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Meet AAHPM President Jean Kutner

Jean Kutner, MD MSPH FAAHPM, who became president of the AAHPM Board of Directors at the 2014 Annual Assembly, discusses her professional background and goals for the Academy in the coming year.

Q. What led you to the specialty of hospice and palliative medicine?
A. Had hospice and palliative medicine existed when I was training, I would have selected it, but it didn’t exist as a specialty at the time. As an undergrad at Stanford, I had an interest in medical ethics, specifically related to end-of-life decision making. I originally had planned to pursue a career in ethics; however, my early mentors suggested that if I really wanted to influence physicians, I should go to a medical school. I also had been interested in the clinical aspects of ethics, but this was the push that set me on my path.

As I continued to gain clinical experience, I had a growing sense that we have to do better and provide better care for people with serious illness or at the end of life. As an internal medicine resident, I connected with Dr. James Tulsky and his early work around do-not-resuscitate discussions, participated in his early studies, and observed the research process. This fueled an interest in academic medicine. Following residency training, I completed a research fellowship, which confirmed my interest in pursuing an academic research career. I followed research training with a geriatric fellowship, during which I worked part time at a local hospice as medical director, joining the faculty at the University of Colorado School of Medicine in 1997. Palliative medicine was the tie that brought together all of my interests in the ethics of end-of-life decision making and enhancing care for people with serious illness through research and clinical care.

Q. Which aspects of providing palliative care do you consider most rewarding?
A. I think the most rewarding aspects are the times when we can ease stress for patients and families and provide them with a better experience and managed symptoms.

Q. How did your background prepare you to become president of AAHPM?
A. There were a number of components that helped prepare me for this role. I have been an active member in AAHPM for many years and have been involved on several levels, which gives me a good perspective on the needs of the diverse membership of AAHPM. I have been active in special interest groups, task forces, committees, and was chair of the Membership and Communities Strategic Coordinating Committee.

I have firsthand clinical and research experience in both community-based and academic hospice and palliative care settings. I also have extensive experience in program building and leadership. For example, I started the palliative care consultation service at the University of Colorado Hospital, developed and directed the Population-Based Palliative Care Research Network, am cochair of the Palliative Care Research Cooperative Group, and have been head of an academic division of more than 250 faculty at the University of Colorado School of Medicine since 2002. I feel that my diverse experience in leadership will be very helpful in my role as president of AAHPM.

Q. What would you like to see AAHPM focus on during your term?
A. There is so much to focus on! Overall, the broad vision is, as a professional organization, to make sure current and future needs of patients with serious illness and their families are met in the rapidly evolving healthcare environment. This comes with great opportunities, but also great threats. We’ve come a long way, but we need to keep increasing awareness of hospice and palliative medicine and address urgent workforce, regulatory, quality, and research perspectives to make sure needs are met. We’ve got our work cut out for us. We are growing in recognition, but it is time to be proactive to make sure we deliver on the promise of meeting patient needs.
Q. What can be done to help others—physicians and medical professionals, patients and family, lawmakers, and the media—become more aware of palliative care?

A. Figuring out the right combination of stories and data to back them up will help get attention. We need to explain what palliative care is and then show data that demonstrates that hospice and palliative medicine improve the things people care about.

Q. When you have free moments outside of your demanding positions and your commitment to AAHPM, where can we find you?

A. For 2 weeks out of the year you can’t find me—I go backpacking in the wilderness and totally unplug. Otherwise, I like to run, ski, and spend time with my friends and family, especially my 4- and 7-year-old nephews.

Q. Tell us about a patient or family who has influenced your work.

A. Most recently, that would be a friend who died in December 2012. I learned so much during the year she was ill, including what an amazing and incredible palliative care community we have, for whom I am grateful. My friend called me in January 2012 after she received news from her primary care physician that she had metastatic cancer. She called me to help navigate and translate the world she was being thrown into. It turned into a year-long experience of providing palliative care support from a distance.

I have close palliative care colleagues in San Francisco, whom my friend saw even before seeing her oncologist, and who worked with her oncologist concurrently over the course of her illness. My friend would call me regularly to talk about her medicines, symptom management, how to talk with her oncologist, how she was coping with this devastating diagnosis, and when to decide she’d had enough chemotherapy.

She had made a promise to her niece that she would take her to New York City. To assist her in achieving this goal, I traveled with them as support. It was reassuring to be able to call palliative care colleagues both at the University of California-San Francisco (UCSF) and Mount Sinai in New York to plan her symptom management and create a backup plan while traveling. My friend developed progressive respiratory distress while we were in New York and was admitted to the palliative care unit at Mount Sinai. I am deeply grateful for everything that my palliative care colleagues at UCSF and Mount Sinai did for my friend and her family, and me, during her illness and, especially, the last days of her life. This experience reminded me of the significance and importance of our work, as well as the deep commitment and sense of community that professionals in our field share.

Q. What else would you like AAHPM members to know about you?

A. It is a true privilege and honor to serve in this role, and I am humbled to have been nominated by my colleagues.

Beyond that—many people know that I often knit during meetings. This is a habit that I picked up many years ago in medical school—when I knit, it means I’m paying attention.

(Continued on next page)
Meet AAHPM President Jean Kutner (continued)

Education
University of Colorado School of Medicine, Geriatrics Fellowship (1996-1997)
University of Colorado, MSPH (1996)
University of Colorado School of Medicine, National Research Service Award Research Fellowship (1994-1996)
University of California–San Francisco, MD (1991)
Stanford University, BA (1986)

Specialties
Internal Medicine
Geriatric Medicine
Hospice and Palliative Medicine

Years in Hospice and Palliative Medicine: 17

Current Affiliations
Gordon Meiklejohn Endowed Professor of Medicine
Division Head, Division of General Internal Medicine
Department of Medicine, University of Colorado School of Medicine

AAHPM Activities
Member (1999-Present)
President-Elect (2013-2014)
Secretary (2012-2013)
Board of Directors (2010-2013)
“One-on-One” Mentor (2006-2013)
Chair, Membership and Communities Strategic Coordinating Committee (2008-2010)
Council Chair, College of Palliative Care (2000-2009)
Abstract, precourse, and workshop presenter at Annual Assembly (2002-2008)
Annual Assembly Steering Committee (2004, 2006)
Annual Assembly Program Chair (2005)
Research Task Force (2002)

Key Awards
5280 Magazine “Top Doctor” in Hospice and Palliative Medicine (2008-2013)
10th Annual Society of General Internal Medicine Distinguished Professor in Geriatrics (2013)
Joseph Addison Sewall Award, University of Colorado Anschutz Medical Campus (2013)
The AAHPM Gerald H. Holman Distinguished Service Award (2010)
Pioneer Award, University of Colorado Hospital (2009)
Circle of Life Award: Celebrating Innovation in Palliative and End-of-Life Care (July 2002)

Ohio State University College of Medicine (COM) and Wexner Medical Center seek a Director for the Division of Palliative Medicine. The Division of Palliative Medicine is made up of highly specialized physicians recruited from some of the country’s top programs. Our specialists are leaders in their field who champion a personalized approach to medicine.

The Division of Palliative Medicine, established in 2012, is a community of palliative care professionals with over 25 FTEs in Palliative Medicine across 5 hospitals. The division is highly engaged in education.

The ideal candidate will be a known or emerging national leader board certified in their primary specialty and Hospice and Palliative Medicine, have a proven record of program development, teaching success and administrative experience that will translate into inspiring and successful leadership of the division and contribute in a meaningful way to the future of the medical center. Academic appointment, rank and salary will be commensurate with qualifications and primary board certification.

The Search Committee Chair is calling for letters of nomination, applications (letter of interest, and full resume/CV), or expressions of interest to be submitted to: Dan Dolan, Administrative Director of Recruitment and Employment (Dan.Dolan@osumc.edu).

To build a diverse workforce, the Ohio State University Wexner Medical Center encourages applications from individuals with disabilities, minorities, veterans, and women. Ohio State is an EEO/AA Employer.
An excellent clinician notices what others may not. Awareness and presence in the clinician-patient-family encounter allow the hidden to become visible. It can help the patient and clinician move forward in a challenging clinical situation. Will the proposed intervention prolong life in a meaningful way or cause more suffering without significant benefit? Did the patient pause and glance out the window or look down with tears when asked a particular question? What was the mood in the room? Was silence used well to create space for deeper inquiry?

Reflection begins when the referring clinician shares some of the patient's story. Then, data is gathered: the occupational therapist noticed the patient has specific cognitive issues that were not there a month ago. The nurse observed the patient has pain and anxiety about a family issue. The chaplain remarked curiously that the patient does not want her minister to come. Reflection continues as the encounter unfolds, and then in debriefing with the care team.

Healing occurs on many levels not only for the patient and family, but also for the clinician and clinical team. As we touch the vulnerable places in others who may be very ill and frightened, we have the opportunity to heal vulnerable places within ourselves. We need tools, such as writing, to do this.

The 55-word story requires no specific talent and is a fast and effective method for a busy team to get in the habit of noticing, reflecting, and healing.1-3 On our palliative care inpatient service, I encourage learners and seasoned clinicians alike to write what they noticed in a clinical encounter or the feelings that were percolating in them on a particular day. Write for 10 minutes, then cull the unnecessary words until just 55 remain. Often those clinicians who most resisted writing are amazed at what is uncovered by this unpretentious practice. With permission, I share a few of these precious jewels.

**Perspective | Elizabeth Fleming, MD**

The flowers were fading in the corner of the room.

She has been here too long. Multiple admissions for a body breaking down: dementia, hyponatremia, aspiration, infection. A nursing home fall caused a brain bleed, and they chose surgery.

Her daughter is frustrated.

She doesn't hear the patient, who just wants to go home.

**Pain | Jennifer Mastrocola, MD**

So much deep pain,

So much suffering. It was as if the flood gates had finally opened, allowing years of turmoil, angst, and betrayal to come forth, burying us in your sorrow.

But why is this all about you? Rather, isn't it always all about you...

You, left behind, full of guilt, fear, and love.

**When Is It OK to Die? | Adrianne Gasper, NP**

When is it OK to die?

I trusted you with my acceptance. Instead, I was second guessed.

My family, uprooted in their grief, spiraled into anger.

“It was as if I was in a foreign land, and no one spoke my language.”

But I knew my release from this world was coming, and I resigned.

**Hope | Eric Marty, MD**

Hope is a powerful opiate for my patient with CP rehabbing in a nursing home.

I saw him the other day, and he was glowing.

Last I’d heard, he was asking to be shot.

We threw the kitchen sink at him, but couldn’t touch his pain.

And then someone said it: home—by next month.

Lucille Marchand, MD BSN, is professor of family medicine at University of Wisconsin (UW), Madison, and medical director of the St Mary’s Hospital inpatient palliative care consultation service in Madison, WI. Contact Dr. Marchand at Lucille.Marchand@fammed.wisc.edu.

Adrianne Gasper, NP, is a clinician of the St Mary’s Hospital inpatient palliative care consultation service in Madison, WI.

Elizabeth Fleming, MD; Eric Marty, MD; and Jennifer Mastrocola, MD were UW family medicine residents rotating on the service when they wrote these 55-word stories.

**References**


New Listserv Connects Members Advocating for Sound Health Policy in Their States

Gregg VandeKieft, MD MA FAAHPM, chair, AAHPM State Health Policy Issues Working Group

A few years ago in my home state of Washington, a package of proposed budget cuts included the elimination of the Medicaid hospice benefit. As a member of AAHPM’s Public Policy Committee, I was fortunate to have access to individuals with advocacy experience and expertise from across the country, including some who had successfully opposed similar measures in their own states. They shared position papers, data demonstrating that eliminating the hospice benefit would increase Medicaid’s net costs, and suggestions on how to effectively collaborate with other key stakeholders. Using these resources, I worked with a coalition of groups that successfully lobbied for the continuation of the benefit.

Today, state-level policies increasingly are affecting individuals’ access to high-quality palliative care services and our members’ ability to care for their patients. In the past year alone, many states considered proposals that threatened Medicaid hospice reimbursement, excessively restricted opioid prescribing, and constrained end-of-life treatment decisions.

As a national membership society, AAHPM’s primary advocacy focus has been on federal legislative and regulatory issues. Given the Academy’s size and resources, we cannot track issues day-to-day across all 50 states, nor can we weigh in on all of the issues that are pertinent to our members. We do, however, wish to leverage our resources to promote state-level policies that best meet the needs of our members and their communities. Toward that end, the AAHPM Public Policy Committee’s State Health Policy Issues Working Group was formed. We have provided input to a national organization of state lawmakers to aid them as they craft recommendations for states that are developing policies to address opioid abuse and diversion, and we have established relationships with state hospice and palliative care organizations to learn how the Academy can add value to state-level operations that already are in place.

In December, AAHPM launched a State Health Policy Listserv to connect members who are interested in state health policy issues. We hope it will enable our members to stay abreast of issues in other states, network with colleagues to effectively solicit and provide support for state-level advocacy efforts, and allow them to learn from other’s successes when issues arise within their state. I encourage you to visit aahpm.org and register to join the conversation.

In the following first-person accounts, members of our State Health Policy Issues Working Group share ways they have been active in advocacy work within their states. I hope you will find inspiration in their stories, and I look forward to hearing from many of you on the Listserv as we support one another to promote public policy that benefits people with serious illness and the professionals who care for them.

VandeKieft is the medical director for palliative care and hospice at Providence St. Peter Hospital in Olympia.

Florida—Changing Prescribing Rules to Benefit Patients, Providers

Chad D. Kollas, MD FACP FCLM FAAHPM

In 2011, the Florida Legislature passed two new laws designed to rein in rogue pain clinics (also known as “pill mills”) and reduce the rate of deaths from diversion and misuse of prescribed pain medications. One of these laws (F.S. 456.44) established a registry for physicians who prescribe controlled medications and mandated prescribing agreements between these providers and their patients with chronic, nonmalignant pain. The law excluded several groups of physician providers from the mandate, however, including anesthesiologists, neurologists, certain surgeons, and physicians certified in pain management. A subsequent ruling from the Florida Board of Medicine also excluded physicians employed by hospices from the requirement to use a prescribing agreement.

Troubled by the law’s lack of clarity regarding the definition of chronic, nonmalignant pain and the exemption for hospice physicians, but not other physicians certified in hospice and palliative medicine, I shared my concerns with the majority leader of the state Senate and worked with his legislative assistant to develop language to amend the law in the spring 2012 session of the Florida Legislature.

This effort had mixed results. The legislature clarified that the term “chronic, nonmalignant pain” applied to “pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.” This removed a prior exemption for patients suffering from rheumatoid arthritis-related pain, but did not create an exemption for outpatients with chronic pain from terminal, noncancer conditions. The legislature did exempt physicians prescribing controlled pain medications in an inpatient setting, thereby providing relief for physicians providing inpatient palliative care.
As palliative care physicians, we are experts in understanding what our patients need to preserve their quality of life during serious illness. We should convey our patients’ needs to policymakers and help them understand how to change laws to better meet those needs. Advancing policies that benefit our patients will in turn advance the specialty of hospice and palliative medicine.

Kollas is the medical director of palliative and supportive care at the UFHealth Cancer Center at Orlando Health.

Ohio—Expanding Scope of Practice to Ease Family Burden

Ruth Thomson, DO FACOI FAAHPM

In Ohio, we saw that death pronouncement in the community sometimes was delayed due to hospice nurses having difficulty contacting the patient’s attending physician in a timely manner. Delayed responses to pages, or cross-covering physicians feeling uncomfortable with pronouncing a patient they had not directly cared for, created delays in body disposition to the funeral home and placed an increased emotional burden on the grieving family.

With the goal of expanding their scope of practice to allow registered nurses, advanced practice nurses, and physician assistants to pronounce death for hospice patients, I sought support from my organization’s CEO, a health policy attorney, and Midwest Care Alliance (MCA), our state hospice and palliative care organization, to help advance the cause. We developed legislation, and I collaborated with hospice medical directors across the state to increase awareness and gain traction. I met with state legislators to discuss our issue, wrote and presented a resolution to the Ohio Osteopathic Organization, and presented the case to the Ohio State Medical Association (OSMA) Legislative Committee. In addition, our advocacy attorney and MCA’s lobbyist monitored several Ohio bills for opportunities to attach our legislation.

The effort was challenging. Many nonhospice physicians did not see this as a concern, so gaining understanding and acceptance was not easy. We had to consider the positions of many different stakeholders, such as the Ohio State Board of Nursing. We also had to be cautious not to derail pending legislation by attaching our language. Eventually, after much blood, sweat, and tears, we achieved success with the passage of HB 284. Gov. John Kasich signed the bill into law on December 12, 2012.

If you identify an important cause that will improve the lives of your patients and their families, isn’t it worth fighting for? Maneuvering through the process of passing healthcare legislation can be a frustrating and humbling experience, but also an incredibly interesting and satisfying one. This experience solidified for me that physician advocacy efforts can make a difference.

Thomson is the chief medical officer at the Hospice of Dayton, Inc.

Montana—Ensuring Advance Directives Are Honored, Transferable

Kathryn Borgenicht, MD

When I first moved to Montana, I discovered that the out-of-hospital do-not-resuscitate (DNR) document used, called COMFORT ONE, was honored by emergency medical personnel for patients in their home but was not transferable to other settings. At the same time, Oregon started publishing their data about use of the Physician Orders for Life Sustaining Treatment (POLST) form, which provided that a DNR order could be honored across settings and also expanded the discussion about end-of-life care beyond just that order. I went to the Montana Board of Medical Examiners to discuss implementing POLST in Montana. We identified that we could amend the statute for COMFORT ONE and replace it with POLST through administrative rulemaking and avoid going through the legislature for approval.

Since that time, we have proceeded with some fits and starts. Now POLST is used across the state, is honored in all settings, and has become a new standard for conversations about end-of-life care. In many communities, POLST is completed with the majority of patients in nursing home and assisted living settings. However, we are a grassroots initiative with no funding and limited time to monitor the use of POLST in our state, and, as in other rural states, we have a large geographical area to cover, so we continue to struggle with consistent education and usage. Despite this, I continue my advocacy by serving on the National POLST Paradigm Task Force; chairing our statewide POLST coalition; and speaking across the state about palliative care, hospice, and the importance of advance care planning.

As a palliative care physician, my mission is to promote the best care of our complicated, seriously ill patients. Although I can do some of this one-to-one with patients, advocacy on a larger basis has allowed me to have a greater impact on patient care. It also has added to my job satisfaction to know that I am helping to improve the overall medical system.

Borgenicht is the medical director for Bozeman Deaconess Hospital Palliative Care and the Hospice of Bozeman Deaconess.
Mechanical circulatory support (MCS), particularly left ventricular assist devices (LVADs), increasingly has been used. Recent calls from the Centers for Medicare & Medicaid Services (CMS) and guidelines from the International Society of Heart and Lung Transplantation (ISHLT) appeal for broader involvement of palliative care in both the decision-making process and end-of-life care for patients receiving LVADs.

The use of LVADs has become more routine in the past decade after the initial Randomized Evaluation of Mechanical Assistance for the Treatment of Congestive Heart Failure (REMATCH) trial, in which the use of a pulsatile-flow LVAD was shown to be superior in terms of survival at 2 years compared with optimal medical management for advanced heart failure. Prior to that study, LVADs were used as a “bridge to transplantation,” to get patients through the uncertain time they are awaiting an organ. Despite the survival benefit noted in REMATCH, the complication rate for these LVADs was not inconsequential. Patients could experience a range of adverse events, from bleeding to stroke, infection, device malfunction necessitating urgent device replacement, or, eventually, death. In the search for durable and less cumbersome devices, the continuous-flow LVADs were introduced and studied compared with the pulsatile-flow devices in the HeartMate II Study. In this study, the continuous-flow LVADs were shown to be superior to pulsatile-flow devices in terms of survival and have become the standard of care for patients awaiting transplantation.

Although the initial intent was to use LVADs for patients awaiting a transplant, some patients either refuse heart transplantation or are not suitable transplant candidates. Given the improved device durability, prolonged survival and longevity, and improved symptom burden that LVADs could provide, the use of LVADs as destination therapy (DT) has become more appealing. In DT, an LVAD is utilized to sustain someone who is not transplant eligible or who has chosen to forgo transplant as an end-stage maneuver that is aggressive yet palliative. DT has become increasingly utilized and more readily available at multiple academic and community healthcare institutions.

Despite increased longevity, quality of life, and survival for many after DT implantation, the end-of-life experience presents some frequently occurring challenges. Some of these issues are medical: patients still are at risk for developing serious infections, such as drive-line or blood-steam infections, but also for complications from stroke (either hemorrhagic or thrombotic) and chronic complications, such as gastrointestinal bleeding and progressive debility in the setting of other disease processes. After continuous-flow devices were implanted more regularly, it was discovered that a bleeding diathesis due to activity deficiency caused by acquired von Willebrand’s accounted for some bleeding complications, which is often coupled with concurrent anticoagulation with warfarin. Beyond device-specific complications, patients who received LVADs still faced an uncertain future, given that patients undergoing DT invariably will die with the device in place. In the past 5-10 years, efforts have been made at multiple institutions toward improving informed consent prior to LVAD implantation and promoting shared decision making and preparedness. A legitimate concern is that an LVAD could keep someone alive for a prolonged period by maintaining circulation despite underlying poor quality of life or medical status—a state referred to by some as “destination nowhere.”

Despite initial calls for synergy between palliative care and the MCS team during and throughout the spectrum of illness, many palliative care providers still encounter challenges in interacting with the multidisciplinary MCS team. A recent article in the Journal of Pain and Symptom Management provides suggestions on how palliative care providers can approach patients with LVADs and promote advance care planning and shared decision making. This manuscript was published online ahead of press in parallel to the proposed decision memo from CMS, which mandates that DT patients should be managed by “an explicitly identified cohesive multidisciplinary team of medical professionals” including “a palliative care specialist.” Earlier in 2013, the International Society for Heart & Lung Transplantation published MCS guidelines strongly suggesting that a) a palliative care specialist should be a member of the multidisciplinary MCS team, b) palliative care consultation should be a part of the routine pre-implantation goals-of-care process, and c) consultation should occur to facilitate end-of-life discussions or advance care planning.

With these changes, one can anticipate that calls for palliative care integration at all levels of care for patients
with MCS will continue. Total artificial hearts (currently utilized only as a bridge to transplantation) already are being encountered on many medical campuses and will present other ethical and care-delivery challenges. Palliative medicine providers are encouraged to familiarize themselves with the basic premises of MCS utilization: how MCS is being encountered in their own institutions, and how they may be called upon to be a part of multidisciplinary MCS care.

References


Keith M. Swetz, MD MA FACP FAAHPM, is a consultant and associate professor at Mayo Clinic, Rochester, MN. He can be reached at swetz.keith@mayo.edu.
Most doctors would acknowledge the risks of coming to work sick (for example, while infected with influenza)—not only the danger of spreading infection among patients, but also the risk of feeling subpar physically and, as a result, practicing suboptimally. However, almost all have done it, notes Eric Widera, MD, director of hospice and palliative care at the San Francisco VA Medical Center and associate professor of clinical medicine in geriatrics at the University of California-San Francisco.

“Doctors may feel an overwhelming dedication and sense of duty to their work, their teams, and their patients, and undervalue the risks of coming to work when feeling ill,” he says. “How is burnout different than that?”

Accumulated, unresolved, interpersonal, and work-related stresses can lead to a syndrome characterized by detachment, cynicism, and ineffective performance, which is often called burnout, Dr. Widera says. “When we forget about taking care of ourselves—when we feel that we’re the only ones who can really do this job—we expose patients, families, loved ones, and fellow team members to potential harm.”

This heightened sense of duty by some hospice and palliative medicine (HPM) physicians, coupled with a lack of institutional support, a sense of loyalty to colleagues, and an unwillingness to confide in others or ask for help, can trigger a vicious cycle of stress leading to emotional distancing and disengagement from patients as a self-protective mechanism. This in turn leads to greater depersonalization from the work and burnout. Particularly in HPM, with its emphasis on personal rapport, careful listening, and whole-person responses to the range of needs of seriously ill patients, this kind of distancing can undermine the whole point of the service.

There is extensive literature on burnout among health professionals, which finds that one-half or more of both physicians and medical trainees experience symptoms of burnout. These include emotional exhaustion, loss of energy, depersonalization, a low sense of accomplishment from their work, decreased ability to show empathy, and compassion fatigue. Burnout suggests more than just work stress; rather, it is more like a feeling of having nothing more to give to the job.

A study in *Archives of Internal Medicine* found that 45.8% of physicians across specialties already suffer from a symptom of burnout—a higher rate than the researchers expected and higher than most other occupations or professions. Emergency medicine, general internal medicine, neurology, and family medicine physicians reported the highest rates of burnout. Personal manifestations of burnout identified in the literature include substance abuse, automobile accidents, marital and family discord, physical health problems, and even higher than average rates of suicide among doctors.

“Burnout is the opposite of engagement with your work,” Dr. Widera says. “Tasks that used to energize you become unpleasant and unfulfilling. Over time, the loss of energy turns into exhaustion, feeling involved with your job turns into depersonalization and cynicism, and what used to feel like a sense of efficacy turns into an overwhelming sense of personal ineffectiveness. Burnout happens to highly motivated and committed professionals—the type of people who choose to go into hospice and palliative care.”
That makes it imperative for HPM professionals to learn and practice techniques of self-care to protect themselves from burnout. “For me, the heart of self-care is recognizing that it’s not actually just about me;” Dr. Widera says. “The cost of the lack of self-care is a much bigger problem. If we come to work in a suboptimal place, it affects our patients and our teams,” leading to medical errors and patient dissatisfaction with care. Instead, the physician should focus energy on rebuilding engagement, “promoting an environment that supports the development of energy in [the] work, involvement in the care of patients, and personal effectiveness.”

**More Research on Burnout and Its Antidotes**

Although burnout research has focused mostly on general medical settings or other specialties, several recent studies speak directly to the experience of HPM. Swetz and colleagues surveyed HPM physicians regarding their methods for avoiding burnout and finding fulfillment in their work, uncovering a variety of strategies to promote personal well-being that emphasize physical health, professional relationships, and transcendental perspectives. A Portuguese research team detailed burnout levels and protective factors in palliative care nurses and physicians, and Australian researchers concluded from three questionnaires of physicians that “levels of psychiatric morbidity and burnout in palliative medicine are not higher than in other specialties.” Kearney and colleagues have described practices of empathy, engagement, and “being connected” as keys to professional survival, as is an educational program designed to enhance mindful communication.

More recently, a team at the Carolinas Palliative Care Database Consortium, a community/academic quality partnership between Duke University and three area community-based palliative care organizations, has been studying the phenomenon, prevalence, and characteristics of burnout in the context of palliative care workforce concerns.

“There is a lot of turnover of physicians, advanced practice providers, and nurses in our field, which we think may reflect high caseloads, exhaustion, and burnout,” explains researcher Arif Kamal, MD, director of palliative care and quality research at Duke University Medical Center. “We wanted to gain perspectives on how burnout affects our precious professional resources, determine the prevalence of the problem, and learn what techniques clinicians are using to protect themselves.”

An electronic survey including the Maslach Burnout Inventory (www.mindgarden.com/products/mbi.htm) was sent to all members of AAHPM last year and through relevant social media. A total of 1,200 respondents, mostly physicians but including other clinicians as well, “makes this the largest burnout survey by far in our field,” Dr. Kamal says. “We also gathered data on median age, longevity, plans to stay in the field, and reasons for considering leaving.”

The survey sampled job responsibilities and coping behaviors and asked respondents whether they would still opt for HPM if they could revisit their career choices. “We requested e-mail addresses from anyone willing to do qualitative follow-ups and we’ll be conducting focus groups to get a narrative sense of what burnout feels like,” Dr. Kamal says.

Analysis is still preliminary, Dr. Kamal reports, “but we have found protective factors such as being married, having children at home, working fewer hours, not working weekends and holidays, and having multiple onsite colleagues.” Researchers hope to end up with a
prioritized list of modifiable factors for institutions to adopt that could prevent people from leaving the field.

Mindfulness and Other Preventive Strategies

“As a specialty, we haven’t seriously addressed how to take care of each other. With rapidly expanding demand for our services, we’ll only be asked to see more and more patients,” Dr. Kamal says. HPM professionals need to get together and collaborate—both in their workplaces and across the specialty. Research is important, “but so is just talking about these issues as a field. There’s a fear that talking about our own job stresses means revealing that we are human.”

Duke recently started a monthly closed-door debriefing session for its palliative care clinicians to talk about difficult cases, with a focus on personal rather than clinical responses. Dr. Kamal says this debriefing session is modeled on the Schwartz Center Rounds professional support model developed at Massachusetts General Hospital (www.theschwartzcenter.org/ourprograms/rounds.aspx). “We also conduct critical reflection exercises with our residents,” he adds.

“We know certain emotions lead to stress and exhaustion. If you are seeing palliative care patients sequentially and allowing yourself to care about each of them, you may be creating stress hormones in your body,” says Louise Aronson, MD, associate professor of medicine at University of California-San Francisco and author of A History of the Present Illness, a book of stories from medical practice, several of which address burnout and palliative care.

“The first step is being aware of how you show stress, and if you are extremely grumpy or argumentative in situations where it’s not appropriate, or else constantly feeling tired,” she observes, “then it’s important to ask yourself, ‘What helps me when I’m feeling this way?’ Some data suggest that exercise gives you more of the good hormones and burns off stress. Third, hopefully you work in an environment where you can say to your team, ‘I’m feeling burned out,’ and not have it sound like, ‘I’m weak; I’m a loser; I’m letting you down.’”

Self-reflection might help clinicians recognize the need to take some time off before the symptoms of burnout escalate, Dr. Aronson says. “Write it down. Get feedback from others.”

It also is important to find ways to accommodate a professional’s need for time off without creating more stress for the rest of the team. These might include having access to float staff as backups, banking hours of work in advance of the need for time off, and sharing on-call or fallback coverage with other palliative care providers in the community, Aronson says.

According to Dr. Widera, the essence of self-care in the face of job stress is to restore the humanity of palliative care. “We should practice what we preach in family meetings—acknowledging that we’re human and that we have feelings. We should name what we’re feeling to give us more conscious control over that emotion. We should talk to the team, write it down, and use mindfulness techniques and reflection exercises. People have different ways of reflection—from physical exercise to mindful meditation. And we need to spend time on the things generally suggested to help with burnout.”

Those techniques include promoting strong teamwork; teaching good communication skills; adding variety into the job so it isn’t all spent with patients; emphasizing life/work balance through families, hobbies, and recreation; and taking the full complement of vacation days every year. Dr. Kamal recommends his colleague Brian Sexton’s “Three Good Things” (www.youtube.com/watch?v=57ru-P7EuMw), a resilience-promoting journaling exercise in which you jot down three good things that happened that day every night before going to sleep.
The Quest for Meaning

Hospice and palliative medicine doctors tend to talk more about wellness and self-care than other specialties, notes Elise C. Carey, MD, chair of the Section of Palliative Medicine at the Mayo Clinic in Rochester, MN, and cochair of the 2014 AAHPM & HPNA Annual Assembly, which included a plenary session on these topics. “We are more aware of the issues. That doesn’t mean we always do it. But a highly functioning palliative care team will spend time talking about how to keep the team and its members well,” Dr. Carey says. She also describes a state of “crispness—as opposed to burnout,” where a physician with a fair amount of self-awareness might recognize that he or she is getting close to the edge of burnout and needs to pull back.

Often what puts HPM physicians at risk of burnout is being placed in managerial roles earlier than would be ideal in their career trajectory, a need largely driven by the specialty’s youth and rapid growth. New fellowship graduates may be hired to build and run palliative care programs when their training emphasized clinical over administrative skills. Their institutions don’t always understand the realities of palliative care, including the time it takes to be successful, according to Dr. Carey. “They’re more used to measuring RVUs (relative value units of productivity), but what we do in palliative care is more likely to lead to cost avoidance. So palliative professionals can fall into a bind,” she explains.

“I have become burned out before. When it happened to me during my first year on faculty at my previous institution, I had started a new consultation service. Neither they nor I thought it would be as successful as quickly as it was.” Dr. Carey told her superiors that the caseload was becoming untenable, but they didn’t heed the warning. When burnout symptoms escalated, Dr. Carey ended up taking a 3-week vacation with her family to reflect on her priorities and needs. When she returned, she was able to work with the division chief to revise her position so that it not only was tenable but also more satisfying. She emphasizes the great personal rewards to be derived from HPM, “as long as you are fully present and engaged with your patients—and taking care of yourself in the process.”

Dale G. Larson, PhD, professor of counseling psychology at Santa Clara University, who gave the plenary presentation on these issues with Dr. Aronson at the 2014 AAHPM & HPNA Annual Assembly, published seminal research in the 1980s detailing helper secrets and self-concealment as invisible stressors in hospice work. “Early studies by Mary Vachon and others showed that hospice and palliative care providers were not uniquely stressed,” Dr. Larson says. Organizational issues and workload demands often were bigger contributors to burnout than the nature of the work itself—in which the clients are confronting the existential challenges of serious, life-threatening, or terminal illnesses.

Still, he notes, frequent encounters with death, dying, and grieving families can take their toll, contributing to emotional exhaustion, demoralization, and diminished capacity for caring. Experienced HPM professionals typically have found a way to negotiate these stressors. “If you haven’t found that capacity in yourself—if you can’t courageously find a way to live in a world where loss is inescapable, acknowledging that grief and loss in some way—it’s hard to continue in this field,” Dr. Larson says. “That means a philosophy of life enabling you to integrate and transform loss so that it’s not continually unsettling you.”

Ultimately, Dr. Larson argues, citing the late social psychologist Ayala Malach-Pines, what underlies many of these cases of burnout is the failure of the professional’s existential quest for meaning.

References

Larry Beresford is a freelance medical journalist in Alameda, CA. He can be reached at larryberesford@hotmail.com or on Twitter @larryberesford.
HMDCB’s First Application Cycle Launches

Following 2 years of preparation and planning, the Hospice Medical Director Certification Board™ (HMDCB™) launched the application cycle for the 2014 examination on December 16, 2013. A steady stream of applicants has completed the online application process by selecting one of three pathways to meet the eligibility requirements: practice, certification, and training. All candidates must complete the application before it closes on March 25, 2014.

HMDCB offers an experiential pathway for eligibility for individuals who have been in practice as a hospice physician for at least 2 years but who have not completed a 12-month fellowship in hospice and palliative medicine or do not hold certification in hospice and palliative medicine from the American Board of Hospice and Palliative Medicine (ABHPM), the American Board of Medical Specialties (ABMS), or the American Osteopathic Association (AOA).

Candidates seeking to earn their Hospice Medical Director Certified™, or HMDC™, credential will take the computer-based examination at one of more than 190 authorized Applied Measurement Professionals, Inc. (AMP) testing centers across the United States during the May 8-23, 2014, testing window. Thereafter, the examination will be available annually.

Preparing for the Examination
In preparation for the examination, candidates are strongly encouraged to become familiar with the content blueprint and use it for guidance on areas where they may need further study. The published content blueprint, which provides detailed information on the content areas to expect on a typical examination, can be found at www.hmdcb.org.

Other resources for preparation might include:
- federal regulations, journal articles, textbooks, or other publications related to the content blueprint
- continuing education programs and courses
- the sample test questions printed in the candidate handbook available at www.hmdcb.org
- the computer-based testing tutorial available through AMP’s store.

Federal agencies and related organizations in the field of hospice and palliative medicine may offer materials or review/preparatory courses relevant to the examination for HMDC™ candidates. HMDCB neither sponsors nor endorses training, educational opportunities, or preparatory courses for the HMDCB examination.

The resource list below is for informational purposes only. This is not intended to be a comprehensive list of sources.

American Academy of Hospice and Palliative Medicine
847.375.4712
www.aahpm.org

Centers for Medicare & Medicaid Services/Conditions of Participation for Hospices
www.cms.gov

National Hospice and Palliative Care Organization
703.837.1500
www.nhpco.org

State Hospice Organizations
www.hospicedirectory.org/cm/about/state_hospice

For more information on HMDCB, visit www.hmdcb.org today!

SCHEDULING THE EXAM
A reminder for those who applied during the 2014 registration cycle: the deadline to schedule initial examination appointments with AMP is April 18, 2014. Candidates will receive confirmation of eligibility with instructions on scheduling either online or by telephone from AMP.
TAKING THE HOSPICE MEDICAL DIRECTOR CERTIFICATION EXAM?
THESE AAHPM PRODUCTS CAN HELP YOU PREPARE.

**HMDC Prep** **COMING SOON**
This 75-item multiple-choice online practice test assesses your knowledge in hospice practice. Content is based on the HMDCB exam blueprint.

**Hospice Medical Director Manual**
This book defines best practices, offers tools and sample documents, and provides answers about physician roles in hospice, employment contracting with a hospice, and the medical director’s responsibilities on the hospice team and within the organization.

**Recordings of the Hospice Medical Director Conference**
These recordings highlight the clinical, administrative, and regulatory aspects of your work. Audio and synchronized PowerPoint content and separate audio files are included.

**Compendium of Online Resources**
Developed with your needs in mind, this recording library of clinical and regulatory content will help expand your knowledge base.

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*Note:* AAHPM has no direct role or input in the development of the HMDC Exam. The Academy relies on the public published material about the exam to develop its products.
AAHPM Points of Progress

More than 30 committees and task forces representing the efforts and expertise of hundreds of Academy members have made significant progress toward implementing AAHPM’s goals. This progress report highlights accomplishments within each goal area of the strategic plan during the last quarter of 2013.

Strengthen Member Engagement
David Wensel, DO, chair, Membership and Communities Strategic Coordinating Committee

Membership remains steady at 4,700 individuals and is composed of 83% physicians; 11% affiliates; and 6% fellows, residents, and students, with prospective members encouraged to join when they register for an AAHPM meeting or purchase a product. Ask your colleagues to join the Academy so they can enjoy the many benefits of membership.

The Membership Committee is continuing its discussion on ways to retain current members and attract new ones. Their proposal to research the next steps toward strengthening the communities model was approved by the board and includes onsite focus groups during the Annual Assembly, an e-mail survey of all members, research of how other medical society communities are structured, and a final report with recommendations.

The Communities Committee approved the formation of a new special interest group (SIG) related to pharmacology. The SIGs met in person in San Diego, CA, and each is continuing its work on projects important to its constituents. There are now 26 member communities. Visit the individual SIGs’ Web pages to learn more.

The Diversity Task Force will generate a plan for greater diversity and inclusion of underrepresented groups within the profession, among members, and in Academy leadership positions. They conducted a session on unconscious bias at the Annual Assembly to better inform and will be working with a consultant to assist with the plan.

Build Workforce and Leadership
Jean S. Kutner, MD MSPH FAAHPM, chair, Workforce Committee

The Academic Palliative Medicine Task Force is planning for an in-person academic strategy meeting to bring together thought leaders in the academic sector to assess and explore opportunities, identify priorities, and set the strategic direction for AAHPM academic initiatives over the next 3-5 years.

The Leadership Development Committee is continuing its work on the AAHPM Leadership Forum in cooperation with the American College of Physician Executives. The Forum, which launched at the Annual Assembly with the AAHPM Ignite program, will continue with the interactive, in-person small-group AAHPM Ascend program in the fall, and the modular Web-based self-study AAHPM Elevate program available beginning summer 2014. The Forum is intended to help emerging hospice and palliative care leaders expand their leadership skills (see article on p. 24).

The Workforce Committee has reviewed the 19 workforce recommendations developed by workgroups comprising 26 AAHPM subject matter experts and, in their most recent meeting, further refined and developed a project plan based on the complexity, impact, and urgency of initiation.

The recipients of renewal awards supported by the Samuels Foundation for partial funding of fellowship training programs in the greater New York City area were announced in November. The Academy applied for and received approval for a new grant from the Y.C. Ho/Helen and Michael Chiang Foundation, which will support a pediatric track within an adult hospice and palliative medicine fellowship training program beginning in 2015. Applications will be available in the spring.

Advance Knowledge and Competence
Tim Holder, MD FAAFP, chair, Education and Training Strategic Coordinating Committee

The Intensive Board Review Course will run concurrently with the Hospice Medical Director Conference on August 21-23, 2014, in Boston. Registration will open in April. Visit www.aahpm.org to register.

The sixth edition of the popular Primer of Palliative Care is now available in soft cover and e-book versions. Visit the store at www.aahpm.org to purchase your copy. Discounts are available for bulk purchases of the print book.

HMDC Prep, an online practice test of 75 items including references and rationale that will help prepare hospice physicians for the upcoming HMDC™ exam, will be available in the spring—just in time for the first Hospice Medical Director Certification exam. Watch your e-mail for notification.

The recordings for the webinar series on the Collaboration for REMS Education (CO*RE) are available now at no cost to learners as an enduring product with continuing medical education credit in AAHPM’s online store. Physicians and other prescribers of extended release/long-acting opioids are strongly encouraged to
complete this Food and Drug Administration–approved curriculum and earn the certificate of completion.

AAHPM has worked with the American Board of Internal Medicine (ABIM) and the Accreditation Council for Gradual Medical Education to play an active role in the development of reporting milestones for hospice and palliative medicine fellowship programs. Work on curricular milestones will continue later in 2014.

In addition, ABIM has approved the HPM FAST modules for self-assessment Maintenance of Certification credits.

Promote Quality of Care and Evidence-Based Practice

Sydney Dy, MD, chair, Quality and Research Strategic Coordinating Committee

AAHPM responded to a request for stakeholder input from the Institute of Medicine Committee on Approaching Death: Addressing Key End-of-Life Issues. The Public Policy Committee, the Quality and Practice Standards Task Force, and a member survey guided the Academy’s response to questions on issues ranging from medical and psychosocial care to advance care planning to cost and financing. The Academy submitted comments to the National Quality Forum’s Measure Applications Partnership to guide that body’s input on performance measures under consideration for federal programs. AAHPM also commented on the American Academy of Neurology’s draft muscular dystrophy measurement set, which covers matters such as a multidisciplinary care plan, pain evaluation, and end-of-life issues.

AAHPM and the Hospice and Palliative Nurses Association (HPNA) have partnered on Measuring What Matters (MWM), a project to identify a recommended portfolio of performance measures for all hospice and palliative care programs. MWM will yield a core set of basic measures, additional advanced measures, and aspirational measure concepts needing further development. A Clinical User Panel is assessing measures across factors such as importance to patients/families, actionability to providers and organizations, and overall potential impact. A Technical Advisory Panel already has evaluated 75 published quality measures in hospice and palliative care for scientific soundness. Feedback on core measures will be sought from AAHPM and HPNA members, patients and families, other organizations, and the public.

Increase Advocacy and Awareness

Chad D. Kollas, MD FACP FCLM FAAHPM, chair, Advocacy and Awareness Strategic Coordinating Committee

AAHPM continues to increase public awareness regarding hospice and palliative medicine and grow its social network presence. Nearly 8,500 individuals receive the e-publication Hospice and Palliative Medicine SmartBrief twice a week. Encourage your colleagues to subscribe at www.smartbriefs.com/aahpm.

The External Awareness Task Force is helping redesign the Academy’s websites, aahpm.org and PalliativeDoctors.org, and will review analytics to assess performance. They continue to review scholarship applications for the AAHPM Hospice and Palliative Medicine Lecture Series, which funds members who present hospice and palliative medicine content at meetings where HPM is not the primary focus. For more information and to apply, visit aahpm.org.

Chad Kollas, MD FACP FCLM FAAHPM, the Academy’s representative in the American Medical Association House of Delegates, attended its interim meeting focused on public policy advocacy. Alternate delegate Devon Fletcher, MD, also participated in the mid-November conference.

The Public Policy Committee’s Emerging Payment and Delivery Models Working Group continues to publish Hospice and Palliative Medicine Profiles in Innovation, which highlight programs integrating palliative care into evolving systems. Read past issues at aahpm.org. The Committee’s State Health Policy Working Group launched an Academy Listserv for members looking to discuss state-level developments impacting patients and HPM practice (see page 8).

Working Group chairs Phil Rodgers, MD FAAHPM, and Gregg VandeKieft, MD MA FAAHPM, joined the Academy’s lobbyists at Hart Health Strategies as presenters on AAHPM’s Advocacy Town Hall webinar held in December. Participants learned about the Academy’s 2013 policy priorities and advocacy accomplishments and received an update on congressional efforts to reform the Medicare physician payment system. Registration was free to Academy members thanks to an unrestricted educational grant from Purdue Pharma.

As part of a $50,000 Choosing Wisely® grant AAHPM received from the American Board of Internal Medicine Foundation and the Robert Woods Johnson Foundation, the Academy hosted a free webinar in November to more widely disseminate AAHPM’s “Five Things Physicians and Patients Should Question in Hospice and Palliative Medicine.” Access a free recording in the aahpm.org store.

The Academy is grateful to the many volunteers who continue to provide the leadership and guidance needed to direct its programs and activities.
Are You Receiving All of Your Member Benefits?

Your membership in AAHPM entitles you to a number of benefits and announcements that are delivered to you via e-mail, including:

- PC-FACS
- AAHPM Health Policy and Advocacy Update
- Hospice and Palliative Medicine SmartBriefs
- an e-newsletter for first-year members
- opportunities to participate in Academy initiatives
- confirmation of your registration to AAHPM events.

Sometimes spam filters won’t allow these notices to get through. To ensure that you are getting the most from your membership and continue to receive e-mail from the Academy, please add info@aahpm.org, resources@aahpm.org, and advocacy@aahpm.org to your list of accepted e-mail addresses. Also, make sure your membership record is up to date with your current contact information. You can verify and update your information in three ways:

1. **Log in** to the Members Only section of aahpm.org to verify that we have the most current contact information on record and update your information. It’s also a good time to sign up for one or more of the 26 member communities.

2. **Call** Member Services at 847.375.4712 and speak to a Member Services representative who will be happy to assist you.

3. **E-mail** your current information to info@aahpm.org.

Be sure to take advantage of all of your member benefits. If you have any questions, please e-mail info@aahpm.org or call 847.375.4712. Thank you for your continued support.

Gordon J. Wood, MD

It is difficult asking people to donate to a well-known cause, but try seeking financial support for a brand new initiative. It’s a formidable challenge, even for a program vital to the future of hospice and palliative care.

From 2009-2011, AAHPM piloted a successful 3-year program designed to equip 32 young academic physician leaders from across the United States with skills needed for advancing the field of palliative medicine, where the demand for care is outpacing the supply of physicians. Thanks to the support of generous donors and past programs participants, AAHPM is launching the Leadership Development Program.

Gordon J. Wood, MD, director of Palliative Medicine and Supportive Care at Northwestern Lake Forest Hospital in Lake Forest, IL, is a past program participant who understands that, although such initiatives are expensive and difficult to sustain without membership support, they are essential for physician leaders like him who are eager to move the profession forward. Now an active fundraiser for the **Shaping the Future campaign**, Wood stresses the long-term value of mentorship and peer-support in leadership development.

“Supporting these types of programs fosters communities and provides the mentorship that [young professionals] need to take our field to the next level. Without the funding to do that, we’re not taking full advantage of the incredible talent that surrounds us,” Woods says. “Creating such communities for future generations is how we move forward.”

Please join your colleagues in supporting the **Shaping the Future campaign** by donating on aahpm.org or sending your donations in the accompanying envelope.
PRIMER OF PALLIATIVE CARE

The essential introductory text for those who care for patients with serious illness and their families.

CONTENTS INCLUDE

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- Pain management
- Dyspnea
- Gastrointestinal symptoms
- Delirium, depression and anxiety, fatigue
- Spiritual and existential suffering, the search for meaning, provider self-care
- Goal-setting, prognosticating, surrogate decision making
- Last-resort options
- Care during the last hours of life
- Special considerations for infants and children.

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Assess your knowledge in key areas of hospice and palliative medicine. Each online practice test contains 25 questions with explanations and up-to-date references to provide guidance and further study. The three modules focus individually on three key clinical topics:

- **Prognostication**
  Disease-specific prognostication, communication, and the impact of mechanical interventions

- **Psychiatry and Cognition**
  Mental illness, delirium, and decision-making ability

- **Pediatrics**
  Pediatrics, adolescents, and developmentally appropriate care

AAHPM designates this enduring material for a maximum of 2 AMA PRA Category 1 Credits™.

ABIM Maintenance of Certification (MOC) credits are now available for those who are eligible. Earn 8 Medical knowledge self-assessment points per module towards your MOC Part II requirements.
Call for Nominations

AAHPM Board and Nominating Committee
AAHPM members are invited to nominate colleagues for the AAHPM Board of Directors and nonboard member positions on the Nominating Committee. We urge your participation in this process—it is an important way to promote diversity, balance, and fresh ideas in the Academy. Self-nominations are welcome. An AAHPM officer or director at large must be an AAHPM physician member in good standing. Nominating Committee nominees may not have previously served on the board of directors. There are openings for the following positions: president-elect, treasurer, secretary, director at large (seven positions), and Nominating Committee (two positions).

Nominations will be accepted May 1-June 1 on aahpm.org. All eligible nominations will be considered by the Nominating Committee. Each candidate will be required to complete a board competency self-assessment survey after applications have been submitted.

AAHPM Awards
AAHPM members are invited to recognize a fellow colleague’s accomplishments by nominating him or her for an AAHPM award. All Academy members may submit nominations for the following awards:

The Gerald H. Holman Distinguished Service Award recognizes outstanding and dedicated service to AAHPM. The award will be presented to an individual or group that has advanced the mission of the Academy in a significant and lasting way. The nominee must be a member of AAHPM.

The Humanities Award recognizes a person whose work has advanced the relationship between humanities and palliative care, and who has employed the discipline of the humanities to improve end-of-life care. Candidates for the award include poets, artists, musicians, medical educators, and others involved in medical humanities in the broadest terms.

The Lifetime Achievement Award recognizes outstanding contributions and significant publications that helped shape the direction of the hospice and palliative medicine field.

The Josefina B. Magno Distinguished Hospice Physician Award recognizes a hospice medical director or hospice physician who provides the highest-quality services and innovative programs and who demonstrates exemplary dedication to the practice of palliative medicine in a hospice setting.

The Award for Excellence in Scientific Research in Palliative Care recognizes meaningful, exemplary research contributions to the hospice and palliative care field. The recipient is expected to present research within the broad context of the field.

The Project on Death in America Palliative Medicine Leadership Awards recognize two physician leaders who have advanced the field of palliative care—one nationally and one in the community—by educating the next generation of palliative care leaders. The award promotes the visibility and prestige of physicians in academic and clinical settings who are committed to mentoring future leaders and serving as role models for health professionals engaged in improving the care of people who are dying.

The Early Career Investigator Award recognizes a member of AAHPM who is developing as a research leader, showing promise of contributions to the development of a scientific foundation for practice and research, conducting or facilitating research by others that advances the hospice and palliative medicine field, has a beginning record of scientific publications, and contributes to the AAHPM community at large. The nominees for this award will not yet have achieved independence as an investigator (ie having R01 level funding or its equivalent).

Nominations will be accepted on aahpm.org May 1-June 1. Eligible nominations will be sent for AAHPM Awards Committee consideration. The awards will be presented at the 2015 AAHPM Annual Assembly in Philadelphia, PA, February 25-28, 2015.
Congratulations, 2013 Fellows of AAHPM

By demonstrating a significant commitment to scholarship in the field of hospice and palliative medicine, the following individuals have earned the designation of Fellow of the American Academy of Hospice and Palliative Medicine (FAAHPM) this year:

Clay Anderson, MD FAAHPM
Susan M. Bauman, MD FAAHPM
Ella H. Bowman, MD PhD AGSF FAAHPM
Maura J. Brennan, MD FAAHPM
Amy Margaret Corcoran, MD FAAHPM
Diane Dietzen, MD FACP FAAHPM
Giovanni Elia, MD FAAHPM
Bruce Ellsweig, MD FAAHPM
Daniel Fortier, MD CMD FACP FAAHPM
Anthony N. Galanos, MD FAAHPM
Elizabeth T. Galfo, MD FAAHPM
Sandra W. Gordon-Kolb, MD MMM CPE FAAHPM
J. Hunter Groninger, MD FAAHPM
Pamela S. Harris, MD FAAHPM
Cory Ingram, MD MS FAAHPM
David N. Korones, MD FAAHPM
Ruth Lagman, MD MPH FACP FAAHPM
Charles S. Mills, MD FACP FAAHPM
Bates D. Moses, MD FHM FAAHPM
Ryan Nash, MD MA FAAHPM
JoAnne T. Nowak, MD FAAHPM
Alex Okun, MD FAAHPM
Lynn Bunch O’Neill, MD FAAHPM
Daniel E. Ray, MD MS FAAHPM
Amjad Riar, MD FAAHPM
Jeanette S. Ross, MD FAAHPM
Jules Sherman, DO FACOI FAAHPM
Timothy Short, MD FAAHPM
Maria J. Silveira, MD MA MPH FAAHPM
Stewart W. Stein, MD FAAHPM
Sharon Tapper, MD FAAHPM
Jane deLima Thomas, MD FAAHPM
Thuy Hanh Thi Trinh, MD MBA FAAFP WCC FAAHPM
Christina Ullrich, MD MPH FAAHPM
Kenneth M. Unger, MD FAASM FACP FCCP FAAHPM
Grace M. Varas, DO FAAHPM
Deborah Way, MD CMD FAAHPM
Jeanie Youngwerth, MD FAAHPM

INSPIRE greatness

At Mercy Medical Group, a service of Dignity Health Medical Foundation and aligned with Dignity Health, the fifth largest hospital provider in the United States, we lead by example. By always striving to give our personal best—and encouraging our patients and colleagues to do the same—we’re able to achieve and do more than we ever imagined. If you’re ready to inspire greatness in yourself and others, join us today.

PALLIATIVE CARE PHYSICIAN - Sacramento, California

Our multi-specialty group, with more than 300 healthcare providers in the Sacramento region, is currently looking to add a Palliative Care provider to our busy Geriatrics Department. Qualified candidate must be a BE/BC Palliative Medicine specialist who can develop an ambulatory Palliative Care service with the ability to provide inpatient and SNF consults. Additional responsibilities will include educating physicians, nursing staff and community members about palliative medicine and building an Advanced Illness Care Program with Mercy Hospice. Call will be 1:8 with access to Hospitalists 24/7 and a strong built-in referral system.

Our physicians utilize leading edge technology, including EMR and PACS for imaging, and enjoy a competitive compensation and benefits package, including bonus potential and a very desirable retirement plan.

Sacramento is one of the fastest growing cities in the nation and one of the most affordable places to live in California. The area offers a wide variety of activities to enjoy, including fine dining, shopping, biking, boating, river rafting, skiing and cultural events.

For more information, please contact:
Physician Recruitment
Phone: 888-599-7787
Email: providers@dignityhealth.org
The vision of the new AAHPM Leadership Forum—an innovative collection of new training opportunities developed in partnership with the American College of Physician Executives (ACPE)—is to identify and refine the critical, nonclinical leadership skills that hospice and palliative medicine physicians increasingly need for success.

“The Academy has been exploring, testing, and creating this type of curriculum through a variety of programs and projects over the past 5 years,” says Nancy Hutton, MD FAAP FAAHPM, who chairs the AAHPM Leadership Development Committee. “Through research and practice, we have identified leadership competencies for clinicians moving into leadership roles within a variety of hospice and palliative care settings.”

The AAHPM Leadership Development Program is designed to maximize knowledge transfer and the application of the 11 leadership competencies adopted by the committee, which include:

1. interpersonal skills
2. communication skills
3. professional ethics
4. clinical excellence
5. ability to convey a clear, compelling vision
6. continuous learning and improvement
7. system-based decision making/problem solving
   a. ability to build coalitions of support for change
   b. ability to address the needs of multiple stakeholders
8. financial acumen and resource management
9. social responsibility.

In the fall of 2012, AAHPM entered into a partnership with the ACPE to develop and deliver the program content. Training opportunities are multimodal, incorporating both live, face-to-face didactic instruction and Web-based self-study. The first live program was piloted during the 2013 Annual Assembly in New Orleans, LA, and received high marks. Additional refinements to the overall program concept and curriculum were made following member focus groups and feedback from participant evaluations.

According to Dr. Hutton, the AAHPM Leadership Forum offers something for everyone with sessions that can be taken independently or collectively. “The AAHPM-ACPE offerings are well-suited for hospice and palliative medicine physicians who work in the hospital, hospice, nursing home, or any other setting.” Three distinct programs and types of learning experiences are available in 2014, including AAHPM Ignite, AAHPM Ascend, and AAHPM Elevate.

AAHPM Ignite is a live program offered annually as a full-day preconference program at the AAHPM & HPNA Annual Assembly. This session, focused on physician engagement and influence in organizational management, premiered during the 2014 Annual Assembly and will be offered as a full-day learning experience in subsequent years.

AAHPM Ascend is a new intensive two-day program with focused sessions on relationship building, change management, and coaching and mentoring led by ACPE faculty members and supported by AAHPM senior leadership facilitators who will guide the small-group work and discussions. Participants also will complete a Leadership Practices Inventory®, a 360-degree peer assessment tool that offers a tangible assessment of and insight into your leadership skills, strengths, and opportunities for development from trusted colleagues and coworkers. This program will be held September 14-16, 2014, in Oak Brook, IL, and is limited to 70 participants. Registration is now open.

AAHPM Elevate is a collection of supplemental Web-based, on-demand programs offered through ACPE at a special rate for all AAHPM members. Physicians are able to create and customize their own flexible learning pathway. Self-study courses include ethical challenges, quality improvement, negotiation tactics, strategic thinking and decision making, and finance in healthcare organizations.

Continuing medical education contact hours, a certificate of completion through AAHPM, and potential credit toward one of four ACPE Master’s degrees, as well as toward the Certified Physician Executive credential, are available, depending on how much education members choose to pursue. Individuals may select some or all of the content offered based on their unique leadership and career development goals.

“We received terrific advice and learned a great deal from other national medical societies who have invested in crafting and adapting programs like these for physicians and other healthcare professionals,” says Dr. Hutton. “I suspect this is just the beginning and the AAHPM Leadership Forum, and its offerings will evolve and expand as our field continues to mature and grow.”
AAHPM LEADERSHIP FORUM:
ASCEND
September 14-16, 2014
The Hyatt Lodge at McDonald’s Campus / Oak Brook, IL

Designed for hospice and palliative medicine physicians seeking opportunities to develop and enrich skills that will advance their leadership roles and practice.

Visit aahpm.org for more information.

Accreditation The American College of Physician Executives (ACPE) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing education for physicians.

Designation The American College of Physician Executives designates this live activity for a maximum of 14 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

SAVE OUR SEAT HELP AAHPM RETAIN ITS VOICE IN THE HOUSE OF MEDICINE

AAHPM is fighting for its members’ interests but we can’t do it alone. That’s why the Academy has been a proud partner of the American Medical Association (AMA) for more than a decade. Working with the AMA provides the Academy with unique opportunities to advance the field and amplifies the voice of hospice and palliative medicine in the public policy arena. However, AAHPM’s representation in the AMA is now in jeopardy—and we need physician members to step forward to save our seat in the AMA.

AAHPM must increase the number of its practicing physician members who are members of AMA in order to retain its seat in the AMA House of Delegates. Your membership will help ensure the Academy can continue to

• lead the AMA Pain and Palliative Medicine Specialty Section Council
• influence policymaking on key end-of-life issues
• increase awareness of HPM among other physicians and medical students looking to select a field
• participate on AMA bodies, like the AMA/Specialty Society Relative Value Scale Update Committee Advisory Committee which helps value new CPT codes

Go to ama-assn.org and join by April 1 to ensure AAHPM meets the requirements for representation in the AMA. Already an AMA member? Don’t forget to renew your membership by April 1!
**Mentoring Matters**

The AAHPM Year-Long Mentoring Program funds mentor/mentee pairs with a desire to focus on professional development in education, research, clinical care, and administration. The program is open to AAHPM members and their senior mentors from another institution who will benefit from regular contact over the course of 1 year. The pairs will identify specific goals for the mentorship experience. Pairs are reimbursed up to $1,500 in mentoring-related travel expenses and for Annual Assembly registration, if a planned meeting occurs.

The program is designed to fund new mentor/mentee relationships only (pairs may not have worked at the same institution or on a project or committee together prior to application). Unless a candidate has transitioned to the field of hospice and palliative care midcareer, preference will be given to AAHPM member mentees who are fewer than 5 years post-fellowship or terminal degree. For more information and an application, visit aahpm.org.

**AAHPM Communities Update**

Did you miss the Annual Assembly? AAHPM Communities are your way to stay connected. AAHPM has 26 communities representing diverse special interest areas within hospice and palliative medicine. These communities offer unique opportunities to network, collaborate, and share information with other members who practice in similar settings or who share common interests.

Many special interest groups have a Listserv. This serves as a communication channel to other members throughout the year. Post a comment, ask a question, or share ideas that may help other colleagues. To join one or more communities, visit aahpm.org.

**2014-2015 AAHPM Communities**

- Cancer
- Early Career Professionals (PIT)
- Education
- Ethics
- Fellowship Directors
- Geriatrics
- Heart Failure
- HIV
- Humanities and Spirituality
- Integrative Medicine
- ICU
- LGBT
- Long Term Care
- Osteopathic
- Pediatrics
- Pharmacotherapy
- Physician Assistants
- Program Chiefs
- Rural
- Research
- Safety Net
- Substance Abuse and Diversion
- Veterans

**AAHPM FORUMS**

- Advanced Lung Disease
- Psychiatry/Psychology/Mental Health
- Social Workers
Save the Date
August 21-23, 2014

INTENSIVE BOARD REVIEW COURSE
FOR THE HOSPICE AND PALLIATIVE MEDICINE BOARD EXAM

&

HOSPICE MEDICAL DIRECTOR CONFERENCE

Boston, MA

Registration opens April 2014