TRANSCRIPT: Why Hospice and Palliative Care Expertise Matters—with Dr. Kristi Newport | Part One

Sponsor And Leadership Opening

Jeff Haffner 0:00
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Melody King 0:05
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, author of the book The Anatomy of Leadership, and our host, Chris Comeaux.

Meet Christy And Her Superpower

Chris Comeaux 0:37
Many of us know them as AHPM, and she's also the chief of Palliative Care for Penn State University College of Medicine in Hershey, Pennsylvania. Welcome, Kristi. It's so good to have you.

Dr. Kristi Newport 0:46
Thank you so much. It's great to be here.

Chris Comeaux 0:48
Yeah, and I'm going to totally own. So Kristi and I are we had to reschedule this because of me. And so I'm going to give our listeners a heads up. Hopefully I don't sound too bad, but I actually was diagnosed with tested positive for COVID. If luckily I'm well a week away, but I still sound a little rough. And Kristi was wonderful enough to reschedule with me. So I think it's the first time ever we've had to reschedule a podcast. So thanks for being accommodating with us. Of course, we're just glad you're feeling better. Absolutely. Well, Kristi, I warned you I was going to be asking you this. What's your superpower?

Dr. Kristi Newport 1:18

Oh, yeah. Thank you for just giving me some time to reflect on this. Uh, I think of myself as a gatherer. I enjoy bringing people together for a shared purpose and helping them to convert their passion for what matters most into action. Um, this comes up when whether it's advocating for or supporting an interdisciplinary palliative care team or convening stakeholders for a field initiative or building a playground in our local community. Um, these are all things that I am invigorated by to see just the magic that happens when a group of skilled and dedicated people are brought together and then equipped and empowered to make positive change in the lives of the people around them. Um, it's just awesome. So obviously, you can see why I was attracted to the role with AHPM and why it's been such a great experience for me so far.

Chris Comeaux 2:16

I love that answer. My God, that check so many boxes of things I'm just passionate about. And interestingly, one of the definitions of leadership that I use are is very much in the realm of exactly what you just painted the picture of, Kristi. That's beautiful. Um, and I just I was thinking about first off, thank you again for doing this podcast and thinking of some of the people that have gone before you, whether the chief medical officer role, but also some of the incredible physicians that have been in that. Um, I think the title is like board chair of AHPM, including my mentor, Dr. Janet Bull. And so um you're just so humble and so incredible. And I'm sure you probably think as well. There's a line we actually used a leadership lesson many years ago based upon the Devil Wears Prada um show. And like there's this great line with Miranda, and she goes, You have no idea the legends who have walked these halls. My guess is you probably kind of feel that way, although there's probably not an official hall of AHPM, but kind of the virtual halls, if you will.

Dr. Kristi Newport 3:10

Yeah, yeah, absolutely. I mean, it's pretty awesome to uh literally sit in the boardroom. I'm actually at our our board of directors meeting right now in Atlanta and sit in the boardroom with people who I've learned from, I've been mentored by, um, I've read their articles. Um, it's it is a kind of a surreal experience, but it's also reflective of our field because literally everyone in our field is so approachable and humble about what they've contributed. Um, that it's it's just a really cool experience to be able to ask questions and pick pick the minds of people that are so committed to this work that informs, you know, our ability to do it better. Um, it's it's really pretty cool. And that includes um the folks employed by the academy that came before me. Joe Rotella continues to be a mentor in guiding us and walking in the footsteps of Porter Story before him. Um, and then we get the opportunity to work right alongside our board presidents who change every year. Um, so just a tremendous opportunity for collaboration uh to work together.

Chris Comeaux 4:12

Cool. I'm so glad we started there. And Joe's one of my favorite people in the world. And so after today, tell him that I did say hi. I love love me some Joe Rotella. He's a good guy. Absolutely. Well, Kristi, I actually I did it out of order, but I think it can it, I think I'm gonna do this going forward. I think it's better to ask someone their superpower. But real quick, I'm gonna read from your bio because there probably a couple people have heard of you, but probably appreciate hearing more of your background. So Kristi has been the chief of palliative care at Penn State University, College of Medicine since 2018. She completed her internal medicine residency at Penn State Hershey Medical Center and her hospice and palliative care fellowship at Virginia Commonwealth University. Under Kristi's leadership, the interdisciplinary palliative care team at Penn State Health has doubled in size, expanding access across the health system to five hospitals and four clinics. This is what I love about the reality. She's still practicing while she's playing in her role of AHPM. So she remains active in clinical care, primarily in the outpatient clinic. And in her role with hospice and community care, she's cared for people in their homes, outpatient clinics, community hospitals, and the inpatient hospice center. And since January 2025, Kristi has served as the chief medical officer of AHPM, as we said. And she's serving as the voice of Academy members on efforts including advocacy, education, and workforce development. She currently serves as the co-chair for the fifth edition update, the National Consensus Project and Clinical Practice Guidelines for Quality Impowered Care, and has the privilege of representing the Academy on multiple nationwide efforts to improve access to high-quality hospice empowered care, which leads us to the things I was really interested to talk about. So you're ready to jump in?

Dr. Kristi Newport 5:49
Absolutely.

Why HPM Is A Medical Specialty

Chris Comeaux 5:50
So let's start with a provocative premise. Hospice empowered medicine is indeed a medical specialty, not simply a philosophy of care. What does true specialists and a true specialist in hospice and palliative medicine know and do that distinguishes them from well-intentioned clinicians who happen to just care for serious illness patients?

Dr. Kristi Newport 6:11
Yeah, thank you so much for starting off with this. I think it's an important question. And I think it it requires us to kind of take a little bit of a history lesson, right? Because when you talk about hospice and palliative medicine designation as a medical specialty in the United States, you're actually referring to its approval as a multidisciplinary subspecialty

which occurred 20 years ago when the American Board of Medical Special Specialties officially designated AHPM as a medical specialty. And I point this out because it means that the sub-specialty designation is inexorably linked to the physician role. And I call that out because this was the way that our founders identified was the kind of the way that it needed to be positioned in order to fit within the existing healthcare ecosystem at the time. Right. It was the way to be sure that we could get paid for the work. It was the way we got a seat at the proverbial table. And frankly, at the time, it was the only way to get psychosocial care kind of inserted into the existing healthcare landscape with, you know, meaning and the medical gravitas that was kind of needed. And that was both, you know, in hospice and palliative care. So we we kind of had to fit into this accepted concept of medical care in order to be able to get paid for that work. So, you know, I point that out because it really highlights the fact that to stay in that place where we can continue to deliver this care, physician expertise is paramount. And we can't lose sight of the need to maintain an expert physician workforce. And, you know, we have to acknowledge that this is a constant source of challenge because the way that we had to fit into the healthcare ecosystem doesn't line up with the way that we actually function in our teams and the value that we place on the interdisciplinary team. Right. Um and so we acknowledge that we as a field, we and the academy, and I personally recognize the immense value of people who make up the interdisciplinary team. I tell anybody who listens that I wouldn't be the physician I am today if it weren't for the nurses and the social workers and the chaplains who kind of raised me both at Virginia Commonwealth University as well as hospice and community care in the early years of my career. Um and our conversation today is going to center more on physician expertise, not because those other voices aren't valuable, but because we we want to take this opportunity to identify why it's important to maintain that expertise and demand it now that we do have a seat at the table to ensure that we can continue this interdisciplinary care that we all value so much. And um I'm gonna kind of divert a little bit from your initial question, but but just to again reiterate why this designation was important and the value that it's brought us so far, you know, the work that our founders did to get the subspecialty recognized led to physician board certification, right? And this is a way to have recognition, a formal body of knowledge, defined competencies, accredited fellowships. That then positions us to be able to have divisions, departments, faculty appointments within academic systems, as well as graduate medical education positions. It allows for promotion and tenure pathways in the specialty, and it allows for credentialing criteria within community hospitals. This then speaks to health system financing so that healthcare leaders can identify oh, that's a specialist in palliative care. They've achieved expertise that we need at our table. Um, and so they can identify and value that work. And then, of course, it um allows for an identified um role when we're talking about fee-for-service building or value-based models. Um, so just a lot of really important opportunities that our, you know, founders more than 20 years ago understood that we needed to be positioned for.

Um, but we're kind of in the next generation now, right? So, so um we have to think a little bit differently, but still maintain that that really quality care.

Substitution Models And Lost Trust

Chris Comeaux 10:53
I love that answer. And this is one reason why I want to have this conversation with you. It's not the only reason, but I do get concerned that some of these substitution competitions, um, in fact, let me say it this way. I remember many years, especially going out with Dr. John Morris and John and I making these wonderful presentations and good arguments of why great palliative medicine and palliative care providers would make a difference for hospitals and others. And just many years just making that case. And it's almost like the world has finally turned its head to go, yes, this type of care, caring for those with serious illness, where a lot of healthcare expenditures are, um, a lot of futile care, et cetera. In fact, I did a really interesting kind of research project, and I was trying to figure out like, what is what are we really wasting in healthcare because we're not providing the right care at the right place at the right time, usually because people aren't getting their powder care and hospice care. And the number was somewhere between 150 and 175 billion. And so here's my concern is that now all of these interesting, I'll call them substitution competitions, are kind of looking at this space. And one time Dr. Morris said, and he was being kind of funny, he said the challenges are so vast, but the interventions are so many that you could almost throw a shoe at this kind of population and you would bend the cost curve. He was being a little funny, you can't just throw a shoe, but that these certain interventions, that there are many ways that you could kind of bend that cost curve. So I say all that to say this. This is why it feels timely, is that I'm realizing now our forebearers who have actually laid claim that this is a specialty, does it, I don't want to say it builds a moat, but it it at least claims that look, not everything is the same. One of the lines that we use, we had Brynn Bowman on our podcast recently, and if everything is palliative care, nothing is palliative care. And so I don't know if any of that just invokes some responses from you. This isn't, I'm not coming from just a competitive standpoint. I'm coming from the standpoint of, like I'll give you a good example. There are great people in PACE doing great work, but yet 2% of people within PACE actually get hospice. And then people from a straight data standpoint are saying, see, it was a good substitution. Well, do we really know? And I have a horrible anecdotal example, a physician who you probably know pretty well, Christy, who was the um medical director for one of the major MACs, his dad was in a PACE program. And if it wasn't this physician, he fought. The family didn't sleep for like three days. He had to fight, and finally he got his dad disenrolled and got the hospice care he needed for good pain and symptom management. So that's what keeps me up at night is that we've spent years kind of

building this specialty. Now that our health care costs are crazy for the country as a whole, maybe we get left out of the conversation at some level because we didn't lay claim to, you know what, a great program has this type of specialty as part of it.

Dr. Kristi Newport 14:00
Yeah, I mean, that you you really brought up a lot of differing concerns there. And I think number one is that it begs the ongoing need for research funding to really evaluate the various models of care, to identify what are the issues that can be delivered in a primary palliative care setting, in a primary care office, or you know, what are the issues that are well addressed by a PACE program? While what are the very significant concerns and issues that really must be delivered by specialty palliative care? Um, and particularly what are the ones that really do require an expert position to be involved? Um, and we haven't answered that in every space, but we do at least have um some evidence to point us that, you know, unfortunately, you know, what your colleague demonstrated is that um if we don't really stake a claim and determine what the standards are for the expertise that's needed to deliver this specialty care, people aren't going to get the care that they need. And not only do they not get the care that they need, but then they lose trust because they were promised something that that the people in place were never equipped to deliver. Um, and so we really need to be sure that the promise that's being put out there for specialty palliative care, we are actually delivering on. And we do that by demanding the highest standards of those that deliver the care.

Chris Comeaux 15:27
Very well said. Well, I love how you I love your first answer because I too was raised by amazing IDG team members. Um, you a physician, me as an accountant, believe it or not, and nurses that sent me out on actual visits with patients. Um, so I know that our field talks about compassion, goals of care conversation, patient preferences, these things that we do in depth, but there's clinical expertise that's actually required to manage the serious illness.

The Hard Skills Behind Care

Chris Comeaux 15:55
So, what are, and this is kind of maybe digging deeper on your first answer, what are the clinical competencies that you believe that we should maybe reclaim, but also elevate as I'll use a term you could push back on it, the hard medicine of hospice and palliative care?

Dr. Kristi Newport 16:10

Yeah. So um I often say this to uh learners that rotate with us um, that hospice and palliative medicine folks are not just professional, nice people. You know, I I honestly I just had um a clinician interviewing with me last week who has um no formal training in palliative care that told me she already knows how to do this. And um, I'm sure like she's had some really great goals of care conversations. And to your point, there are delineated competencies, feedback loops that need to be in place to be sure that professionals know what they don't know and are not just doing something because they're they're nice about it, but they they've actually met the competencies. So, you know, I think that brings us back around again. You don't have to just ask me what I think about what makes a competent person, because we have this really well delineated again by our colleagues in the field who have determined, particularly for physicians, what are the competencies that are needed to be a really good hospice and palliative medicine clinician. And our training programs require not only that they've had exposure to these things, but that they've gotten feedback and they've been in an improvement loop to make sure that they can actually walk out of fellowship or training programs and be able to do these things. And that includes patient and family care, medical knowledge, you know, all of those complexities that are way different now than they were even 18 years ago when I was in training. Disease trajectories, prognostication, managing pain and non-pain symptoms now, not only with palliative interventions, but also some disease-directed interventions that we need to understand that we never had to understand before. That is combined with interpersonal and communication skills, as well as complexities of system-based-based practice, um, professionalism, ethics, um, and the ability to teach these things to other people. So these are all the competencies that are required to be a board-certified hospice and palliative medicine physician. And I think we can hold those up, you know, as really the important um elements that we can rely on when we are looking out and we say that person took the time and the effort to go through a hospice and palliative medicine training program and get board certified. And their continuing education and their maintenance of certification in that, in that um specialty tells you that not only did they do it, you know, 10 years ago, but they've invested in the fact that we need to keep learning. Right. I spent a good good um chunk of my weekend last weekend doing my longitudinal knowledge assessment questions, both for the hospice medical um director certification as well as um the HPM certification. And I learn something every time when I am going through that. And both of those sets of questions made me go back to the literature to say, gosh, I thought I understood this. Um, you know, but changes in heart failure management, um, changes in prognostication are just so rapid that, you know, I think it's really hard to say that without um going through that stringent process, that um a physician has all of the competencies they need to be able to practice high-quality hospice and palliative

Humanity As A Non-Negotiable

Dr. Kristi Newport 19:34
medicine.

Chris Comeaux 19:34
Hmm. You know, something just occurred to me to listen to Christy. Um, we had Dr. Mark Stoltenberg. You might know Mark. He works at Harvard, but he also does a lot of global work. Um, and so I did a podcast with Mark, but then I was also I co-facilitate the International Collaborative on MPHI, because I'm very interested in a lot of this palette of medicine work internationally. And we had uh Dr. Morgan Doherty, who's actually with uh WHO that was talking. And she said something about like, there's something about this work that brings people back to like the root of their humanity and compassion. And they see this internationally because you know, they have a lot less tools that we have. And it's almost like they lead with that, and then they're bringing the clinical competencies kind of behind them. That's my interpretation, it's not exactly what she was saying. But I think that's what people think now, then on the state side, because we're so much about the science of medicine within the states, and this is so different than kind of the left brain dominated science-based of so many of the other types of like whether you're neurology, um, just pick all the different other specialists. And so is that what it is? You think that they see this because, oh, well, you guys are nice, because it's almost like a holistic human being. It's right brain, left brain, and heart in this work, which you would think all of medicine would be, but yet when you value these highly technical skills and some of these other specialties. Am I on to something?

Dr. Kristi Newport 21:07
Oh, absolutely. Um, I mean, I will tell again, will tell anybody that will listen that I think our work and our specialty is the ideal way to deliver medicine. Um, because we are understanding who people are, what matters to them, and then we're applying, you know, the interventions and the amazing discoveries to make their lives better. I mean, really, you know, anybody that originally goes into medicine, that often is why they started, right? But, you know, unfortunately, the way that um medicine training in the United States selects people. And the way that we um make it uh so hard physically, cognitively, emotionally to go through training, sometimes it it kind of beats that out of you. Um, and you kind of forget why you got into it to begin with. So um, anytime I am talking with someone who is thinking about entering, Palliative medicine and and particularly those folks that are thinking about joining our interdisciplinary team. Um, I have two main criteria that are non-negotiable, and that is um that the person in front of me cares deeply about other humans and what brings those people meaning and value. And that they do that not only for their patients, but for the other members of the healthcare team. A

physician simply cannot be successful in hospice and palliative medicine without having that deep underlying commitment to the people that are around them. I've seen only a handful of folks that um have entered the field for whom it wasn't the right fit and for whom they they really couldn't, you know, correct their challenges or overcome barriers. And and for the people that weren't successful, it was because they really weren't led by that underlying desire. It just wasn't what um meant the most to them in their practice of medicine. Um, and so to your point, um all of the technical knowledge, um, gosh, it just doesn't get you the whole way if you don't actually care about the people that are in front of you.

Chris Comeaux 23:20
But what I love in the beginning, high five, there's so many pearls in what you just said. But where I would love where you started in the beginning. I mean, I was kind of making the inventory. I mean, you you kind of rattled off things like prognostication, complex symptom management pharmacologically, pharmacol, pharmacological, pharmacological. You can say that word better than me. Yeah. After a week, I can no longer brain blame my COVID brain, deprescribing, um, disease trajectories, communication, ethics, interdisciplinary care. I mean, all of those have a technical body of knowledge, which that in itself is huge, to be able to get trained in that. But then to take the whole human side that you just spoke to, the ability to have presence, to ask great questions, to be able to unpeel the onion, to really find out what does matter most to folks, and then how you even garner the team to be working together to do that. I mean, that's amazing. That's absolutely

Deprescribing Statins Takes Nuance

Chris Comeaux 24:17
amazing.

Dr. Kristi Newport 24:17
Yeah. And I'll give you just a simple example, I think, of what demonstrates what you just said is um, you know, we had a a really great study, it's been years now, that demonstrated people who have a less than year prognosis um do not benefit from continuing a statin, a cholesterol medicine, as long as they don't have unstable heart or neurovascular disease, right? So pretty straightforward study. Seems like that would be very clear, and people should be de-prescribing all over the place, right? Like that's that should be easy. It should be simple that family medicine docs could do it, you could, hospitalists could do it, whatnot. Um, we haven't seen, you know, a great flood of people appropriately deprescribing. And I will say that this is a great example of a simple

technical idea that actually requires, gosh, a good amount of nuance. So number one, we need to prognosticate appropriately. Number two, we need to actually even care about prognosticating, right? It is, it's really not um something that's natural for a lot of folks across the healthcare system to be thinking about that and to be frankly discussing prognostication with their patients, even though we know that it improves outcomes, it improves their mood, it proves the caregiver outcomes and whatnot. So that's number one. Prognostication is not something that people are comfortable with, skilled at, or even prompted to do. Number two, this idea of stopping a medicine that you've been told for years or maybe even decades you can't live without is actually a really difficult discussion for some people. And it can lead to people feeling that they're being abandoned if you don't do it right. It can make people feel like you want them to die sooner. It can make you them lose trust in you because, hey, my cardiologist told me I'm gonna be on a statin the rest of my life. Why would I stop it now? It's not hurting me. You know, what are you telling me and what are you not telling me? Right. And why do you want me to die? And so this simple technical piece um comes with just a weight of um skill, communication, and meeting the patient where they are, assessing their understanding in order to really do it well and in a way that doesn't undermine trust and doesn't undermine a patient or family's confidence that you have their best interest in

AI Teaser And Part Two

Dr. Kristi Newport 26:45
mind.

Chris Comeaux 26:45
That is so incredibly well stated. So I really do think we've we've done a good job in this first part. As we're gonna go to this next section, um, it feels like you've done a great job establishing like this is a field of medicine, this is a subspecialty. It's got incredible nuance and expertise and complexity. Um, and maybe a little bit later I'll kind of throw a teaser that I didn't plan on asking you, but where my mind goes listening to you is in the age of AI, how does this kind of change at all? Um, although I have an interesting idea. I can't wait to hear your answer on that one, but I've got an interesting idea. I've gone to a podcast I did with Daniel Pink, where he wrote a book about the future of like the superpowers of the future in the age of AI. I think you're gonna smile when I share that.

Jeff Haffner 27:32
Don't miss part two of this episode coming this Friday.