chris Comeaux 8:28

That's so good. Well, got a good follow-up then.

[What Actually Makes It Palliative Care](#)

Chris Comeaux 8:31

So if everybody starts doing symptom management, goals of care conversations, care coordination, and then also maybe calling what they're doing serious illness management, what actually makes something palliative care? Or I have a friend who calls it um pal ology, palliative care ology. And of course, you know, we could chase the rabbit of

hospiceology. Do we need clear a clear, maybe national definition of what the product is before maybe the market dilutes it and defines it for us?

Brynn Bowman 9:05

I think we do, and it sounds like you and I are on the same page. Um, we've just kicked off a process at CAPC to develop minimum standards for a specialty palliative care program. Um, and I am really excited that that you all at TCN are going to be represented on that committee. But we're doing it really for two reasons um care quality and reimbursement. We have enough data and experience in our field to say that we can get results for patients and for payers through high-quality palliative care. And to your point, we need to define what that is, not payers, not not policymakers. That is, you know, we need to define what are those minimum standards for a specialty palliative care program. We know, of course, that there is a ton of pressure in the big business of US healthcare to cut costs, cut costs, cut costs, and we absolutely as a field can't allow that to mean cutting quality. Um so our standards development initiative at CAPC will bring together seasons leaders representing all care settings, all types of care organizations to say, at a minimum, this is what palliative care programs need to have and be able to do to achieve the outcomes we want for patients. Um that means the services that you deliver, how you're staffed, how those staff are trained, key quality measures to evaluate a palliative care program, if your program wants to call itself specialty palliative care. I think there has been so much innovation, especially in community-based palliative care in recent years. And if we can start to standardize what are those models and what are those expectations across both our programs and the payers that we're working with, including states in Medicare, it is gonna help us be able to say these are the services we deliver in palliative care, these are the outcomes you can expect, this is what it's gonna cost. And when you talk to the next program down the street, you're gonna hear the same thing. And I think that's you know, important with necessary infrastructure for a lot of the work that our field wants to do in the next coming years.

Chris Comeaux 11:12

And the the timeliness of this, Brynn, feels important. Um, it is interesting. There's a lot of conversations of, again, a lot of these substitution competitions, innovations, even things like lead, for instance. And sometimes people will use the term like hospice-like or palliative care-like services. And it almost feels like they're saying that these are interchangeable parts. And I feel like you're staking a claim on the subscription, I love your term subspecialty, palliative care ology. Um, I have a friend who says, you know, I don't want, if I have a heart issue, I don't want to go to a cardiology-like service. I want to go to a cardiologist because they're board certified, they have all this incredible um knowledge, education, training, et cetera. And I want the best person working on that part. Palliative care feels like the time is now that we really have to kind of stake that claim because of all

these substitution competitions. And unfortunately, the budgetary pressures could create a race to the bottom that will only be evident through the rearview mirror, not in the actual while we're doing it. We're like, well, if the payer is going to call the shots, they're going to go with the cheapest service. But are people gonna get the best quality of care? And sometimes if the if the health insurance is really where the power is, more often than not, their viewpoint is cost. That's not always true. They're great people in health insurance space, but generally they're especially if they have to pay a shareholder, they have to make a margin, unfortunately, costs rise to the top. So, I say all that to say this. It feels very timely that you guys are working on this. I don't know if that creates any reaction

[Minimum Standards To Prevent Dilution](#)

Chris Comeaux 12:55

on you.

Brynn Bowman 12:55

You know, what it makes me think is we need to continue to refine the case and then deliver that case loudly. That a palliative care program that is not equipped, not resourced to provide high-quality specialty-level palliative care is just not going to get the outcomes that any of us is looking for, that we want to get for patients that payers want to see in terms of ROI. Um, and so I think that is the clarion call.

Chris Comeaux 13:26

That is so well said. Now you're making me remember. So, we have a mutual friend, Dr. John Morris. John, I kind of joke, John's kind of like maybe the grandfather of palliative care, at least it feels like to me, because we were early 2001, 2002 working in that together. Actually, John was my first hire as a CEO. And so Dr. Morris and I used to go to these hospitals and have the conversations about trying to prove the case for palliative care. Now, you guys and you're working CAPC, there's so much data that shows as a subspecialty provided, you do great things for people and you bend the cost curve. And I bristle a little bit when I hear some of these conversations about like the interchangeable parts. And, you know, if it's an ACO or whatever the payer is going to be, they're gonna want to pay the least amount. But yet when we step back and look at healthcare, I don't know if this squares with your data, Brian, but somewhere between 150 billion and 175 billion is waste, futile care, one more treatment, one more line of radiation, one more MRI, one more CAT scan. But yet, just if we just looked at hospice, I know powder care is a little bit harder to get our minds wrapped around. You may actually have a number. I know the hospice industry is 30 billion. I happen to work with mostly nonprofits, so they're only a

third. So that's like 10 billion. So, 10 billion spin compared to all this waste. And we know there's great data that great hospice and great powder care saves a lot of dollars. So it feels like that's where we should be focused on the cost, not necessarily the cost of what hospice costs or what powder care costs. I don't again, I don't know if that makes any comments from you.

Brynn Bowman 15:02

Yeah, and I think there's a reality that, like you said, we have a ton of data that palliative care improves outcomes for people with serious illness, for their families. And it is a resource that needs to be applied to the people who are really going to benefit from it. And so, we do have a responsibility to understand, you know, where are those pal patients where palliative care is going to make a difference, you know, where along their disease trajectory. Um, and like I said, make sure that we are fitting into that constellation of services that is supporting people. But yes, the value case is there and it's been proven again and again.

Chris Comeaux 15:38

Is there a number, Brynn? Like, do we know like total billings of palliative care programs throughout the US? Is that a data point that you have kind of readily available again? I know the hospice industry is 30 billion. Do we know whatever the total billings are from part BR today?

Brynn Bowman 15:54

I don't know, to be honest with you. And to my knowledge, I'm not sure anybody else does either. And part of it is how fractured the environment is. We have palliative care programs who are billing Part B. We have palliative care programs who are, you know, contracting with an ACO or an MA plan for the cost of those services. There is some subsidization going on for the budget of a lot of palliative care programs by their home organization. So, there are a lot of different revenue streams.

[New Program Inventory And Access Gaps](#)

Brynn Bowman 16:22

Um and uh we will be launching about a month from now, fingers crossed, um, a new data collection called the Palliative Care Program Inventory. Um, and one of the questions that we'll be asking programs is what are those revenue sources that you're likely braiding together in order to cover the costs of your program? Um, so I hope all of the listeners to this podcast, I don't see how you'll be able to get away from our communications because we're gonna be singing from the rooftops. Um, but when we launch that data collection

platform, it's gonna do a couple of things. Um, one is we're gonna ask programs, particularly community-based palliative care programs, where we do not currently have a national data source on where there is and is not access to community-based palliative care. So we're gonna ask programs to simply raise their hands and say, yes, I serve patients with a specialty program, and here's where I do it across all care settings. Um, and then for those programs who are able, um, a couple of high-level structure process questions to help us really get a sense when you're looking at a community level, a state level, at the national level, where is their palliative care access? What are the what is the capacity of those programs? And where are the gaps that we really need to focus on filling? You know, I think we as advocates and champions for people with serious illness need that information to act strategically. States who are considering palliative care action need that information, and Medicare needs that information. So, apologies to to give the plug, but really hope that listeners will consider sharing their data because I think it will help us all advance.

Chris Comeaux 18:03

No apology needed. That's why we're doing this podcast to get the word out. And I actually love the way that you phrased a little bit earlier, how you're braiding the reimbursement together, because that's actually pretty apropos. Um, you know, powder care administrators, and quite often they're also a provider, sometimes they're wearing two hats. They've been the MacGyver's of healthcare in many respects because there is no perfect reimbursement, which gets to my next question. Could

[Training Non-Specialists Without Losing Teams](#)

Chris Comeaux 18:28

Palliative care kind of become a victim of its own success where the principles spread everywhere, but the specialty itself struggles economically?

Brynn Bowman 18:38

You know, I, I think I think about a couple of things. We're working with a fantastic partner right now, the Michigan Oncology Quality Consortium. They're looking at their state and saying we do not have uh specialty palliative care teams working in most of the rural parts in the state and in tribal lands in the state of Michigan. But there are oncology practices. So can we do palliative care skills training for the clinicians who are working in those communities so that we can do a better job of meeting those cancer patients' palliative care needs? And so for all of these very good questions that you're asking to get at some of the central tension points in our fields, to me, this is a big both and um we are not right now reaching every patient who needs us, and we need to be part of the solution, helping

to get palliative care services to as many patients as we can get them to. Um, and we need to continue to defend the business case and work towards better, more real, reliable reimbursement mechanisms for specialty programs where they're doing their work.

Chris Comeaux 19:44

I think I think it was a meeting with you and I, and I heard the statistic, the percentage of hospitals that now have palliative care programs, is that a statistic you have off the top of your head?

Brynn Bowman 19:54

It is, it's 87%.

Chris Comeaux 19:56

Man.

Brynn Bowman 19:56

Um, and once you get to 300 plus beds, it's over 90%. So, I think we can say now palliative care is a standard of care in U.S. hospitals, over 50 beds. There are there are gaps. Rural areas, as I as I keep harping because I grew up grew up in rural America, rural areas, for-profit hospitals are the least likely to have palliative care. Um, but that number has been way up there for many years now.

Chris Comeaux 20:21

Um, when we got our teams together for the first time, which was so great because it just felt like there wasn't enough time. We were just so much great passion and energy. One of your team members said, well, palliative care reimbursement doesn't suck as bad as it did in the past, alluding to, you know, we've got PP, PCM, TCM, all the different codes to honor more of that diversified interdisciplinary team. And it does appear like CMS is becoming more interested in defining and understanding palliative care through their coding and payment policy. So, we think we understand that they're looking at these S codes and maybe other mechanisms for identifying palliative care. Is could that be significant? And is this a coding issue? Could this be the beginning point of an actual foundation where palliative care programs could maybe break even, make maybe even make a little bit of a margin where it's not us braiding together all these different things, or am I just kind of dreaming a little bit?

Brynn Bowman 21:21

We could

CMS Signals And The Reimbursement Runway

Brynn Bowman 21:22

all dream, but no, I I don't think this is a dream to me. This is really significant. Or CMS is putting out really significant signals that they are focused on Medicare beneficiaries with serious illness and that they recognize that more needs to be done. So, I think that is a hugely positive indicator. Um you know, over the last uh four or five months, there have been three separate pieces to that. In the proposed hospice rule, CMS put out a request for information about how palliative care teams are billing and what is not quite working about that. So that way fields opportunity to say, uh, you know, thank. you for these new billing opportunities since 2022, 2023 that have made it a little bit easier for us to close budget gaps. And, you know, some gaps still remain. I'm sure we'll get into it, but in the proposed home health rule, CMS clarified that people with serious illness can qualify as um, you know, having skilled need under the home health benefit. And then most recently in the proposed physician fee schedule was another request for information that was pretty wide ranging. And asking questions about, you know, who who are the people with serious illness who need to be eligible for palliative care services, how might those services be paid for? And I think that when you sit back and you look at those three instances together, it seems very clear that the folks at CMS are looking at all of the levers at their disposal across Medicare programs and saying where can we tweak dials to make sure that more Medicare Medicare beneficiaries can get access to palliative care. So it's a big opportunity for the field to to weigh in on that conversation.

Chris Comeaux 23:07

And I know we can't, it's always risky when you try to look in the crystal ball, but I've asked a couple other people, hey, especially as they look at these potential S codes and what they can mean when you look at the detail of how the codes could be potentially funded, what could be the runway on that? This is what I've generally heard because we now have the wage index just came out. So another RFI related to that I think. So maybe 2028 might be the soonest you could see a reimbursement. Would you push back on that or again not asking you kind of go on record that absolutely.

Brynn Bowman 23:40

That feels right to me. This feels like the fact finding year um but but again that that you know uh across home health hospice and the fee schedule I I think this this reflects back to what I had said earlier which is palliative care is being delivered by every type of organization under every confect payment mechanism. So I think Medicare is also seeing the environment like that where there are a lot of providers capable of of delivering palliative care. They would have an easier time doing it if if uh the the payment made

more sense and where all of the places that we can encourage that to happen. I hope that's what they're saying and I'm so excited to see it.

Chris Comeaux 24:23

Which

[Home Health Rule Clarification Explained](#)

Chris Comeaux 24:24

let's get you alluded to this and I have to admit a lot of my other peers that I've talked to we're all scratching our heads. So the proposed home health rule is particularly interesting because it feels like they are acknowledging community-based palliative care within the home health environment. But what was that accomplishing? It is it a clarification are they staking a claim of like well home health is where palliative care will be I've heard a lot more often than not people are scratching their heads going, well if this is the first place for Palliative Care with an Apart A service, does that mean home health will own palliative care going forward in the future? And I'm like, I don't think that's what it means, but it is weird that's the first one that they've come kind of come out related to.

Brynn Bowman 25:08

I don't think it's what it means. And there was a ton of confusion around this just to get the fact straight there was no new payment in the language that came out in the in the home health in the proposed home health rule it was a clarification that people with serious illness essentially can qualify as having skilled need and be be cared for under the home health benefit. That's not the same as as all palliative care in the community is now delivered under home health. Home health agencies really need to think about a robust more robust service package if they're saying we have a specialty palliative care program in addition to our home health services. So to me it was one of the places that CMS is looking that's how I read it and and not an indicator that you know that community-based palliative care is now all roads are leading to home health, but that home health agencies are a potential community-based care provider that can be addressing some of their patients' palliative care needs.

Chris Comeaux 26:12

Yeah I think that um not calling anybody out but there was a very provocative news article that went out that I think didn't help kind of saying there is now a palliative care home health benefit. I it's not exactly what the tagline but it was pretty close to that. And I think it caused it aided to the confusion.

[Headlines, Confusion, And Part Two](#)

Brynn Bowman 26:30

I think the headline has since been created but it sure did encourage the confusion.

Jeff Haffner 26:36

Don't miss part two of this episode coming this Friday.