PSW Oral History Interview with June Simmons 2025

Mei Kameda (00:00)

I don't think we've actually met and talked, but I've seen you and I know of you. And I'm hoping that our interview can be more like a conversation like you and I are sitting on a nice comfy couch and drinking our coffees and having a conversation.

To introduce myself, my name is Mei Kameda and I'm currently a palliative care and hospice social worker serving on the advisory council for the project led by Vickie Leff and Terry Altilio called Palliative Care Oral History Project. And today I have the honor to talk with June Simmons, who is someone that I've known of for many years before I even graduated from undergrad in health education prior to my current career in geriatrics and palliative care and hospice care. So, June, would you introduce yourself to everyone who's listening?

June Simmons (01:05)

Hi, I'm June Simmons. I am currently the founding chair of Partners in Care Foundation, a nonprofit in Southern California. It's a long history with these issues of home and palliative care and late life care from my early years at Huntington Hospital in Pasadena at the Visiting Nurse Association of Los Angeles and then later here at Partners in Care. So, I'm delighted to see you lifting up this history and I see you have many pioneers that are very foundational to the field. I'm glad to also have a chance to comment on the record.

Mei Kameda (01:50)

Thank you. One thing that I wanted to ask is when you were first hired at Huntington Hospital, you were told do something with older adults, do something with geriatrics. And I'm wondering how did that request settle for you when you first heard that request at the hospital as a social worker or just newly going into work in the medical field?

June Simmons (02:15)

Actually, I was hired at the hospital because Joint Commission said they had to have an MSW and they didn't have a social work department. They just had the patient charitable funds, and they were looking for someone affordable and manageable. I was early in my

career post MSW, I was just about maybe two years out. And so, I was delighted to take a tabula rasa, a hospital that had no social work, and see if there would be a way to encourage them that it had value and to get them to know how to deploy it. So, the introduction of aging services as a specialty came much later for me as the evidence of the demographic shift we're now really seeing, obviously, began to be more clear. But that was actually in the 80s. And I was pleased to encourage the hospital to then adventure on a model that eventually was called Senior Care Network. But before that, we began to address issues of late life care and the gaps in the system that existed there.

This is before there was a hospice. This is before Kubler-Ross was recognized So I've been at this a while, let's say. So we've made a lot of progress, just so you know, in those years when death was not a thing. That time, think people actually didn't die. It was a big surprise when they did. And we had very few supports around it or before it and much less choice than we see now.

Mei Kameda (03:54)

I'm wondering when you brought up, when you're developing Senior Care Network and bringing end of life care topic to the forefront of the healthcare setting, how did others react to that?

June Simmons (04:07)

That's a good question. At the time in healthcare, when someone died in the hospital, very often they, if you'll pardon the expression, they put them in a bag and they didn't really have a way for the family to say goodbye, to spend time with the deceased. So, we were able, without much resistance that I remember, to persuade them to commit a viewing room down near the emergency room and to be able to begin to have a protocol where people would be able to spend time with the person they lost and properly say goodbye, see them. These are, as you know, important pieces of families coming to grips with these losses, whether they're sudden or expected.

So, I think the resistance to hospice came later; the openness to trying to provide a better, more supportive pathway as long as social work did it, it was okay. Even for neonatology, which was later developed as a service, those parents had no way to spend time with their infant if they lost them. So, the social workers would transport the infant to the viewing room and spend time with family; that was just new, but it wasn't resisted. I would say, as you probably have seen in the history, the hospice as a benefit took years to come. But

even before that, the idea of hospice, it was a volunteer hospice that was founded in our community. I was on that board. That was all done out of love and kind spirit and considered a nice augmentation to real health care, as they would have phrased it.

Mei Kameda (06:01)

It's really refreshing to hear that social worker played a really integral role in providing compassionate and sensitive care. And I, often, see challenges in healthcare of trying to meet metrics and numbers. And it is really refreshing to see (that) and hear that doing something kind and compassionate to grieving families was something that that was really at the forefront at that time.

June Simmons (06:36)

You very often need a physician voice that opens the gate for an intervention. There are always some champions of this kind of work. And so, we had benefit of that there. And then we had experiences like a famous and highly regarded, but not very gentle surgeon who thought he didn't, because we then introduced social work into the emergency room. And if somebody was really at risk of dying or getting terrible news, a social worker had created an office, again, a separate private space, with support from certain physician leaders in the emergency room, and they would prepare and stay with family. And this physician had a patient who was dying and said, “I don’t need you people”, and went in and just delivered the news. And the family began to scream, pound their head against a wall, and throw up.

And the physician learned a lesson and events like that really helped to demonstrate the value of helping people prepare themselves to walk through an unexpected, difficult, very painful, disruptive experience. And to have some support doesn't take forever, doesn't take, you know, but it takes some special measures in order to help people successfully navigate that and to have their health providers not be hated, abused, sued or otherwise punished for failing to understand what people need to win in a tough situation.

Sometimes really terrible things can open a door. If things are bad enough, it can give you an opportunity to demonstrate a problem in a more obvious manner. So, this was useful that way. Hospice came later, palliative care came, I think, after hospice was so resisted as it still is, not fully understood or utilized.

Mei Kameda (08:40)

In your personal experience, what has been a major challenge that you faced as a social worker going into this field of geriatric end of life care, hospice and palliative care?

June Simmons (08:56)

Well, that initially it was not reimbursed. Now there are some ways to cover the cost of people's time to deliver supportive service to a person, or a family does take professional time and that time is not free. So, you do need a way to have a sustainable funding base in order to have the organization not just say, let's see what things we're going to be nice about and generous about and subsidize those. It should be built in the delivery system. So that's a big change. So, I think those are important forces to understand - an economic model that can be a win-win to help everyone adopt some of these discoveries we learn about - what are better ways to care for people. And then have people then move through the health experience and recovering from it more successfully. but it has to be a win-win. So, we spend a lot of time looking for cost benefit to the system. We want the hospital to do things for people around these other needs. We need to see. So sometimes it wasn't reimbursement. Sometimes it was reducing the , bad press of someone be feeling hurt or injured, or in some extreme cases, people suing, bringing expensive solutions to what should be a human interaction. Sometimes it's philanthropy to demonstrate case. Nowadays, it's partly organizations, medical organizations are judged by scores on quality of care on certain measures. And if you can impact those, you know, if you look now at the star rating for Medicare Advantage plans, if they succeed with a score of four stars, they get a 5 % full reimbursement bonus. As an organization, that is gigantic. That is a significant difference for anybody. If you got a 5 % raise, you'd go like, oh, nice. That's noticeable. So, you get it across a whole system of care. It's big. So, these are all ways of calculating how do we really make it practical so we can do the right thing? I hate to say it's a good business, but it has to also be good business. It can't be self-sacrifice. Even you don't want to work for free. like having a salary, and so do I. So how do we make it so these things are really able to be provided and sustained? A big debate in modern America.

Mei Kameda (11:39)

Now you make a really good point. I remember when I was in school, we were talking that one of our policy professor was telling us about how social workers need to know the economic model. We need to know the system. We can't shy away from that because we're nervous about it or, let me just do my job. But the one way to really advocate for our

clients and our patient and our community is to be aware about how to be smart with the delivery system to provide that compassionate human care.

June Simmons (12:13)

Yes Because people running that system are people too. You know, we would really like to enhance life quality for all people. We would not like to rip one off so we can help another. So, I think being able to work through and often, you know, we're certainly not trained in school. That took me a long time to realize if I had a social worker in the ICU waiting room helping people bring their card, their insurance card in so the bill could be paid, or helping them apply for Medicaid, then I was reducing the accounts receivable and bad debt for the hospital. And that is a meaningful economic outcome for that institution, which we all want the hospital or the medical practice to be strong and stable and able to have the resources it needs. So, you learn as you go, or you learn from others. We're all still learning right now. There's new ways to bill Medicare for social work.

And so we're building out tools so social workers can learn those so that we can bring these kinds of services. I saw you had Judy Peres as an interviewee. And she had a whole practice that supported people around issues of aging and late life care and death and dying. Because she could bill as a social worker, because she couldn't give up , economic safety for her family and she could do good, do well by doing good. Very important. Money, a form of mental health rescue. We don’t want greed, we don't want corruption, but we do need economic safety and sufficiency for everybody in the system, including us.

Mei Kameda (13:53)

Absolutely. And I think it really does uplift our profession when we have economic value and interventions in the work that we do, Then, you know, we don't need social work. We can just go with volunteers. There's the reason why we have social work profession and skills, clinical skills. Yeah, definitely.

June Simmons (14:13)

Yeah, we even, for instance, one of our arguments was, and there was evidence for it, having social work in the emergency room team helps make the other professionals , more efficient, but nowadays also helps prevent and reduce burnout because we see so

many rough things. So yeah, there are many ways to think about the value proposition that what we want to see adopted will bring so that it is a shared success on the part of all. So that's a very respectful model. It's an easier way to ask, but you get less resistance also. And if you're coming in saying, could we co-design this together? How can we make this work broadly so everyone gets as much of what they need as possible?

Vickie Leff (15:04)

June, I'm going to jump in and ask you something about that. Knowing that the field has not always had a long history of robust research in this arena to be able to deliver to the C-suite - this is the value proposition. How were you able to make that case when there wasn't always the kind of data that we would have loved to have had for lots of different reasons? It's hard to capture some of that value in an analysis. How did you manage that?

June Simmons (15:40)

Yeah, research takes a long time. No, your point is well taken. Sometimes it's a story or like the situation in the ER with the doctor where everything went nuts and they went, maybe this is a bad way to do it. That's expensive when you have a situation like that for everybody, including that guy who maybe gets fewer referrals for surgery, who knows what, you know. So, data's critical, we live in the age of measurement now, but it's still hard sometimes. Health plans either don't have access to their own data or don't share it. So, but you want as much hard measurement; was just on a webinar where they were showing how they worked, health care and social work together, and looked at what difference did the intervention make from a various perspectives. And everybody wants to know - how are we most effective? So, it's not all research as such. Some of it's analytics, metrics. We were just approached by McKenzie, and they would like to work with our agency to see the impact of community health workers and community care hubs as a delivery system for social care for complex populations with many social care challenges that impact their health outcomes and therefore the cost of their care. Can we get a total cost of care through our interventions and we improve it?

So here we have someone like Mackenzie who has an institute, and they would like to ask this question. So, we go great because they can ask it. I don't really have the resources as you say to just do it and when they report it, it's like I said, well, should have a physician speak in certain settings. If a McKenzie speaks, it will be much more credible than June said. We did this and we think X. So, I think partnerships and using the amazing technology that's emerging, sweeping all of us, these are all important tools. Building

metrics into how we practice, that's the ideal way, figuring out what you need to ask and see what your result was.

Mei Kameda (17:56)

In a way also knowing your audience, And when you present.

June Simmons (18:00)

What do they care about? That's right. Yeah, it's like listening to another human being who's trying to do something and seeing where you might be better together than apart. This is what the actually the CEO at the hospital and I asked him, how do you work with those physicians? And he said, “I help them see that we are better together than apart”. And I think that's a nice rule for living. It's finding ways of mutual benefit. They're not enough for some hard changes, but they're powerful for many. They align nicely with our character. It's easier as a social worker, instead of saying, I want some money, to go in and figure out a way to enhance the system that's to everyone's benefit and to look at how to document that and make sure it's true. So, good questions.

Yeah, I'm probably speaking differently than maybe you were expecting, but important to see how this is of value in each of the sectors that are impacted.

Mei Kameda (19:07)

I'm really glad that you brought that up because the sense that I get, not for everyone, sometimes in our medical systems, we're all really siloed, Like the doctors do their own thing, nurses do their own thing, social workers. And it's rare that you see integrative, interprofessional delivery of care. And you said it spot on how important it is to outcomes when we do together collaboratively, right? With each of our strengths coming in.

June Simmons (19:39)

We can say, wow, look what happened with that family. Could we all think how else this could be done and what would work? What would make sense? So, I think a question is

almost better than a recommendation if you have a question that matters to the other people. So, you have to see, OK, something's going. There's always something going wrong. Wherever you are, it's a good solution to yesterday's problem. I think that it's always good to search for the shared need for change whenever you can. can't always find out, but often, if you ask yourself that, you might have a better shot at finding it.

Mei Kameda (20:26)

What really motivated you to kind of get started through this going through these challenges and accomplishment, what really truly motivated you in this whole process?

June Simmons (20:38)

Well, I started because I had to, in my role at the hospital, I had to help people select a nursing home, often for their spouse, and then the other spouse was going to be bankrupted. I have to say I didn't find that very uplifting yet how do you find the nursing home when really it's just a financial matter. A lot of times what people need is food and personal care and safety. It's not the medical care. And they're in the medical setting as Medicaid will pay for it. So that's most of my career and then Kubler-Ross came along. And I always remember she had an illustration of a small person with a tank coming and a stop sign being held up by the small person and really bringing to life what, how universal death is and how it impacts people in anticipation in the fact and after the fact and grieving and, Dame Saunders from England and that whole move to bring a different kind of environment to this inevitable point in life and then seeing, you know, it's a terrible thing to say. We used to call it assault and battery care where sometimes health care just doesn't know when to stop and they just keep saying, isn't there more we can do? And they say, well, we'll try this, we'll try this. Sometimes, you know, what we found for palliative care was it's the informed consent. It's the people actually getting information about what their choices are. We did all this research with Kaiser in the last year of life and found if the team could gain the trust, the person and their family, and they could have a meaningful conversation, the nature of care changed. The people, the family and the care team had a much better experience, and it dropped the cost of care in the last year of life by 30%.

Okay, that's a perfect example. Then Kaiser was able, in light of that, which they'd invested a lot in the research, we were just assisting with the physician and nurse leadership and social work role there too, as research supporters. They adopted that home palliative care

as a benefit. They're like, that's a bucket list in my career. That's a dream come true. You know that now you've found something and it scales because the case was so clear. And it was everyone winning, you can hear my same formula, terrible suffering, probably on the part of all, and finding a shared solution together that's better for all and sustainable. These things are really important design elements as we're still working for change. People still go to hospice three days. I have a dear friend whose best friend just went into hospice and it's the same thing where people resist. They don't wanna stop. I'm not ready to go. that's real. You have to respect that. But they should know you have this treatment. This is what's going to happen and this is what you're going to get. This much more for all that suffering and do you want that? And then people can choose. They make pretty good choices.

Mei Kameda (24:07)

Yeah, so giving different pathways so they have all the information and giving that human being the option to make what is an acceptable quality of life for them, given these different options that were presented.

June Simmons (24:19)

You know, all the human beings around hospice decisions have various concerns and considerations.. And that's one of the roles social work can play so well because you're not going to give them the pain meds or the procedure. You're not going to save their life. You can be the platform for a thoughtful consideration and a chance to bring forward the feelings. Maybe the medical team does or doesn't have time to listen. Some nurses will, some doctors will, but social work can and bring in other resources and supports as well. But I think that conversation process is really classic social work in my mind.

Mei Kameda (25:03)

And when I was reflecting about - thinking about how you were responding, it made me think about back in 2015, that was, there was a publishing that happened Dying in America and proving yes..

June Simmons (25:18)

Yes I was on that panel. ran and got it. said, we're going to have this. Better see - when was that and pulled it off the shelf. Yes, that was a great experience. Very interesting. It was the second such inquiry from the Institute of Medicine. So a lot of work because that certainly, especially at the time, was a major policymaker to try to influence Congress to change the way our health benefits are structured. So, it did make some progress, I guess. It had a long hard time. It was supposed to end in a year, and there were issues of consensus that took a while to resolve and be able to bring it to a successful consensus-approved publication. So, it's interesting, all the researchers, I'm not a researcher, all the academics, the medical practitioners all sitting at the table. So was, you know, very important and intimidating and inspiring experience; one I valued a great deal and these things still do have value. I think this quite a big tome. I thought, I forgot how big it was. And then the job was to try to go out and speak about it, spread the word about this resource and get it adopted. In those days, we didn't have all this Zoom and webinars and all the kinds of methods we have now. We had to show up, talk about it, still good. So, the more you want to know about that, think it was Judy Peres was on that group as well.

Mei Kameda (27:04)

I'm wondering, when I speak with other social work colleagues, they feel very intimidated being in a committee, a larger project with different professionals. And I'm wondering, how, how did that feel for you being in several committees and board and how helped you? How did you feel about being in that setting? how did you kind of integrate yourself into the work that you were involved in?

June Simmons (27:26)

Well, that was 10 years ago. I'm older. So, I do think that one gains. I think that still it's intimidating to be with people with such different credentials and expertise in a setting that really values the research, the science, and the academic capabilities. So, I was perhaps one of the lesser skilled members honored to be chosen, but social work had to have a place at that table. So yeah, I don't know if I did a good enough job of being a social work voice along with Judy Peres, but yeah, I would say those are intimidating things. Now, when you're there, you're there for a couple days, you know, so you have a chance over coffee before the meeting starts and over lunch and over dinner. So, if speaking in the arena is pretty hard there, you can work around the edges of almost any human project, ask questions, bring observations, raise concerns, see if there's somebody you trust.

could say, what do you think if I said this, it would work out? You have to kind of work as a person.

And now I think I am just old enough. I've just tried in a thoughtful and respectful way to just say what I have to say. I feel a little bolder. The world has leveled everybody to some degree, I guess, now. So, it might just be a little easier now. I notice if I go to some gathering with people with fancier accomplishments than mine. I just go as a person. I just participate. So, I think that's ideal if you can, because really we each have different things we bring. They're all good. And if the other guy doesn't value it, well. Nothing ventured, nothing gained, you know? So, and it takes a lot of repetition to make our point sometimes. We should not be above repeating ourselves.

Mei Kameda (29:40)

Being comfortable with repeating ourselves and hoping that it will land somewhere sometime.

June Simmons (29:48)

Well, you know if you do counsel people, you realize in that setting you have a more accurate perception. In the work setting, I think, I'll give them the facts and that'll be that. The fact is, this is all behavior change, identity change, perception change. And just like in the therapy room or the counseling room or a discussion with a best friend. It has to evolve. You have to simply discover what are the barriers in someone's perception? What are their objections? I'm sort of well-known for saying no just means it's a much longer discussion than I was planning on. But what I mean by that is that if you bring something and someone goes, yeah, there, there, dear, we're not doing that, then you need to understand why because you'd think you have a point, but they have something real. It's in the way. Whatever it is, if we can't address it, we can't move forward. So, I think it's very important to have extended conversations in the interest of change, whether it's getting a person to take their meds, getting someone to move around and exercise because it's such a primary health driver, whether it's getting someone to treat other people differently, but whatever it is, it's all behavior change. We like to say when we're trying to get system change, make me change my workflow and I'll have to kill you. Because we see all this resistance to changing in the system for even good things. It's just deep. It's very human. So I think if we really are respectful of that, it's just a human reality. And the people often

have particularly understandable, whether we agree or not, have understandable reasons why they're a barrier to change. So, you gotta go there and hang out. I guess maybe not have a beer. That might be a way, but you know, coffee at least to make these mutually respectful efforts to evolve forward. My father used to say progress are most important product. So it's not like here, there, it's moving along together over time. Sometimes like therapy, two steps forward, one step back, you know. Sometimes one step forward, two steps back. But it's the nature of change for human beings. It takes quite a bit to achieve for oneself and with others.

Mei Kameda (32:29)

I think it just shows how complex humans are and have been for many years. And also important for us social workers to recognize that we're humans too, right? That we have our own process and progress and perception and to really keep that in mind when we're delivering the care that we are.

June Simmons (33:00)

Really important. Yeah, and people who like - CEO of the hospital or, you know, a fancy doctor or rich or something that we might find intimidating, that's still a person. And, you know, it'd be good if we can find a way to make a relationship and not, you know, some people look at people we care for as good and people who have power as maybe not so good or they're not as respectful or kind. I feel like, let's just be equitable. They're all people and they all have reasons for who they are, how they are, what they are. If you want to work with them, you have to try to get it. Some change, some can't, you know. But I feel that respect ought to be a universal commodity that we could...Spend with ease.

Mei Kameda (33:56)

What else would you like for people to know about the legacy of specialty of palliative care in hospice?

June Simmons (34:07)

That it's really made good progress and needs to be furthered. Certainly in the hospice, I do not see that the social work role is equally well developed in all settings. And so these,

maybe all of the hospice model, once it got paid for, began to have some compromises now, you know, under President Reagan, we put healthcare in for-profit as well as non-profit. And I was just reading, this week that they did a study of for-profit and non-profit hospices and the for-profits appeared to spend less money on care and to be more profitable and less generous in their care. I don't know if it's true. But if it is, you'd say, well, then maybe that's something to look at. These are dynamics, the dynamics of venture capital and profit in our nation at this moment seem extremely powerful. And I'm hopeful that we will come through this and realize it - after you have enough money, it's probably good enough. It's hard always to say how much is enough it's good to do so. I feel these are remaining challenges. And even if you got it just right, I used to think, now we have the perfect moment. And then you go like, it's always either going forward or going backward, and usually some of both. So, the work is going to always be there. And the ability to discover new and better ways to do things, always available. So, I just think staying at the heart of learning and discovering and collaborating is, you know, that's what's before us and we should seize the opportunity. We're in a time of tumult. I'm in LA when we have an earthquake. We can have a thing called liquefaction - when the entire, the earth itself becomes kind of liquefied. That's how the dinosaurs at the County Art Museum in the La Brea Tar Pits got stuck there. So that is a moment, liquefaction, when change can occur that usually couldn't because systems are resistant to change. They seek equilibrium and stability, rightly so. So, if you can get good things in at a moment of change, like when that doctor had that family go nuts in front of everybody, embarrassed him and hurt them, then the moment will seal back up. If you can get good things in, it'll stay - like the dinosaurs are still there. So, we realized this is a lifestyle moving forward and seeking ways to better care for each other wherever we can, by any means possible.

Mei Kameda (37:10)

I was gonna ask you if you have moments of feeling discouraged, but your response just now really kind of uplifted my spirit when you were talking about that.

June Simmons (37:22)

Yeah, I think you stay at purpose. Yes, there's forward and back. then what does it permit? if this door closes? Because believe me, there's unlimited human need and opportunities for change. So, we're going to take the ones we can. And we're going to work hard on those because it'll still help to address and alleviate avoidable suffering and it'll give us the blessing of a life of service and purpose which you know is a gift I can see that you enjoy.

Mei Kameda (38:00)

What are your hopes for the future of the profession?

June Simmons (38:05)

Social work? I think, you know, we need to seize the moment. And we're broadening the workforce definition. So, you know, you see professions, tend to get to higher and higher credentials. So, we want that, you know, I got a license early on and I got a master's degree you know, community health workers. All of these are important. We have rampant human need, in need of comfort, guidance, access to resources, counsel, help in their behavior change to achieve better lives for themselves. So, I hope social work then plays a key leadership role in that and also a big voice for positive change wherever we can, either on our own or through the voices of others that we partner with. Yeah, I'm, you know, I'm bullish on social work.

Mei Kameda (39:02)

Thank you. One last question that I have to wrap up the interview June is, in the story of your work in the field, what one word has anchored you?

June Simmons (39:18)

I don't know if it would be purpose or trust. if I could have two words, I would take those two.

Mei Kameda (39:26)

Two is fine.

June Simmons (39:28)

Yeah, if you kind of know what you really, lights your fire, the work that you're going to be driven. I feel like what we do best is the work we care about, just as a person. It's like, what matters, you know, is a whole question now. And for any people to change their behavior,

what matters to you? And so, I think that purpose, like that a sense of one's purpose and building trust with others are an important combination of ingredients for thoughtful and respectful, but hopefully powerful change.

Mei Kameda (40:07)

Thank you so much June. We really truly appreciate your time and your thoughtfulness and your responses and I feel, it feels really surreal to me that I'm talking to you right now and having these discussions..

June Simmons (40:23)

Remember person to person? There we are. I'm very proud of you that you were in our G-SWEC program and you're doing this project. You should really feel so good about this work. Good for you. I think it's... my pleasure for us to speak one to another as we are.

Mei Kameda (40:39)

feel very privileged.

Vickie Leff (40:45)

I'm thrilled that we just interviewed Judy a few days ago. And so, to speak with both of you back to back it has been so inspiring and so grateful for the wisdom and the history and providing context for folks is really important. So, thank you so much.

June Simmons (41:04)

Well, thanks for doing the work. You go, girls.

Mei Kameda (41:09)

Thanks so much.

Vickie Leff (41:11)

Thanks June.