

Transcript | **The Future of Palliative Care: Who Will Lead, Who Will Pay, and What Comes Next? | Part Two**

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Welcome And The Big Question

Jeff Haffner 0:40

Welcome to TCNTalks, and Anatomy of Leadership. We continue our conversation with Brynn Bowman in Part Two, The Future of Palliative Care. Who will lead? Who Will Pay? And What Comes Next? And now here's our host, Chris Comeaux.

Who Leads Community Palliative Care

Chris Comeaux 1:02

So as we go into this next segment, Brynn, this raises a really provocative question. Who's best position, and I hate to say own it, but I'm just going to phrase the question this way because I want to see how you answer it. Who's best positioned to own community-based palliative care in the future? Health systems, hospices, home health agencies, physician practices, payers, or maybe an entirely new group of entrants?

Brynn Bowman 1:24

Yeah. You're just asking the simple questions on a Friday afternoon, Chris. Thanks a lot.

Chris Comeaux 1:30

I didn't tell you I was going to ask you some tough ones.

Brynn Bowman 1:32

You know, this world looks different from all of those stakeholders' perspectives. If I am a payer, I am looking at who are my members who have the highest utilization and the highest cost. And I'm thinking about how do I get them efficiently deliver the right additional services to prevent unnecessary utilization. So I think when you look at that group, then who would get filtered into a net as being identified as patients who need palliative care are the highest spenders. I think as a field, um, we believe that more people than that need palliative care. Um, and it, you know, when we're thinking about the hospice agency looking at gaps in their community, for example, and understanding that they have the opportunity to fill those gaps with the home visiting palliative care program. Here's another question, I guess, long story short, where I think it's both and. Right now, all of those players are delivering palliative care, are evaluating where palliative care fits within the other suite of services available to patients, are trying to figure out who are the patients that benefit most from palliative care. What is the right level of service intensity for longitudinal palliative care delivery? And again, this is where I think, as a field, if we are able to converge on uh some consensus on those issues, it will help us to sort of standardize those conversations with our health systems, with uh insurance partners, um, with the other providers working in our communities or in our regions. So I think I guess no, I don't think we should be thinking in terms of ownership, except in terms of care quality, which we as a field should absolutely own. Um, you know, we should be leading the way there.

Chris Comeaux 3:25

I mean, I didn't tell I was going to ask you this, and I want you to push back if you disagree with that statement. And I'm gonna own I'm very biased because I've got 30 years now in hospice, palliative care less so because palliative care wasn't around when I started in hospice in 1995. But hospice, in my viewpoint, birthed palliative care, some of the interdisciplinary work, focusing on a care plan, amazing communication skills upon helping families think through care pathways and efficaciousness as far as the best um clinical treatments.

Brynn Bowman 3:59

Seeing the caregiver as part of the unit of care and as a care partner.

Chris Comeaux 4:04

The patient all of those things were started in hospice. We're still working on making hospicology, hospicology, but certainly here we are in 2026 a lot further than we were 40 years ago. And that hospicology, birth powderology. Does that feel accurate? Although I

do know that there are frontiers that then palliative care is a subspecialty, like for instance, formicotherapy, a lot more difficulty. We do a lot of deprescribing, but it's a lot more complicated because you're in concurrent care type situations. So I get that powder care itself then birth new frontiers. But would you push back on me kind of characterizing that hospice birth palliative

Hospice Versus Palliative Care Reality

Chris Comeaux 4:46

care?

Brynn Bowman 4:46

You know, we have a saying at CAPSI, all hospice is palliative, not all palliative is hospice. Um and some of these are real differences about, you know, unique clinical circumstances and priorities and patient goals at the end of life. And some of these are synthetic differences that were sort of carved out when the Medicare hospice benefit came online. Um, one of the things I think about there is a person with serious illness, if we think about their illness trajectory, you know, they don't go along for months or years with sort of a low level of need and then suddenly fall off a cliff and have a huge level of need. Occasionally, it depends upon every person's sort of clinical scenario. But right now we have this sort of wonky setup where we're able to provide, you know, palliative care at a much slower intensity than hospice. Um and then suddenly, because you know, because of uh the MHP parameters, and then if a person gives up their disease treatment, then they go on to this really rich, wonderful benefit that is hospice. And I think that's you know, all of these questions that we're asking sort of need to add up to how do we better figure out how to get the right dose of palliative care to people at the right time, in the right place, um, so that that can be a more seamless trajectory. Um that is meeting patients where they are.

Chris Comeaux 6:15

Yeah. And wasn't trying to create kind of a meaningless kind of debate, well, who created it? But it really wanted to set you up for this follow-up question, because most of our listeners are hospice

Are Hospices Getting Outflanked

Chris Comeaux 6:26

leaders. So for hospice organizations listening, is powd of care still a natural, I'll call it adjacency, or are many of these hospices programs at risk of being outflanked by organizations who maybe have better access to risk contracts, attribution, physician billing, data, capital, where the referral lives, all that sort of stuff. Because sometimes I do think we get a little stuck in that. Well, we we did create it. And and I do think there's some truth in that. I've never like makes me wonder back in how Diane talked about the early days. Do we trace our roots to Cicely Saunders? Not because we're wondering who found it, but there are some interesting fundamentals I think involved in that that I hope inform that future if we're indeed at risk. That's the real question behind the question.

Brynn Bowman 7:14

I mean, I'm such a firm believer that a community-based hospice agency knows its community well, knows its patients, knows the other people in the ecosystem who are providing care or services to their patients. And I think that can be a huge driver of positive outcomes from palliative care delivered by those community-based hospice agencies or home health agencies. Um, so I think that's really important. I do think um that, you know, the the further along we go, uh, the more that it requires investment in technology, in really, you know, beefing up infrastructure and operations to be able to capitalize on these new billing opportunities, on new contracting uh opportunities. And I I don't have to tell you that. That's the service that that TCN is providing your members of kind of help with those back-end services, which is a perfect example of this. But I do think, you know, it will require investing in those sort of capabilities, operational capabilities in order to take advantage of new.

Chris Comeaux 8:25

Which has been difficult. If we look through the rearview mirror of, you know, in some respects, hospice leaders have been kind of experts of bootstrapping stuff, especially the nonprofit kind of space. Um, you know, our many of our nonprofits, their communities invested millions of dollars via donations and bequests. And then we took those dollars and created Powell Care programs. In fact, I do have a for-profit friend who said, Look, you guys are obligated to do that. We have to pay taxes. You don't pay taxes. So you've kind of got this interesting fiduciary responsibility to your community to take those donor dollars and do these um more innovative upstream services, which gets to then my next question. And you kind of alluded to this earlier in the first segment. But palliative care, for years we've said, hey, palliative care creates tremendous value, bends the cost curve, paradoxically creates great patient satisfaction at a time that people are dealing with serious illness. But we just never had a reliable way to pay for it. So now we've got all these interesting new streams, ACOs, Medicare Advantage, Medicaid initiatives, value-based arrangements, maybe these future codings like the S codes, PCM, CCM, TCM, all those things. So we're finally reaching a point where the economics are catching up with

the clinical value. Two questions behind all that. I assume you would agree with all that. Like we're on the dawn of maybe a new age. Some people may come and go goody, profits to be made. Other people, I think, would go, finally, we have resources to take it to the next level. What are your thoughts about kind of that interesting crossroads that we might be at?

Payment Finally Catches Up

Brynn Bowman 9:58

I really agree with you that it feels like a new time. Um, there is a lot happening now, maybe a new phase of evolution in the field. There's a lot happening now that we were dreaming about five years ago, but it didn't seem realistically to be on the short-term horizon. Um the attention that that CMS is paying to palliative care and really thinking about, you know, how better to make it work. Um that we had California and now Hawaii and New Jersey um providing palliative care to to Medicaid beneficiaries. Again, that was a dream for a lot of years, and now it is happening, and other states are looking at it and trying to follow suit. Um, you know, those are vulnerable patients who have a high level of need, who are very soon going to have better access to care that they need. Um I, I think in general we're seeing kind of more widespread recognition that people with serious illness are a population that needs an added layer of support. Um, and we have, as you alluded to, just more data backing up that value case, more case examples of getting this done. So yeah, I do think um that the economics are starting to catch up. We're not there yet. Um, there's still a lot of work to be done. And that work is scattered across Medicare, Medicaid, payment contracts, you know, value-based payment arrangements. Um, and we need to be pushing on all of those fronts and doing education and looking for those replicable success factors, getting the word out to the field about how to make it work. But again, the threat here, I think, is that if we enter into payment contracts that are underpaid, that don't appropriately specify what specialty palliative care is, we risk not getting the outcomes that patients need. So that's a threat to sustainability long term. Um and so it's really an imperative that we figure this out. And I, I see CAPS lane here or call to action is exactly that. We we want to be synthesizing what is working in those payment contracts, how are back to the braiding, how are programs um braiding together, whether it's different billing codes and traditional Medicare, um and help uh figuring out what are the success factors in the that indication innovation and getting the word out, helping scale those solutions to programs nationally, just like what you're doing, Chris, with your members. So I think that the the national organizations right now, we need that field infrastructure, the sharing the innovation, the new program standards, tools and technical assistance on how to design and lead palliative care for sustainability. And we also need to be continuing to pursue clinical education so that we can build out a workforce that's

capable of providing that care. Um, but when I look back, um, these are good problems to have. And some of them are new problems because of new opportunities. Um, and and we're still on a growth trajectory.

Hospice Lessons Tech And Workforce

Chris Comeaux 13:02

You know, one of the things that occurs to me, again, I've got 30 years now, Brynn, in hospice and palliative care. And you probably have seen the the curve, the bell-shaped curve. It's used to illustrate many things, like even the life cycle of a human being, but industries have that bell-shaped curve. I now know in the rearview mirror that hospice is on the right side of the curve. In other words, our heyday of the reimbursement is now in the rear view mirror. I get the sense that you're on the precipice. Like the sweet spot is like the top part of the curve, the left side, the right, the right side. What would I go back and tell myself now that I know it's in the rearview mirror, what would we have done differently? Um, some of it, the technology wasn't there. So this almost feels like, my God, the timing is so good. Because what AI is potentially going to do with products that actually serve providers, as opposed to what EMRs have been, which is more of a pain in their rear end and creating friction with them providing care. So, what are some things I wish I would have gone back and told myself, we're in the heyday. What are those investments I wish we would have made that we'd have a better, we'd be in a better position today? And so off the top of my head, that's one is like we, we, I wish we could have made better technology investments. I don't know if really if we did, if we'd had better products, because some of it's just where it was in the life cycle. Um, might be an interesting thing for you to keep asking hospice leaders like me, going, hey, what would you guys wish you would have done 10, 15 years ago that would put you in a better position now? Those might be great lessons. Might be unfair to ask you that and more fair for you to ask me that, but I wonder if anything occurs to you framing it that way. I was going to turn around and say, well, and the technology is the first one. Workforce. Like, I wish we'd have doubled down on what I would now call hospicology. I cringe when people talk about hospice-like services. There's some amazing things in PACE as an innovation. It does have a lot of interesting things, quite like palliative care that you could say were informed from hospice like interdisciplinary work. But then when people say, well, only 2% of people get hospice who die on PACE, and that's a success because it's been a substitution competition. Part of where I'd like to debate that now was like, but do we know if those people are getting great end-of-life care? Do we really know? Or is it just, you know what, we save some money? That makes me cringe. So then I go, well, what would I wish we've gone back and done? And this is where the wonderful physicians, Dr. Janet Bull and Dr. John Morris, that I was privileged to work with, hospice and

palliative care certified physicians, CHPN certified nurses. And so that true meat on the bone that made hospicology, I kind of wish we'd done it at an even better level. So that's what I would pay for to you, which might feel affirming because I feel like that's exactly what you're trying to do in the palliative care side.

Brynn Bowman 15:52

Yeah, you know, one thing I think about it's an interesting discussion, Chris. One thing I think about is you know, 30 years palliative care was in its infancy. And folks like John Morris, um, who I've called a friend for a long time and lucky to do so, Diane Meyer, who founded CAVSI, you know, were the pioneers starting this starting the first palliative care programs and really starting to define what is the the model of care delivery for palliative care in the hospital for the most part at that time. And in order to build out a specialty and a field, you know, there had to be a lot of defining here is what we are, here is what we aren't, um, you know, achieving uh specialty certification across professions, uh, building up the research portfolio, you know, to build the evidence base for palliative care, refining the science, um, and really to say this is this is how we are different and unique from the rest of healthcare. Um, and I think now, maybe to synthesize what you're saying about substitution competition and the Wild West and all of these players out there, we may have to be nimble and we may have to be flexible to continue to sort of leverage the growing attention and focus on the population of people with serious illness, while not being so rigid that we miss opportunities to get paid to be serving patients that really need our help. And I'm thinking specifically, for example, of there's a large population of homebound or mostly homebound older adults with serious illness, and a lot of experimentation is happening on how best to meet those people's primary care needs and palliative care needs in the home. And I think more and more competitive community-based palliative care programs are going to be asked to, or maybe even expected to, also take on some primary care responsibilities. Um and I worry because as a field, I think we have a long history of being asked to do more with less. Um and and and what I hope is that you know, we have a culture of receptivity to this evolution and this change. Because if we're going to be held accountable for patient outcomes, that may be what it takes. Because if not us, then who if we are in the home with those patients? Um and so and so I guess what I you know what I mean is there is a sort of need to assert what quality looks like, define minimum standards for our healed. I do think another regret, I wish we'd done that five years ago. Um, but we're doing it now, and and that's the next best thing. Um, but then I think balancing against the flexibility to be where we need to be and sort of meet meet the needs of patients and of pairs um in order to, you know, be able to deliver quality care. So I think it's a it's a balancing act.

[Stop Doing More With Less](#)

Brynn Bowman 18:56

Um and I don't know, I'm curious. I'll turn the tables on you. What does that spark for you?

Chris Comeaux 19:01

I'm so glad you turned the tables on me because I'm like sitting here. I love doing this podcast because when I do get answers to questions that I'm searching for, but sometimes the biggest gifts are the questions I walk away with. And this is a question I think I'm gonna walk away with, and maybe it'll be a gift to you in the same way, that I could look back and now um and go, you know what? One of the things that I thought was awesome, John and Janet, we were innovators. Like doing palliative care when we did, we were innovators. But also we said yes to too much. And if you become all things to all people, and you don't backstop it with palliative careology, hospicology, and also quality measures, although I got to give Janet Bull uh credit because she was one of the key people, what was QDAC and um like trying to get a quality standard, and she was very visionary in that. I wish we'd have doubled down on that even more so. And I do think is especially the people I've grown up with in the hospice, because we have such beautiful hearts, and business is not exactly our first competency, we say yes to too much. And then you get spread thin across too many initiatives, and then maybe you don't do everything well. And that's probably my quick answer of like cautionary tell, if I could go back in a time capsule and tell myself what I know today. But by the same token, is like, well, wait a minute, Chris, are you saying that? Because I could totally see, Bryn, that this gravitational pull, like I remember when we said, okay, palliative care is more of a consulting practice. Now it's becoming more of a co-management practice. And then if you're going further upstream with some type of um amalgamation of that co-management with primary care, we did a great podcast with Dr. Bethany Snyder about what is a for elderly practice, which is starting to kind of define that kind of smushing together. And then that even makes that complexity even more so. I mean, running a great palliative care program is hard enough. Then you start going further upstream. Now you got more medical complexity, um, which makes new competencies for perhaps the field, systems and processes that have to come along with that. And so I guess my cautionary tells you flip the tables on me is I think you got to innovate, but you also have to be careful. Last year, every year as a CEO, I feel like my goal is to have a theme that kind of sets the prioritization for the year. And I had a head scratcher of a term that many staff were like, what the hell does that mean? But the term was maintain innovation. And I actually got it from um a podcast I had listened to. And it was kind of speaking out of both sides of the mouth of going deep on what is is not sexy. More often than not, it's not, it's not. That's the maintain innovation. But it's also poking on the fact that we have to keep improving and do some innovative

things. But sometimes we chase the shiny and we don't go deep on what is. And that's probably my way of reconciling this tension. But I'm gonna walk away and keep thinking about it because I have a feeling it's gonna be my challenge, but probably your. As well. Does that resonate?

Brynn Bowman 22:01

Absolutely. And I want to uh underscore as hard as I can something you just said, which is no, we should not continue to do more with less. That is, I mean, uh setting aside how difficult that is for our teams and unsustainable that is, that's not gonna i i if we're spread too thin, we can't provide quality care. Um, so what are we doing? And if by developing new competencies and capacities we can be a more attractive partner to our health systems, to partners who can provide for our services, you know, there may be opportunities there. And I don't know, I sit with this question too. Um it's a difficult one, but it is raised often enough, you know, in my conversations with organizations around the country that I think it's one that we're gonna be sitting with for a long time and thinking through what's feasible, what's appropriate?

Chris Comeaux 22:57

Are you guys already building out because you've always been such the education, just elites, building out those amazing educational competencies that have created this field of palliative care as a subspecialty? Are you already doing some things around that home-based primary care space that are kind of leading educational modules, et cetera? Or is that like a high priority right now?

[Home-Based Primary Care Crossroads](#)

Brynn Bowman 23:18

We're very much in listen and learn mode right now. Um, we just posted a synthesis of the literature um on organizations providing both home-based primary and home-based palliative care. And um, there isn't a ton of literature right now, and there are a ton of models. You know, again, there's creativity happening, there's innovation happening. Um, but what we're trying to understand is how is it is it working? How is it working? Um, you know, how is it paid for? What do we know about outcomes for patients? You know, is this feasible and and and how? Um so listen and learn mode. Um and I think we'll keep sharing what we learn back to the field to keep this this conversation going.

Chris Comeaux 24:05

I didn't tell you I was gonna ask you this one, but as I think about like, you know, sometimes they're foundational questions that build on. Palliative care has got such great

literature of the cost savings. Because going into value-based care attribution is such a core domino, it's almost like the like I gotta stake that claim because if I have attribution, then I potentially control maybe where the cost savings go, et cetera. Is that part of the thought process that may settle this for Palliative Care? Or is that an unfair question because there's so many other things like the S codes, et cetera, that that may make palliative care feasible?

Brynn Bowman 24:40

Yeah, I think I'm gonna go back to it, and maybe this is cheating, but I think I'm gonna go back to the the answer of sort of both we are we need um I think we need better, more standard standardized formula for how to make this work if we're contracting with plans or with ACOs. Um, I think we need to get really smart about how to use the codes we have and that are better than a few years ago. Um as we're pushing for, you know, new payments to open up inside of Medicare. And then the third thing that I'm really uh that we're watching closely that makes me pretty excited is looking at state action. There's so many strong state advocacy coalitions or associations that are really partnering with with health policymakers in their states and evaluating, you know, what is the impact of unmet need on Medicaid beneficiaries or dual eligible benefit beneficiaries. Um and and the palliative care value proposition makes a ton of sense. Um so it's all that's actually a very fair answer.

Chris Comeaux 25:52

That's a fair answer. Let me think of a, I just thought of a different way to ask you the question. By the way, you're doing awesome because I didn't tell you I was gonna ask you these, and these are really tough questions. And so, like I'm thinking of that kind of journey that we've made from consulting practice to co-management practice. Maybe this is the crux question. Is palliative care competencies and some leading age new competencies around the primary care competencies, does that mean that you should be the quarterback of the team? Because co-management, just think of what the term means. And I do think we do an amazing job from a co-management standpoint. Attribution is kind of like the quarterback of the team, saying this is the person attributed to the primary amount of the care, or at least it's what it should mean. Quite often it's more of a financial definition. But I think for really where the puck is going for value-based care, it's who's best situated to be the quarterback of the team is that palliative competences.

[Accountability Attribution And The Quarterback](#)

Brynn Bowman 26:46

Right. Who's well, at the end of the day, who's taking accountability um for outcomes and for total costs of care?

Chris Comeaux 26:53

And you you're actually I love how you flip that because in some respects, right, it is first in accountability. Second, then if you're gonna accept accountability, you better not do that if you don't know what the hell you're doing.

Brynn Bowman 27:03

Well, and we've been put through our paces in the last bunch of years. You know, all of the leaders like Bethany Snider, um, who have been sort of chipping away at this equation of what constitutes the right, you know, contract elements and payments that allows for the type of care delivery that achieves the outcomes you need. I just keep, you know, I'm uh keep repeating myself here. But I, you know, I think it's interesting. We have a you and I both know, we have a landscape of a lot of big players who are coming in and saying, we we will care for this patient in their home and we will we will take care of what ails them, um, and we will keep them out of the hospital. Um you know, and we don't always know what how well that's going, and we we don't always have perfect visibility into that. But I think that's the reality that that's what's happening because this is a a population of patients with really high needs and high health care costs. And so that's that's the mix that we're swimming in. Um and so I think as our you know smaller organizations, um, as our palliative care programs are thinking about how to be viable, be sustainable, we just we need to be clear-eyed um about that about that landscape.

Chris Comeaux 28:21

How's that? So good. That's great. You're doing great because I've really thrown some tough ones at you. Because I'm thinking of like, these are great questions. I'm not sure how in the heck I would answer.

Brynn Bowman 28:31

There's no perfect answers. That's the problem.

Chris Comeaux 28:33

But those are the great questions, right? Because then you keep wrestling with them, and that will then guide us to navigating this really interesting future that we're in.

Brynn Bowman 28:40

So because I've been so well, and we've been in this world for a couple of years now, you know. I mean, um, all of the dynamics that I that I just talked about have been in place for for a little bit, and yet we do see have successful examples in our field of navigating all of

that, achieving viable contracts, or braiding it together through billing. You know, they're those making it work. So there's there's there's a viable path there, and we better all be beefing up our skills and how to how to continue to to play in this environment, which is tough and crowded and you know, and unfortunately too much rule by profit

Three Bets Leaders Should Make

Brynn Bowman 29:20

motive.

Chris Comeaux 29:20

Well, good, good segue to last couple of questions I have for you. So these a lot of the leaders listening, many of them are hospice people. We do have some health system people, people that are in palliative care serious illness programs. So, what do you think are two or three bets they should be making right now to be relevant for however palliative care is going to play out over the next five years?

Brynn Bowman 29:41

Yeah, so I guess uh three things come to mind. Um, it and and I've mentioned that, but I really think exploring what it takes or what the investment is around better and better technology and infrastructure that helps a a hospice unlock some of these new opportunities for payment um and therefore for quality, you know, those barriers are really real. You've set it to the operational barriers, but I don't I think it's going to become more important, not less important. Um, so I think really sort of investing in in thinking how to take those leaps. Um we talked about scope um and sort of what's happening vis-a-vis primary care in the home and palliative care in the home. Um so I think that's something, again, where consideration needs to be paid for what are the needs of the patients in your community, um, who else is is um is meeting those needs and and where are the gaps. Um and then number three, I'll say it again. You're gonna hear in a month about CAPSI's program inventory. Please, I really think we'll be all helped by having these national data about palliative care access and palliative care gaps. This is gonna help the field's advocacy efforts. Um so please consider it's gonna take just a few minutes, but please consider um participating in the program inventory. Um because I think we'll be we'll be able to make hay with that data in a way that is that is down the road beneficial to all of the community-based palliative care programs.

Chris Comeaux 31:18

Awesome. All right. Last question for you, and then I'll let you in your final thoughts.

Medicare Benefit Yes And Yes

Chris Comeaux 31:23

Does America ultimately need a defined Medicare palliative care benefit? Or would creating one actually constrain the innovation we're beginning to see and need to see?

Brynn Bowman 31:33

Yes, and yes, obviously. Americans need to consistently have access to palliative care. They need to not be like um whether a benefit is the pathway to that, you know, I I really don't know. Um I think this is where we can and should be learning from states who are leading the way. So we talked about SB 1004 and California, now Hawaii and New Jersey are implementing their palliative care benefits. Um and as those states implement, I think we have a lot to learn from about building capacity in the state to deliver care under a benefit. For right now, for example, there are a lot of clinicians being trained in care skills in the state of New Jersey, which is wonderful. And you know, but, but building up that capacity is key. Um, we will be learning very soon about a lot of operational considerations for implementing a benefit, billing to workflows, to patient awareness and engagement. Um I think right now at CAPSE, we're looking at the states, um, you know, working with them to understand the lessons that they're learning in real time. Um and thinking about what are the lessons, whether it's a benefit, whether it's some kind of bundle payment, um, or whatever else that we can we can take to the rest of the country.

Chris Comeaux 32:58

Well, thanks, Brynn. Well, what final thoughts do

Optimism Education Demand And Closing

Chris Comeaux 33:01

you have?

Brynn Bowman 33:01

So I think my final we've covered a lot of ground here today. And so I guess my my sort of summary thought is holy cow, there's a lot happening. Um one thing that we haven't mentioned um because we had too much else to talk about is um interest in attention from demand from other sort of referring specialties for palliative care education, um, for better guidance on how to integrate specialty palliative care services or collaborate with palliative care specialists. So I think I first person to say there are a ton of challenges to solve. Um, and and there's a long road ahead. And it just really feels to me like uh there

have been so many positive indicators of the last five years that should give our field a lot of, you know, optimism and energy that we're working in the right direction.

Chris Comeaux 33:57

That's very well said. You know, something occurred to me. We uh we've done a couple podcasts with Dr. Byock, and you think of Dr. Byock, Dr. Meier. And so one of the things that Dr. Bayok said is I remember the day we were sitting around the fire and the very embryonic stage of the benefit, dreaming up a day there would be textbooks, there would be an academy, and all those things that now we've kind of benefited from. And I love it, it was kind of cool because you could see him reminiscing over like the last 30 years plus of his career. But then I think about you and I, because we were privileged to be alongside the Janet Bulls, the Dr. Diane Meiers. And what will they say about you and I? Like, we do have these challenges, and we're at this amazing crossroads. I don't know if I'd want to be anywhere else. And yet there are these challenges. I don't know if you if that feels very true to you, and what will they say about the work that we've done when we reflect back 30 years, 20 years from now?

Brynn Bowman 34:54

You can't, first of all, I I know about the campfire, and oh my gosh, can you imagine being a fly-in-the-wall or an ant on the log? Um, and the number of times that I've asked Diane Meier, you know, tell me what it was like in the early days when you're looking at a blank piece of paper and building a field. I mean, the guts that that took, the strategy that that took, the leadership that that took, and the conviction over time that this crazy big swing was worth taking. So I think, right, you and I have have different challenges today. It is different taking a house that is built, keeping the lights on and adding another wing than it was from, you know, starting by putting up the studs. And oh my gosh, it's exciting because it does still feel like things are moving, things are changing. Um and getting from, you know, B to C can't be harder than getting from A to B was. I just I, I think here we go. Keep up the momentum.

Chris Comeaux 35:54

Well, well, thank you for the work you guys are doing. I look forward to us collaborating. Um, you guys are doing great work. I look forward to us doing great work together.

Brynn Bowman 36:03

All right. Thanks so much for having me, Chris. What a great conversation.

Chris Comeaux 36:06

Yeah, I truly agree. This is this is everything I was expecting, and even more. So, again, appreciate you. Tell your team we how much we appreciate the work that you guys are

doing. And to our listeners, we appreciate you. You know, at the end of each episode, we'll always share a quote, a visual. The idea is to create a Brain Bookmark, a thought prodger about our podcast subject to further your learning and your growth, and thereby it sticks. We're looking for like a brain tattoo. Be sure to subscribe to our channel, TCN Talks and Anatomy of Leadership. We don't want you to miss an episode. I'm gonna ask Brynn any links that she wants to include. We're gonna include those in the show notes as well. There'll be a link to my book, The Anatomy of Leadership. You know, it's easy for us to reel against the world and be frustrated by things. Let's be the change that we wish to see in the world. So thanks for listening to TCN Talks / Anatomy of Leadership. And here's our Brain Bookmark to close today's show.

Jeff Haffner 36:54

"We should not be thinking in terms of ownership except in terms of care quality, which we as a field should absolutely own. We need to be absolutely confident in our expertise and also pragmatic about how to give the best care to the most people." — by Brynn Bowman