TRANSCRIPT: Embracing the Four M's: A Path to Person-Centered, Reliable Hospice and Palliative Care | Part One

Leadership And Purpose Opening

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, author of the book, The Anatomy of Leadership, and our host, Chris Comeaux.

Meet The Host And Guests

Chris Comeaux 0:22
Hello and welcome. I'm excited today. We have two special guests with us today. We have Kelly McCutcheon Adams, who's a senior director at the Institute for Healthcare Improvement. Welcome, Kelly. It's good to have you. Thank you, Chris. Grateful to be here. And we've got Margherita Labson, who's the president and CEO of McLabson Consultation. Hey, good to see you, Chris. Yeah, let me, I know a lot of our listeners know both of you, but let me go ahead and introduce you via your bio. So Kelly McCutcheon Adams, she's uh L-I-C-S-W-M-S-W. She's a senior director at the IHI. She's the director of and serves on the faculty of the IHI Breakthrough Series College regarding running successful collaboratives. She's currently focused on leading the IHI age-friendly action community, coaching and mentoring leaders of collaboratives around the world and grant administration. She's a medical social worker with experience in ER, ICU, and nursing home, subacute rehab and hospice settings. Ms. McCutcheon Adams serves on the faculty of the U.S. Department of Health and Human Services, the Oregon Donation and Transplantation Collaboratives, as well as on the faculty of the Gift of Life Institute in Philadelphia. She has a BA in political science from Walshley College and an MSW from Boston College. So Kelly, again, it's good to have you. I warned you I was going to ask you this question, but what's your superpower?

Kelly McCutcheon Adams 1:43
Well, can I have two? Sure, absolutely.

Chris Comeaux 1:46
You can as many as you want.

Kelly McCutcheon Adams 1:47
I mean, there's many, but no, just kidding. Um, I think one of my superpowers is um pointing at elephants in rooms, naming, you know, sort of naming the hard thing, saying the hard thing, um, which, you know, can be a good skill and probably drives some people crazy. Um, and then um another superpower I have is mailing cards, birthday cards, sympathy cards, retirement cards. Like I am uh I'm a snail mail person from way back and um brings

Superpowers And The Elephant Test

Kelly McCutcheon Adams 2:18
me a lot of joy.

Chris Comeaux 2:19
And that is becoming more and more a superpower, right? As people go more in the realm of technology. Definitely. That's awesome, Kelly. And I love I love the naming of the elephant in the room. That'll be a good segue in just a little bit. Well, let me introduce Margherite. So, Margherita Labson, again, president CEO of Mick Lapsen Consultation Education Services. She spent most of her 40-plus year career working to advance safe, quality home-based care, primary medicine, home health, skilled, home health, and infusion, pallic care and hospice care. And during her 25 years as executive director of the home care at the joint commission, she led the development and launch of the first certification for home-based pallic care providers and the first award-recognizing franchisers devoted to promoting quality home care services. She left to continue her postgraduate studies and now works as a strategic advisor to CHAP as well as to many other providers and associations to ensure compliance and promote the advancement of high-quality palic care, hospice care, and home health care. So, again, Margherita, so good to have you. Nice to meet you. So I warned you as well. What's your superpower? That's my superpower.

Margherita Labson 3:23
I would tell you, Chris, I'm really good at putting people together with the people and the resources that they need. You know, I'm Italian, I know a guy.

Chris Comeaux 3:35
That's so cool. I think that you may win the prize of the coolest answer to date. I know a guy. That's a really great way to I love kind of pithy little statements that you know communicate. That is awesome, Margherita. Well, this is exciting. And so, um, gosh, I think it was two years ago. It actually started with John A. Hartford and kind of introducing us to

the concept of the forum's on the TCN Talks / Anatomy of Leadership podcast. We had Kai Dr. Kai Wen on, and um, and you guys, I didn't tell you this. Guess who we had on the podcast a few weeks ago? Dr. Don Berwick, who is the father of IHI, who was that was a phenomenal podcast. So, so many cool reasons

What The 4Ms Framework Means

Chris Comeaux 4:14
to have you guys. But what I want to talk to you about is the 4Ms. We have glommed on to the 4Ms as Teleios Collaborative Network and like jumped in with both feet because we love just what it means and its impact, which is why I'm so excited to talk to both of you. So there may be listeners though who have heard the term, but they're not deeply familiar with what are the 4Ms and why has IHI invested so heavily in this framework?

Kelly McCutcheon Adams 4:38
Sure. Thank you. What an important question to start off with. Um, so the age-friendly health systems work um is an initiative of the John A. Hartford Foundation, the Institute for Healthcare Improvement, and the American Hospital Association. Goes back, gosh, I meant to look up the year, I think 10 or 11 years now. And it is a framework that helps us organize how we think about care for older adults. And it's an essential set of um evidence-based practices. It causes no harm, which is a key, key issue. Um, and it aligns care with what matters to an older adult. And so we've you said it, the four M's. There are four different areas in the framework, which are what matters, um, mobility, mentation, and medication. And the mentation piece, just to be clear, includes delirium, dementia, and depression. And if I can pop back into history just a tiny little bit, um, the way this came about was that there was um expert review of 17 care models that existed at either level one or two A, which surfaced 90 care features, like the different ways that you could look at care. And then an expert meeting was held to get down to the vital few. Um, and the the focus on that in finding the four M's was to focus on core issues um that had strong evidence and that helped um simplify, uh, you know, that that the framework helped simplify care and that there was synergy among the four M's. So I'm not sure if that's getting at all the parts of your question, but that's kind of the history and and what the 4Ms

How IHI Spreads Age-Friendly Care

Kelly McCutcheon Adams 6:32

are.

Chris Comeaux 6:32
Now, big it segue then, Kelly. So, what is IHI? Because I was pretty stoked. I can't remember how I bumped into this. It was probably through just a conversation with Margherita and some of her other work, but the fact that you guys were focused on that. So, what is IHI doing to accelerate the adoption of 4Ms, specifically in the hospice and powdered care space? And if organizations are interested, how can they get involved in your work related to that?

Kelly McCutcheon Adams 6:58
Yeah, uh good question. Um, so the work has evolved over time, which to me is honestly the most exciting thing about it, which is that it's not stagnant, it's not limited. Um, it's work that started with a focus in ambulatory care and in hospital care. Um, how could care teams organize their thinking? And and honestly, that to me is is one of the greatest strengths of the age-friendly work, is that it's a way to organize your thinking as a clinician, as a practitioner. If I can give a personal example, um, I have an 89-year-old neighbor, he's amazing, and I've become a caregiver for him over time. And when I go to his primary care appointments with him as a friend, I am organizing my own thinking in how I talk with his primary care doctor. Like I'm, you know, I'm like, what matters to Al is that he can stay in his own home and therefore, you know, and I'm kind of moving the conversation to make sure that mobility and mentation and medication are aligning. So I just want to name that as like it's a way for us as friends, as family, as clinicians, you know, as social workers, as chaplains, you know, to align how we put our thinking together. And so in those early days, um, the focus was around, again, ambulatory care, hospital care. And what has happened over time, which I think is tremendously exciting, is that teams um at IHI with expert faculty have been put together to say, okay, well, what about nursing homes? Okay, what about convenient care clinics? Um, and Margherita was involved in the work um that prototype what does it mean to be age-friendly in home health? And so then that leads to guides, that leads to new care descriptions. So we're always expanding out to say, okay, what does it mean to be age-friendly in these different settings? And the reason that we get to be with you today is because Margherita and I have been involved and are still involved. We're kind of at those final stages in the hospice prototyping of the age-friendly work, which is how would a hospice team organize their care and organize their thinking around the four M's to help accomplish what matters most to that older adult.

What IHI Is And Why It Exists

Chris Comeaux 9:27
But something that just occurred to me, Kelly, is that folks, we probably should have done just a little bit of what is the IHI? Because I know the IHI. And why would I be talking to Dr. Berwick as you keep talking? I'm like, it makes total sense. But some of our viewers may be like, well, wait a minute, IHI.

Kelly McCutcheon Adams 9:43
Um well, I have had the pleasure and the privilege of um working at IHI for the past 22 years, which means um I was there under Dr. Don Berwick's leadership. He is the founder. It's one of the greatest privileges of my life. Um and he founded um IHI in 1991, along with other colleagues like Paul Batalden from Dartmouth and others, because they saw um an incredible gap. And this gap still exists. We're we're still you know, chipping away at this gap. The gap between evidence-based practice, what is known to be evidence-based, and what's actually happening at the bedside. So in 1991, um, when I Chi was founded, it's a nonprofit organization. It uh is based in Boston, although we've become a virtual organization. We still have an office in Boston, but for a long time we were very physically centered in Boston, working on six continents to improve health and healthcare worldwide. And what Dr. Berwick and others did was to bring the science of improvement from manufacturing from commercial aviation into healthcare. Um, how do we build reliable systems and reliable processes? Um, so as an example, at the time that they were getting started, if you went to an emergency department and you were having a heart attack, you had a coin toss chance of whether or not you were getting an aspirin, a known evidence-based practice, and you had a coin toss chance of whether or not that was gonna happen for you. So that's an example of the evidence base exists, but it's still an absolute system of chaos as to whether or not that's gonna happen. So that was the foundation of IHI. And over these, gosh, where are we, 35 years? Over these 35 years, that work has evolved. Safety, quality, equity. What are all the big components um that allow us to build safe, reliable, equitable health systems?

Chris Comeaux 11:38
Um, so yeah, we're still going strong. So glad to ask that. And then it just makes so much sense that you guys would be focusing on the Four Ms then.

Why The 4Ms Work Everywhere

Chris Comeaux 11:46

Um, I love what you said. It's like a thinking framework. And maybe this next question will be for both of you. Why do you believe the 4Ms resonate so strongly across settings ranging from primary care all the way to serious illness care?

Kelly McCutcheon Adams 11:59
Want to go first, Margherita?

Margherita Labson 12:00
No, you go, and then I'll finish.

Kelly McCutcheon Adams 12:04
Um I I mean, at the risk of sounding, I don't know, reductive. Um, it's it's really logical. I mean, and just it just to be super blunt, like it is logical that we would start from a place of, well, what matters to this person? And then the how we focus on mobility goals, how we focus on maintaining mentation to whatever extent is possible, how we think about what medications do and do not align to what matters. I just find there to be so much logic in that. That's what I think makes it sticky. Yes, it's super helpful that somebody came up with four M's, you know, like it's always helpful when the when the words align, but underneath those words, I just think people see the clarity and the logic to it.

Chris Comeaux 12:52
That's a well said, Kelly. I know, Margherita, I want you to comment, but like when I heard Marcus Escobito at uh Johnny Hartford talk about it, it was in the podcast, and it's like, you know, I saw the light, you know, the heavens opened, and it just makes so much sense, like you said. And it is it is brilliantly sticky, I believe, which makes it even more brilliant. Margherita, what would you add?

Margherita Labson 13:13
So I let me just preface this by saying I came to find the age-friendly system when I left after 25 years of the joint commission with a burning question on my plate. And that was why is it if care in the home is so phenomenal, so well loved, why is it that people aren't clamoring for it? Why is the health consumer not demanding it? And the age-friendly approach to care was the only uh framework that offered me an answer. And that was uh this disparity that Kelly that Kelly alluded to just a few minutes ago. Uh the age-friendly uh framework of care is exquisitely simple and powerfully relevant uh from a clinician's point of view. And I've been a clinician since the mid-70s. It really helps the clinician uh organize and deliver care that's absolutely in line with what matters to that individual. Uh and it's built on reliable evidence-based practices. Assess, act on that that just makes sense. If you see something, say, you know, if you say see something, say something. Well, we if assess it, if it if it's positive, do something about it. And it's built on a framework where it's

evidence-based practices, and evidence why do we use evidence-based practices because they produce some reliable results. And these principles and concepts have applicability regardless of the site of service, and that is so important. So we struggle in this healthcare system of ours. How do we transition care from acute care facilities back to the home care facility? You know, how do we do this? Okay, if we're all working off this basic framework of care with what matters first in our minds to that particular individual, then the care aligns all the way across the sites setting. So we have the capability of producing reliable results regardless of where we serve that individual.

Framework Versus Traditional Quality Measures

Chris Comeaux 15:17
That's so good. Well, as I sit here and think again about just it's so great to be having this conversation with you guys under under the umbrella of IHI. So, and thinking about how all the things that IHI has tried to help bring quality measures, what makes the forums maybe different than what we would call traditional quality measures?

Margherita Labson 15:36
I I think I would tell you first of all, that the forums is not a measure, it's a framework. And and in that, um, it's organized to produce these reliable results, but it focuses first and foremost on the older adults, not as a patient to whom we do things to, but as a partner, a full bond partner in their care. So they are the most important partner for us in the delivery of the in the delivery of the healthcare services that they are actually desiring from us. The focus on what matters supports them, not so much what the patient can't do as much as what this older adult can do. And uh so we're not driven by a medical diagnosis that tells us a deficit. We're driven more by what's meaningful, what's important to that person. And rather than this, you know, the if you look at the things, we're we're con we're confounded, if you will, by all the regulatory requirements that have to break things down into these elemental tasks and bits and pieces that we have to then submit in order to justify reimbursement. Well, using an age-friendly approach with this framework of Four M's allows us to align these elements along this framework that by delivering the care we still embrace those elements, but we're just delivering them in a more organized fashion. So we still get the information. The key here is that it's organized in a relevant fashion. And it is the patient that is doing the definition and the description of what matters. So problem and goal are thoroughly individualized.

What Matters In Hospice Care

Chris Comeaux 17:24

That's a good segue then. So um, so let's just go with the first M, what matters? We would think as hospice and powered care organizations, providers, we've prided ourselves, kind of feel like maybe we invented goal concordant care. So, how does excellence and what matters most look like today? And where do you maybe, and really this is the punchline of the question, where do you see opportunities for improvement? Where can we get better? Where can we improve?

Margherita Labson 17:51

Well, actually, the age-friendly approach aligns well with goal concordant care. In fact, it empowers goal concordant care. You know, we uh it uh many times it looks like we have a patient-centered plan of care, but then when you uh uh drill down into that, what does it really turn into? It turns into a series of medical diagnoses uh with the appropriate designed goal. And that may or may not be uh concordant with that older adult's in that older adult's uh desired uh goal. So I you know, um for example, uh let's just take pain. Uh you know, if the patient is calling is is identifying pain as or rather if the diagnosis is that the patient is experiencing pain. However, what is more important uh for that individual is that they are not uh sedated as a result of that pain, but they they have a modicum of they they want to deal with a certain level of pain. Perhaps it is for some seg existential reason for for whatever reason, then that becomes the goal to get them to that level. And that's not to say that it's not that's not already happening, because we know that most organizations, regardless of site of service, already do some aspect of these four M's. Are they just may not be doing it regularly with all four M's for all individuals? Okay. So it assumes that they are doing some level of it. This just the framework just enables them to align them so you're doing all of them at all the all the time. There's a unique difference with this approach. When you come from a position of the age-friendly approach, the age-friendly framework, and you're talking about goal-concording care, rather than looking from a place of uh negativity or disability, we come from a place of uh what is possible, what already exists, uh, and we've we build on that. And and fundamentally that changes uh the approach uh in terms of how you uh how that care is uh delivered, because it's all on based on what matters to that individual and what they are willing, what they uh are willing to uh to manage and negotiate and do, but it doesn't assume we know best as to how the care should be delivered. For example, you have you may have two women with the of the same age with the same diagnosis. That's where the similarities end. How that plan of care is lived out in an age-friendly framework will depend entirely on what matters to each of these uh women and their life journeys. And in that, you're almost assured of an individualized plan of care that capitalizes on all the benefits of medical science by delivering to an individual who has now said, Yes, come, I need your help.

Reliable Systems For Individualized Care

Chris Comeaux 21:08
You know, you remind me, Margherita. My um I grew up in manufacturing. I don't know if you knew that. So corporate America before I fell into hospice at the age of 25. And always joke, I was raised by nurses. I had this amazing nurse mentor at a hospice in Pensacola. And she and I had this kind of ongoing debate, and she's like, Chris, hospice is all art. And you know, I grew up in this right when it was a beautiful time to grow up in manufacturing, because this is when the whole quality initiative was coming in. And so I saw this mass standardized approach. So you kind of saw this like push and pull debate between us. And now I looked through the rearview mirror of my career and and you kind of see this tug of war. I feel like in some respects, this framework could could reconcile it. So maybe Kelly, it could be a segue question to you. How does the IHI coach and recommend that individualization of care plans? And I bet you, you know, story would. Be a great way maybe to illustrate that.

Kelly McCutcheon Adams 22:02
Yeah, I think I mean it is the question, right? I mean, that that is the question, which is how do you take a framework and use it reliably but individually? Like both of those things have to be true. And so um I think what your mentor said to you about art, no, no offense to this person, is there's a false distinction there because I don't want um the pilot of my airplane to tell me uh that commercial aviation is an art. Like I don't want to hear that. I don't want to hear that. I want to know that everything was done safely and reliably and you know to a T because that is how safety comes about. And so I think we've had this real battle in healthcare. I will get to your question, I promise. I think we have this real battle in healthcare of sort of, you know, art versus science. And why it's art and science, which is the very human way that we engage with people about what matters to them. There is some art to that, of course. But if we don't follow that up with the reliable, as you said, Margherita, you know, what medical science brings to us, if we don't marry those things, we're not serving anybody. Um, so I think what IHI uh brings to the table through the age-friendly health systems is that you need reliable systems to engage with every older adult in your care about what matters. If that isn't happening for every person, either because your systems don't support it or you don't have an equitable healthcare system, you know, whatever is the real and true about why that's not happening for every single person, then you're not going to be able to get to effective thoughts about mobility, effective thoughts about mentation, effective thoughts about medication. So to me, it's that intersection of the art of engagement about what matters, so that the medical science can support that. Um, and I think the way that we coach and talk with people about that is that the work is to build the system where it happens reliably. The stories come out of actually doing it. You know, people who are saying um to us. And

what I this is what I love about what matters work is that the the spectrum and range of what we know and understand from people is huge. Like, don't you dare tuck in the sheets at the end of my bed. Don't you dare let my toes get cold. Like, there are very, very, very concrete things that people um need us to know about their lives and their comfort. And I laugh at that because I walk into a hotel, I barely even put my suitcase down before I'm like pulling the sheets out from the end of the bed because I will lose it later if I try to shove my toes. I'm pretty tall, if I try to like shove my toes down there. So in the what matters conversation, there's very concrete things that come up. There's also highly existential and relational things that come up. Gosh, I hope, you know, I hope I, this is not me personally, I hope I can um, you know, work through the estrangement I have with my sibling. I hope I can survive until my granddaughter's wedding. Um, I really don't want to be in pain, uh, versus I can tolerate some pain if I can still talk to people. Um, I want to be near my cat. I want to, I want to go see the ocean again. And and so, in that huge, huge range of ways that people tell us what matters to them, then doing that reliably is what allows us to bring the medical science piece in. So, how does IHI talk with people? We talk and coach people of you gotta build the system where the what matters engagement is happening 100% of the time. Because otherwise, it's just hit or miss. And we don't realize how much bias we introduce into that. We don't realize um how much we think we have the conversation. Oh, we did that, we did that. So it's the reliability that allows the what matters to come forward, and then the medical science can come to bear.

Chris Comeaux 26:24
So good. I'm gonna share with you guys post-podcast taping. There's I've got my Harvard Business Review Top Five Articles Ever. This is probably in the top two. It was an article, and it the title was When Process Becomes Art. And it was the ultimate reconciliation between my nurse mentor and myself. You literally just taught that article, but I'm gonna share it with you because there's a beautiful two by two matrix in that actual article, but literally you just taught it. So I'd love to read it. Yeah, I'm gonna share it with both of you. So let's get to the next one, which is medication.

Medication Decisions Guided By Goals

Chris Comeaux 26:57
So medication management is often one of the biggest sources of burden, challenge, and healthcare risk, cost. Um, what does medic the medication component of the 4Ms, how does that help organizations improve quality? And does it also address like waste, maybe unnecessary interventions, all the contraindicative stuff?

Margherita Labson 27:18

Let me take this one. So I will tell you that if you hold what matters uh as your North Star, that that really helps the interdisciplinary team, especially, and I'm just gonna speak for hospice, you know, at this point. Let's let's just talk about hospice. That helps the IDT go well beyond is this pill appropriate? Is this pill, uh, is this medication covered on our hospice formulary? Is this a pill burden? And really begins to drive down to what is this medication aligned with what matters to this individual? And I need to give you an experience from my postgraduate work. Um, I had the opportunity and the honor of taking care of a hospice patient and being the good hospice clinician that I am, I took down everything. And because this patient was on a narcotic opioid, I immediately laid in uh, you know, of course, our um bowel regimen because that's a we need to have a bowel regimen if we haven't uh if we have a situation where we're giving narcotic opioids and there's a predisposition to constipation. And my mentor at the time said to me, Well, Margherita, I see you have a bowel regimen here. Um and did you confirm that that is appropriate for that particular patient? And I went all through the medical, well, you know, the patient has this, this, this, this, and so forth. And she said, uh, yes, but what matters to him? And I said, Excuse me. And she said, What matters to him? What happened was I completely overrode uh what matters uh in my quest to be a thorough and diligent clinician. Appropriate God knows in almost every hospice orientation, you know, you you we understand if there is a narcotic opioid, you they need to be on a bowel regiment where I failed my patient was, uh I failed to ask this older uh individual what in terms of what does that mean for you, what does that look like? And it uh it uh makes you uh a more effective communicator because it changes the way we communicate uh with individuals. So I went back and using the tools and the resources about effective communication, I got to a very, very different conversation. And he said, Oh, don't order all that nonsense. I'm let me tell you what I do to when I get constipated. It's not it's not a new problem for me. And by gosh, by golly, we never needed to order anything more uh than his customary school softener, how he managed everything else uh with his diet successfully, despite uh the increase in narcotic opioids until the end of his life. God rush your soul. And you know, may you be out of that, but it was an important lesson that's the beauty in what matters. It uh takes the patient from somebody that we're doing something to to somebody that we're actually having a conversation uh with as a partner and we even include the medications. Now think uh of the think of the downstream effects of that. Uh no more over ordering of medications, really zeroing in on those medications that uh that uh uh a particular individual wants. So you're not doing a lot of cost overruns because you're just shoving everything out there in a box only to be destroyed later on. But uh having the conversation forces a more intentional uh more intentional work with an individual, first of all. But second of all, uh the fact that uh he got the desired result that he wanted, I have to tell you, I experienced a new level of clinician satisfaction as well. He made me a better clinician because I learned how to how to communicate better. Think how that could help to inform uh our community of hospice

and palliative care. Just think of the possibilities of just utilizing this framework of care. It could help inform our, it could inform the hospice community of better ways of delivering care to individuals.

Chris Comeaux 31:43
That's brilliant and so well said. And the other thing occurs to me, Margherita, is that we've got this going forward, just because of the workforce challenges, we're gonna have a younger and younger workforce and how important the timing of this feels as well. In some respects, some people might go, well, this is a return to our roots. Um, one of my favorite quotes in the world is a T. S. Elliott quote that we arrive where we first begin, but we know the place for the first time. It kind of feels like this has that. Well, we've we've talked about two of the M's as we're gonna go to

Opioid Fears And Hospice Reality

Chris Comeaux 32:12
this next section. Hey, Chris, I'm so sorry.

Kelly McCutcheon Adams 32:14
Yeah, possibly just I uh since I named one of my superpowers as uh pointing at elephants. I just I just want to name a dynamic around medication that I think has been a really important part of the learning um in the prototyping around age-friendly hospice. And I think this I think this is all very logical within the hospice realm, but for people uh working in other settings, I think this is kind of where the rubber hits the road, which is we have to flip our thinking about medication in hospice. So the very things that we might be trying to do purposefully in other settings, moving people away from narcotics and away from opioids, that we might find ourselves doing the opposite of that in hospice. And so that to me, in the hospice prototyping, has been one of the most important learnings is that we have to kind of override some of that thinking about categories of medicine that are good, quote quote, good and bad for older adults. And we have to kind of shake that script up a bit in hospice. Um, and simultaneously, we have to think differently about, you know, the cholesterol meds and the vitamin D supplement and you know, things that like they had a purpose, but they may not have that same purpose anymore. So that to me has been one of the most key pieces. And just from a personal level, I remember when I was a nursing home social worker, I had a resident who was on hospice, so in the nursing home, receiving hospice services. And the person was short of breath and in pain. And I went to the floor nurse and I said, you know, Mrs. Smith's family is really concerned about her. And the nurse said to me, and I'm not trying to call this person out. I just it really illustrated the issue for me. The person said to me, I don't want to create addiction. And I

was like, whoa, whoa, what are we talking about? Like, this person is actively dying. And even in actively dying, the fears about narcotics and opioids were so strong. And so I think we have to be clear-eyed about that, particularly as we talk about the new generation of nurses. We have to hold that clarity in hospice settings, or we're gonna miss a lot of really important opportunities.

What To Watch For Next

Chris Comeaux 34:37

It it is definitely your superpower, Kelly. And I'm so glad you added it because as we go into the future, there are these substitution competitions, I'll say, like, for instance, pace. Um, that you know, only 2% of pace are actually getting hospice care because of how the actual uh payer model is actually designed. And people are asking the question out loud well, are people getting good quality care? Well, if they're not trained in the way that you're talking about, because this is such kind of a you know, topsy turvy world of looking at certain types of meds, um, that is such a great point. I'm glad you actually pointed that out.

Jeff Haffner 35:09

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