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THANK YOU again to all physician members of AAHPM who are also American Medical Association (AMA) members.

Every 5 years, AMA looks to see how many of its physicians are members of both organizations, and in 2023 we were successful at meeting the 20% threshold required to retain our seat for the next 5 years at the AMA House of Delegates (HOD) and representation on the Advisory Committee to the AMA RVS Update Committee, which advises Medicare on relative value units—how our work is valued and reimbursed by Medicare. Clearly, having AMA representation is critical for us to influence health care at the national level and affects our day-to-day practice.

As in past years, I attended the June 2023 AMA HOD as an at-large delegate from California, meaning that through my leadership roles in my county and state medical associations I have been selected to be one of the delegates representing the physicians and patients of California at the HOD where policy of AMA is debated and adopted. Wearing that hat, I have had the opportunity to observe the work of the AAHPM delegation and collaborate with physicians and medical students who represent the different states, specialties, and communities caring for our nation and its people.

This year it was particularly gratifying to be at the HOD, as our AAHPM delegation submitted two resolutions: one to improve hospice integrity without overburdening hospices taking good care of patients and one to modernize the Medicare hospice benefit. These were crafted from work with hospice experts, our public policy leaders, and the National Coalition for Hospice and Palliative Care (NCHPC).

During the AMA meeting and after review by multiple committees, testimony online and in person, recommendations by a reference committee after considering all the testimony, and finally by additional testimony of the full HOD and voting, both resolutions were adopted as new AMA policy. It is a long process with a lot of opportunity for input, and I am grateful to those of you who provided online testimony to the AMA HOD.

The resolution on improving hospice integrity was not controversial and passed with minimal debate. The one on modernizing the Medicare hospice benefit proved more of a challenge. Our delegation (Chad Kollas, Ruth Thomson, Ana Leech, and Kyle Edmonds)—with support from former AAHPM Director of Health Policy and Government Relations Jackie Kocinski and CEO Wendy-Jo Toyama—did an incredible job garnering support and clarifying concerns with various constituencies throughout the 5-day meeting. Providing additional assistance within our own networks and communities were myself; Karl Steinberg, who represented AMDA–The Society for Post-Acute and Long-Term Care Medicine; and Rachel Ekaireb, an HPM fellow and surgery resident who also represents California.

Throughout this time, we had wonderful support from medical students; the section council that represents specialist physicians; the American Academy of Pediatrics, California; and the PacWest Conference to AMA (a coalition of 13 states and Guam).

Some of you might ask, ‘Why bother with all this?’ First and foremost, it is part of creating a growing voice for change so that we can deliver on the promise of hospice care. I know hospice professionals are working hard every day in difficult circumstances to give the best care possible to every patient. Patients and families deserve high-quality hospice care they can trust. We cannot create change on our own. Like all of health care, it is complex and takes a team approach. By contributing to AMA policy, our AAHPM delegation has made it feasible for AMA to advocate with us on specific issues at the national level. Through this, we add a bigger voice that does not have the same perceived conflict of interest that those of us who practice in the field do. The other reason our AMA participation matters is that leaders in medical student and physician advocacy across our nation are now more knowledgeable about some of the issues that face our hospice clinicians and seriously ill patients and their families.

Being involved with organized medicine—especially as it evolves to be more diverse, younger, and more focused on health equity and how to care for all people—has been rewarding in a way I didn’t think possible when I first was introduced to it. I have found it actually helps my well-being to be able to push for change in things that make my clinical care frustrating, like dealing with unnecessary prior authorizations for much-needed medications.

I know there were other HPM physicians at the AMA HOD who were not on our delegation and were representing other constituencies who also provided support. We even have a pediatrician and
HPM physician on the AMA Board of Trustees, Dr. Toluwalase “Lase” Ajayi, who can provide expertise on hospice and palliative care issues to AMA leadership. Much thanks goes to them as well for their time and efforts. I hope others also will get involved at their local and state levels.

While we were at the AMA meeting, Dr. Ed Martin represented AAHPM in Washington, DC, with other NCHPC members as part of ongoing meetings with U.S. Rep. Earl Blumenauer (D-OR) on improving hospice care.

We also recently submitted extensive comments on the Centers for Medicare & Medicaid Services Fiscal Year 2024 Hospice Proposed Rule.

I am very proud of all of the work AAHPM staff and volunteers are doing, and I thank our membership for their support of the AAHPM delegation to AMA, our expert hospice volunteer leaders, and our dedicated AAHPM staff. I am thrilled at the outcome of their hard work, and we have more to do.

Holly Yang, MD HMDC FACP FAAHPM
AAHPM President

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- Optimized for mobile and tablet devices
- Tools to aid in identifying the most suitable program
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Dr. Barry Reisberg developed scales to correspond to his “retrogenesis” theory stipulating a degenerative reversal of normal human development in primary degenerative dementia.\(^1\)\(^2\) In 1988, he published the Functional Assessment Staging Tool (FAST), a seven-stage, 16-level scale, for predictable linear deterioration in patients with Alzheimer-type dementia (AD) as a continuum from the 1982 Global Deterioration Scale.\(^1\)\(^3\)

The FAST scale is a validated tool for AD. Patients have unique variations and non-AD patients do not follow the same retrogenesis trajectory. Hospice providers use the FAST for documentation and prognostication toward terminally ill status for patients with dementia. Should that same linear regression be applied to other types of dementia?

A role of a hospice and palliative medicine physician is to determine a patient’s prognosis and certify them as terminally ill if that patient’s prognosis is 6 months or less, should the disease run its normal course. Assessment tools such as the FAST score are guidelines, as are Local Coverage Determinations (LCDs).\(^4\) To make these determinations, physicians should be applying their education from biology, physiology, pathophysiology, treatment of pathophysiology, and experience with mortality from such pathophysiology.

Utilizing the FAST score as the sole criterion for dementia-related hospice eligibility is inappropriate, AD or not. Around 50% of hospice beneficiaries are on hospice for 18 days or less, so these guidelines may act as a barrier to admitting rapidly declining patients. The FAST score is not designed to prognosticate in all types of dementia, and attaining a FAST score of 7 or beyond is not essential to qualify for hospice admission.

Consider a patient with vascular dementia returning to her long-term care facility after hospitalization for aspiration pneumonia due to dysphagia. Her albumin is 2.1 with severe protein calorie malnutrition. A hospice registered nurse evaluates the patient and documents a FAST 6e score. The hospice physician can use their expertise in interpretation of the LCD guidelines, understanding that different dementias progress at different rates and the combination of comorbidities can be used to certify for hospice eligibility. The poor prognosis for this patient with vascular dementia correlates to her aspiration and ongoing dysphagia. A FAST score reported as 6e could be misleading to the certifying hospice physician in this scenario and does not apply in prognostication of this vascular dementia patient.

Documenting the components contributing to the physician’s decision making in the clinical record, particularly in the written Certification of Terminal Illness, is a vital component in withstanding the scrutiny of payment-related audits. Clinically, this also guides members of the interdisciplinary group in their care and documentation.

HPM providers must understand that the FAST score is only one component of prognostication for dementia. As specialists, we must differentiate clinical trajectories for all types of dementia and consider comorbidities in our determination of a patient’s prognosis.

Further complicating the use of the FAST are inconsistencies in provider interpretation. One clinician’s FAST 7a is another’s FAST 7c. For a non-ambulatory patient to be assigned FAST 7c, they must first be incontinent of bowel and bladder and minimally verbal.

In the linear model associated with AD patients, there is no “skipping” steps. Again, this linear model does not work for other dementias outside of primary degenerative dementias, like Alzheimer’s disease.
### Functional Assessment Staging (FAST)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>No difficulty</strong> either subjectively or objectively.</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Complains of forgetting location of objects. <strong>Subjective work difficulties.</strong></td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. <strong>Decreased organizational capacity.</strong></td>
</tr>
<tr>
<td><strong>4</strong></td>
<td><strong>Decreased ability to perform complex tasks,</strong> e.g., planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.*</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td><strong>Requires assistance in choosing proper clothing</strong> to wear for the day, season, or occasion, e.g., patient may wear the same clothing repeatedly, unless supervised.*</td>
</tr>
<tr>
<td><strong>6a</strong></td>
<td><strong>Improperly putting on clothes without assistance or prompting</strong> (e.g., may put street clothes on overnight clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.*</td>
</tr>
<tr>
<td><strong>6b</strong></td>
<td>Unable to bathe (shower) properly (e.g., <strong>difficulty adjusting bathwater [shower] temperature</strong>) occasionally or more frequently over the past weeks.*</td>
</tr>
<tr>
<td><strong>6c</strong></td>
<td><strong>Inability to handle mechanics of toileting</strong> (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*</td>
</tr>
<tr>
<td><strong>6d</strong></td>
<td><strong>Urinary incontinence</strong> (occasionally or more frequently over the past weeks).*</td>
</tr>
<tr>
<td><strong>6e</strong></td>
<td><strong>Fecal incontinence</strong> (occasionally or more frequently over the past weeks).*</td>
</tr>
<tr>
<td><strong>7a</strong></td>
<td>Ability to speak limited to approximately <strong>a half-dozen intelligible different words or fewer</strong> in the course of an average day or <strong>in the course of an intensive interview.</strong></td>
</tr>
<tr>
<td><strong>7b</strong></td>
<td>Speech ability is limited to the use of <strong>a single intelligible word</strong> in an average day or <strong>in the course of an intensive interview</strong> (the person may repeat the word over and over).</td>
</tr>
<tr>
<td><strong>7c</strong></td>
<td>Ambulatory ability is lost (<strong>cannot walk without personal assistance</strong>).</td>
</tr>
<tr>
<td><strong>7d</strong></td>
<td><strong>Cannot sit up without assistance</strong> (e.g., the individual <strong>will fall over if there are no lateral rests [arms] on the chair</strong>).</td>
</tr>
<tr>
<td><strong>7e</strong></td>
<td>Loss of ability to smile.</td>
</tr>
<tr>
<td><strong>7f</strong></td>
<td>Loss of ability to hold head up independently.</td>
</tr>
</tbody>
</table>

*Scored primarily on the basis of information obtained from knowledgeable informant and or/caregiver.

**Scoring instructions:** The FAST Stage is the highest consecutive level of disability. For clinical purposes, in addition to staging the level of disability, additional, non-ordinal (nonconsecutive) deficits should be noted, since these additional deficits are of clear clinical relevance.

Rather than document FAST 6e for the above patient’s prognosis from end-stage vascular dementia, the level of disability is better expressed in words, such as, “This patient is incontinent of bowel and bladder, unable to verbally express needs, non-ambulatory, and unable to sit up without support due to lack of core strength. These indicators demonstrate end-stage debility of the patient’s neurologic disease.”

It has been my experience that hospices are paying the price of misapplication of the FAST score. This comes from struggling with prognostication for certification and recertification, which results in both barriers to admission and discharging patients who remain terminally ill. This price paid also comes from the auditing world where I have seen it applied to deny providers financial reimbursement for excellent hospice care based on misinterpreted audits. These payment-related denials typically surround inconsistent documentation by clinicians and lack of “progression on the FAST score,” even in non-Alzheimer’s type dementia patients.

Ultimately, through prognostication and documentation, hospice physicians support the business and care of hospice. Utilizing our expertise to go beyond the guidelines established for the generalist and justifying such rationales will allow more patients to benefit from hospice and reduce worry that audits will decimate the agency or employer.

Lauren Templeton, DO HMDC FAAHPM, is a practicing hospice medical director in Texas and works as a physician consultant with Weatherbee Resources. In this role, she serves as a national expert in the hospice industry, helping hospices with education surrounding payment-related scrutiny including assisting with audit responses and expert witness testimony. She serves as a member of the regulatory committee for the National Hospice and Palliative Care Organization and is very passionate about advocating for the role of the engaged hospice physician. Dr. Templeton lives on a ranch in Texas with her husband and two young boys.

References

Bibliography

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How precious is a lifetime.
How precious is a day.
How precious is the moment that
So blithely slips away.

In a day, a flower blooms.
It opens petals wide.
And in a day, it drops them
As it bends and wilts and dies.

A child is like a flower
In the soft years after birth.
Living life by moments,
And measuring not her worth.

And as the years continue,
She hears an added song,
Loses child’s awareness,
As she learns to not belong.

Anticipating differences
Where once there was but whole,
Allowing only glimpses
Of her being, essence, soul.

Why is it a surprise
When our days become our years?
The child now grown and lovely
Tends her own child’s fears.

Concealed within, her glowing spark,
A well into the springs
Some meaning she’s sensed hidden
’nearth accomplishments and things.

With the passing decades,
Her petals start to fall,
She senses herself finite,
And moving toward the wall.

What once she took for granted,
Then sensed in her child’s zeal,
Now seems just a shadow,
And she wonders, was it real?

She longs to cling fast,
Hoard the precious moments that she lives,
When all she has to hold them
Is the reverence that she gives.

With reverence she remembers
Life is boundless, sweet and new,
That each moment is a lifetime.
And yes, the last one too!

Chance events remind us
That we are in the stream,
That life is wholly flowers,
And reality the dream. ●

Steve Roth, a family physician and geriatrician, cares for patients at the AccentCare inpatient center hospice in Milton, MA. He lives with his wife in North Andover, MA, where they love playing with their grandchildren and hiking in the nearby hills and mountains of northern New England.

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Among the many changes triggered by the coronavirus pandemic, the dramatic increase in adoption of telehealth by patients and healthcare providers stands out.

Upon declaration by the U.S. Department of Health and Human Services (HHS) of a COVID-19 public health emergency (PHE), federal policymakers rolled out legislation and issued regulatory waivers that immediately facilitated greater access to telehealth services.

Chief among these was removing geographic and originating site restrictions that had required both that a patient live in a rural area and be located at a physician’s office or certain other clinical sites to utilize telehealth. Important for hospice and palliative care, the Drug Enforcement Administration (DEA) also adopted temporary policies to allow DEA-registered practitioners to prescribe controlled substances without having to interact in person with their patients.

Three years on, telehealth has changed how care is delivered. An American Medical Association (AMA) survey showed that 80% of physicians conducted telehealth visits in 2022, which is nearly triple the rate in 2019. Palliative care practices were among those that pivoted during the pandemic. Leveraging communications technologies to expand their capacity to treat patients with serious illness, some Academy members say as much as 70% of their practice is now conducted via telehealth.

Now, with the May 11, 2023, end of the PHE, many of the telehealth practices to which patients and providers have become accustomed have either ended or been extended temporarily. In the face of these changes, AAHPM and our stakeholder partners are continuing to advocate for permanent policies that will ensure equitable access to and payment for virtual care.

**Key Waivers Extended**

AAHPM supported the provisions in the Consolidated Appropriations Act, 2023 (CAA)—which passed Congress and was signed into law at the end of 2022—that extend through December 31, 2024, key telehealth flexibilities that were permitted during the COVID-19 PHE, including:

- continuing the expanded list of qualifying telehealth providers
- waiving originating site and geographic location requirements
- covering certain audio-only telehealth services
- using real-time, two-way, audio-video telecommunications technology to satisfy the face-to-face requirement for hospice recertification
- allowing federally qualified health centers and rural health clinics to provide telehealth services to Medicare beneficiaries as distant site providers (versus being limited to serving as an originating site where a beneficiary is located)
- extending the Acute Hospital Care at Home program.

The expanded list of Medicare-covered services can be provided via telehealth through the end of 2023, giving the Centers for Medicare & Medicaid Services (CMS) time to collect data that may support their inclusion as permanent additions to the Medicare Telehealth Services List.

CMS has offered a rulemaking approach to updating provisional telehealth services in its proposed 2024 Physician Fee Schedule.

Policies adopted during the PHE to allow DEA-registered practitioners to prescribe controlled substances to patients without a prior in-person interaction or telemedicine visit in a DEA-registered facility also have been temporarily extended.

In late February, the DEA issued proposed rules intended to establish permanent prescribing flexibilities under certain circumstances. Notably, the DEA’s proposals would not permit the prescribing of Schedule II and/or narcotic controlled medications via a telehealth visit without a prior in-person medical evaluation by the prescribing medical practitioner or referral from a medical practitioner who conducted a prior in-person medical evaluation.
In the [Academy’s comments](#) on the rules, AAHPM explained how the DEA’s proposals create significant barriers for patients with serious illness and noted that its referral requirements were not only onerous (eg, a prescriber would have to validate whether a referring provider is registered with the DEA, despite the lack of an automated or low-burden mechanism to do so) but also failed to recognize the realities of team-based care (eg, a referral must note the name and National Provider Identifier of the practitioner to whom the patient is being referred).

Additionally, AAHPM expressed concerns that the complexity and prescriptive nature of some of the requirements could have a chilling effect on referrals, with some clinicians likely unwilling to refer patients under the qualifying telemedicine referral mechanism, due to concerns they may be liable if the prescriptions are later associated with abuse or diversion.

AAHPM urged the DEA not to finalize its proposals through at least the end of 2024, to align with the extension of Medicare telehealth flexibilities Congress enacted via the CAA. Rather, the Academy argued for the DEA to use its regulatory authority to continue the telemedicine prescribing flexibilities for controlled substances that have been in place during the COVID-19 PHE and use the time to work with stakeholders to implement a telemedicine special registration process. Such a process would enable qualified practitioners to prescribe controlled substances via telemedicine without a prior, in-person medical evaluation and thus better support timely, effective care for patients with serious illness, including those receiving palliative care.

Separately, AAHPM asked the DEA to clarify that in-person evaluation requirements for prescribing of controlled substances do not apply to patients enrolled in hospice or, if they do, to ensure that a telemedicine registration process would allow for such an exemption.

Given the overwhelming response to its proposals—which generated more than 38,000 public comments—the DEA recognized it would require additional time to finalize permanent policies. So, along with the Substance Abuse and Mental Health Services Administration, the DEA ultimately issued a rule, “Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications,” which took effect May 11, 2023, and extends the full set of telemedicine flexibilities adopted during the COVID-19 PHE for 6 months—through November 11, 2023. Under this temporary rule, however, the DEA also is effectively providing a 1-year grace period. That is, the full set of telemedicine flexibilities for prescribing controlled medications that have been in effect during the COVID-19 PHE will be extended through November 11, 2024, for any practitioner-patient telemedicine relationships that have been or will be established up to November 11, 2023.

“NOW, WITH THE MAY 11, 2023, END OF THE PHE, MANY OF THE TELEHEALTH PRACTICES TO WHICH PATIENTS AND PROVIDERS HAVE BECOME ACCUSTOMED HAVE EITHER ENDED OR BEEN EXTENDED TEMPORARILY.”

### Flexibilities Slated to End

During the COVID-19 PHE, CMS waived Medicare and Medicaid requirements that physicians and nonphysician practitioners be licensed in the state where they are providing services if certain conditions were met. Upon termination of the PHE, however, state licensure requirements again apply.

The PHE also permitted Medicare-covered providers to use any non–public-facing application to communicate with patients without risking federal penalties, even if the application is not in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HHS Office for Civil Rights allowed a 90-day transition for this flexibility, with the nonenforcement discretion ending on August 9, 2023. The HHS Office of Inspector General enforcement discretion regarding collection of cost-sharing for telehealth/virtual services ended with the PHE in May.

The policy allowing virtual presence to satisfy direct supervision requirements will be in effect only through the end of 2023 (though CMS has addressed this in the 2024 proposed Physician Fee Schedule). AAHPM has called on CMS to allow additional time to study the impact of direct supervision via virtual presence and to consider the potential benefits of extending this flexibility permanently to a small subset of services for which virtual supervision may be of high value and low risk of patient harm.

In the wake of the coronavirus outbreak, CMS also amended regulations to allow hospices to provide services to Medicare patients receiving routine home care through telecommunications...
technology (eg, remote patient monitoring; telephone calls, audio only, and teletypewriter; and two-way audio-video technology), when it was feasible and appropriate to do so, though only in-person visits were to be recorded on the hospice claim. This interim regulatory change expired at the end of the PHE. While the expectation is that hospices can continue to use telecommunications technology for virtual communications in follow up to in-person care (as long as the use of such technology does not replace an in-person visit), AAHPM requested that CMS provide clarification on this policy in the 2024 Hospice Wage Index Final Rule. In that rule, CMS noted that it would “expect telehealth services to be summarily limited to follow-up contact with patients and would not expect to see the provision of hospice services furnished via telecommunications systems.”

**AAHPM Advocacy**

Even before the coronavirus pandemic, AAHPM supported meaningful telehealth policy. The Academy helped inform development of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019—specifically a provision to permit the use of telehealth in recertification for hospice care—and endorsed this legislation designed to expand telehealth permanently while enhancing oversight and gathering data on its impact.

In the last Congress, AAHPM supported bills that would establish permanent policies for the post-COVID era, including the Telehealth Modernization Act and the CONNECT for Health Act of 2021. As the PHE wound down, AAHPM continued to be a strong advocate for needed flexibilities, urging Congress to extend key waivers following the end of the emergency declaration, to allow time for permanent, comprehensive policy to be passed. To establish a pathway for reform, the Academy has joined stakeholders in calling on HHS to complete telehealth-related evaluations by fall 2023 and provide recommendations to Congress, so that lawmakers can develop and pass evidence-based telehealth legislation for implementation in 2024.

Even if permanent policies are enacted, however, it’s clear that a number of other issues will need to be addressed to ensure a modern healthcare system can support high-quality telemedicine. AAHPM will be paying particular attention to supporting efforts aimed at improving coding and payment for telehealth visits, including audio-only encounters, to ensure fair reimbursement for clinician services whether they are performed in person or via telehealth; tackling technology challenges faced by patients and providers; and advancing health equity in the emerging virtual care landscape.

“In AAHPM’s comments on CMS’s 2023 Medicare Physician Fee Schedule proposed rule, the Academy addressed many such telehealth priorities, including to recommend that CMS continue coverage and payment of audio-only evaluation and management services (at their current valuation) and advance care planning services outside the context of the COVID-19 PHE.

Prior to the pandemic, Medicare paid for a limited number of telehealth services in very restricted circumstances at facility rates about 30% below in-office visit rates. AAHPM supports higher Medicare payments (no site-of-service differential) for telehealth visits until they can be appropriately valued by the AMA Relative Value Scale Update Committee (RUC). To that end, the Academy offered details on telehealth in the practice of hospice and palliative medicine to inform the efforts of a joint workgroup of the AMA Current Procedural Terminology (CPT) Editorial Panel and RUC that was charged with updating and expanding the existing CPT code sets for virtual services. RUC will make recommendations to CMS this year regarding the valuation of the codes, and CMS will ultimately determine whether to incorporate the newly proposed coding and values for the 2025 Medicare Physician Fee Schedule.

In March, AAHPM submitted comments on CMS-proposed rulemaking intended to improve the electronic exchange of healthcare data and streamline processes related to prior authorization to further interoperability.

Finally, AAHPM believes that greater broadband access is essential for ensuring health equity and thus has repeatedly called for federal investments that would support expansion of broadband, to
ensure all communities and geographies have the connectivity necessary to leverage the many benefits of virtual care.

While these various policies take shape, AAHPM will continue to advocate for sound telehealth reforms that support the care of patients with serious illness, and our Academy remains committed to working with CMS, regulatory agencies, legislators, and the provider community to consider how best to ensure that telehealth policies appropriately balance patient access with safety, quality, and program integrity.

Jacqueline M. Kocinski formerly served as AAHPM’s director of health policy and government relations. For more information or questions about the Academy’s advocacy efforts, email advocacy@aahpm.org.

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Major changes are coming to the landscape of scientific research on the care of patients with serious illnesses. These impending transitions are creating questions for the community of hospice and palliative care research scientists. What will the future of serious illness research look like? Who will provide the needed funding, leadership, and home base to keep the field moving forward?

Recently announced developments include:

- the decision to close the National Palliative Care Research Center (NPCRC) at the Icahn School of Medicine at Mount Sinai in 2025
- the end of federal funding for the Palliative Care Research Cooperative group (PCRC) this year
- Cambia Health Foundation’s Sojourns Scholar Leadership Program choosing its 10th and final cohort of up to 12 researchers to receive 2-year awards for innovative and impactful projects in the field of palliative care
- the National Institute on Aging (NIA) leading efforts to convene subject matter experts from other relevant institutes to augment strategic coordination of palliative care research within the broader National Institutes of Health (NIH)—the leading federal agency supporting medical research.

“The Academy has been studying current and future needs and considering ways to increase its support for the research agenda. We don’t have all the answers but know we’ll play an important role,” said Joe Rotella, MD, AAHPM’s chief medical officer.

There is a tremendous need to study how to prevent and relieve the suffering associated with serious illness. Research costs a lot of money and thus depends on government support, he said. Can NIH provide the necessary funding and infrastructure for this important research within its relevant institutes?
AAHPM, along with other groups, is trying to step up its own leadership, collaboration, and community building. “We have a sense of urgency balanced with a deliberative approach to ensure that we can sustain our commitments over the long haul. In fact, we’ve always had a strategy to support research, even as we acknowledge that the funding picture has recently gotten tighter,” Rotella said.

AT A CROSSROADS

“There are a couple of big needs in serious illness research. One is for solid funding to conduct the research, so that we can learn what works and doesn’t work for these patients,” Rotella said. “If you look at the NIH annual budget and how much of it goes to what we would call palliative or serious illness-related research, that’s less than 1% of the institute’s attention. We are asking for a larger share of that attention. We’d also like to see a more coordinated strategy.”

What is needed is a transdisciplinary, transagency approach acknowledging that palliative care doesn’t fit into traditional organ-or disease-specific research institutes, like those at NIH. Though many of the institutes, centers, and offices within NIH address populations that include people with serious illnesses, no single entity is in charge, Rotella said.

“I’m grateful that NIA is saying, ‘Let’s get the attention of the other institutes and talk about what a coordinated strategy would look like.’ NIH is a big agency. They need to help us figure out where we need to fit within the way they do business. We can’t do that alone,” he said. “Then we also need infrastructure that supports the recruiting, training, mentoring, sponsoring, growth, and development of the researchers who will do the work. Some of that support could come from NIH, as it has in the past.”

That will require funding, something AAHPM already has been pursuing. “We recently submitted testimony to the House Committee on Appropriations, Labor, Health and Human Services, Education, and Related Agencies Subcommittee to make the case that successful implementation of a transinstitute strategy at NIH requires enough financial support to develop the next generation of researchers, who will need career awards to get them jump-started,” Rotella said. “We asked for a $20 million appropriation to implement this transinstitute strategy and plan to continue working with lawmakers to ensure it is adequately funded.”

HOW IS AAHPM ADVANCING RESEARCH?

These major shifts in funding and infrastructure may have been an unpleasant surprise to some in the field. But the Academy was already working on building more infrastructure for this research.

Its first State of the Science meeting, which brought research scientists together virtually in 2022 to discuss these issues, will be followed by an in-person science meeting in March of 2024 in conjunction with the Annual Assembly of Hospice and Palliative Care in Phoenix, AZ.

The Academy also awards scholarships for new and early investigators to attend the Kathleen M. Foley Palliative Care Retreat and Research Symposium. The annual symposium was established by NCPRC to help develop research works in progress and teach competencies in research methodology. The next symposium is October 24-26, 2023, in Jackson Hole, Wy.

AAHPM urged Congress last year to ask that NIH report on what it is doing to develop a transinstitutional strategy for serious illness research and to ensure that palliative care is integrated into all areas of medical research. Congress included that request in its Consolidated Appropriations Act at the end of 2022. In March of this year, NIH responded with a Fiscal Year 2024 “Congressional Justification” document, in which it pledged that NIA would take the lead to convene subject matter experts from 10 other named institutes and offices to expand and intensify the strategic coordination of palliative care research efforts, as well as identify future research topics and questions that pertain to palliative care.

In concert with the National Coalition for Hospice and Palliative Care (NCHPC), the Patient Quality of Life Coalition, and senior research subject matter experts, AAHPM recently met with NIA leadership. Rotella characterized the meeting as “fantastic,” saying NIA “confirmed its intention to take the lead on working with all the other institutes, centers, and offices that address serious illness. They told us, ‘We’ll introduce you to the right people at the other institutes.’”

THE RESEARCH COMMITTEE

AAHPM’s Research Committee aims to launch multiple projects over the next few years. The committee is eager to move from planning to action and will meet bimonthly, Rotella said.

“The committee recognized it needed to shift its focus and charges in this evolving research
environment and spent much of the past year examining and updating its committee charges,” he said. “It’s time now to start putting them into action.”

Erica Kaye, MD, recently became chair of the AAHPM Research Committee. She is the director of quality of life and palliative care research at St. Jude Children’s Hospital in Memphis, TN. She credits early career awards from AAHPM and NPCRC, including an invitation to attend the Kathleen M. Foley research retreat, for advancing her own career in research.

“Those opportunities were instrumental in carving out the time and space and making the networking connections to launch my research platform. I’ve also been privileged to learn from existing resources and to be part of the PCRC. I can speak personally and professionally to how important those mechanisms were for allowing me to further my work as a research professional,” she said.

“Now, transitioning into medical leadership and other responsibilities, I oversee the career growth of a number of bright and motivated trainees and junior faculty across institutions. So I am acutely cognizant of the challenges they face in trying to obtain research support and opportunities.”

Kaye described palliative care as a relatively nascent field within medicine. “What’s important is that palliative care does not get siloed. Palliative care is integral to the practice of so many other fields, which rely on it to provide quality, person-centered care across the illness journey and at the end of life,” she said.

NIA has a vested interest in these issues—but palliative care is not just for older patients. “One of the challenges for research in this field is to have a home for palliative care when many fields, specialties, and disciplines claim it as integral to their own work,” she said.

Kaye is optimistic about her committee’s role in “offering some solutions. Our new charges are broad and afford us opportunities to think creatively about how to navigate the current gaps. One thing we aim to do is to partner more closely with the Academy’s Early Career Professionals and research special interest groups and collaborate on development of networking opportunities and logistical support for younger researchers,” Kaye said. “Additional strategies we have discussed include connecting early career professionals with formal mentorship, potentially leveraging existing AAHPM platforms such as its Connect [online community discussion platform].”

The committee plans to advance these goals by working with partnering organizations as well. “In the future, we hope to begin conversations to collaborate with research leaders at the Hospice and Palliative Nurses Association (HPNA) to propose research priorities for multidisciplinary investigators to leverage in their funding applications,” she said. “Additionally, representatives from the Research Committee have met with leaders at NPCRC and PCRC to brainstorm collaboratively about how best to fill the gaps left by their winding down, advocate for increased funding and resources, and create novel opportunities and forums for people in our field to support each other.”

‘REAL MOVEMENT’

Amy Melnick, MPA, is the executive director of NCHPC, which represents 13 of the professional societies that speak for the various professions in the hospice and palliative care sphere. NCHPC also has submitted testimony on behalf of its members in support of a larger role for NIH in promoting palliative care research. Melnick thinks this time of transition is an exciting and pivotal moment for the field.

“It’s official that NIH and NIA have stepped into leadership roles on this issue. They have responded to Congress and said they will lead a transinstitute strategy for palliative care research,” Melnick said. “So far, no additional funds have been appropriated—but for me, having worked in this field for almost a decade, I see real movement.”

Melnick encouraged AAHPM members to follow developments in Washington, DC, and to be prepared to respond when asked to speak up. “When the time is right,” she said, “grassroots advocacy will need to be activated on these issues.”

TRANSITIONING TO PUBLIC SECTOR

The science of serious illness medicine was still in its infancy when NPCRC was launched in 2005, said NPCRC’s founding director, R. Sean Morrison, MD, professor of medicine and director of the Lilian and Benjamin Hertzberg Palliative Care Institute at Mount Sinai in New York
City. At the time, there weren’t many existing mechanisms to support the field’s development, but the Kornfeld Foundation funded the center’s creation.

“We planned to have a 10-year run, with the goal of building research capacity and giving early-stage investigators needed support to secure NIH funding,” while creating a virtual organizational home for the scientists, Morrison said.

From the outset, the goal was to successfully transition science funding from private sector philanthropy to the NIH, along with the existing professional associations, he said. “We also wanted to create an evidence base that would bring palliative or serious illness care to the same level as research for diseases like cancer or heart disease, while creating a community of palliative care scientists.”

But after 10 years of supporting these goals with funds from Kornfeld and 20 other private philanthropic organizations or individuals, it became clear that funding cuts at NIH were reducing opportunities for investigators. “We felt we needed to sustain the field’s growth, so we extended NPCRC’s life for 10 more years,” Morrison said.

“I think we accomplished what we set out to do and more,” he said. “I’m pleased with what we achieved, with 90 percent of the scientists we funded going on to obtain other research funding sources, which were directly linked to their NPCRC awards.”

NPCRC channeled approximately $40 million to the field over the past 18 years, with $30 million in grants supporting research by 146 investigators, which in turn were leveraged into more than $250 million in federal funding.

“We put palliative care on the map through partnerships with leading federal and private sector organizations,” Morrison said.

Palliative care has established an extraordinarily strong clinical field with clinical models—particularly hospital-based models—and established strong clinical training programs. “I feel like the field is in good shape, and I’m proud of that,” he said.

But where does palliative care go next?

There’s always a risk with change, he said, “but I’d say there’s a greater risk in relying on fickle private sector philanthropy to fund research.”

Morrison, too, would like to see a transdisciplinary office of serious illness research in NIH or one of the larger institutes. It could provide both career awards for early-stage investigators and the research dollars needed to fund large-scale research studies.

When NPCRC closes, there will need to be a convening or intellectual home for the serious illness research communities, Morrison said. “NPCRC served that role for years. My hope now is that the professional member organizations like the Academy, HPNA, and others will be that home in the way that the American Society of Clinical Oncology offers an intellectual and scientific home for cancer researchers. Finally, there should be a periodic meeting focused on the science of serious illness research. The Academy’s State of the Science meeting last year was a good step forward for the field.”

Serious illness scientists have a lot more work to do, Morrison said. For example, there is a need to devise alternatives to opioids for treating the pain of serious illness and to develop treatments for fatigue. Those advancements won’t happen overnight.

“Science takes time. There’s no way around that,” he said. “We need to invest in science and research so that the care we’re providing is as high-quality as any other area of medicine. We are now at the point where we have so many clinicians, and so many graduates coming out of fellowships. We’ve got to give them the tools they need to provide high quality care, based in evidence-based, scientifically valid studies.”
That’s a need that AAHPM can help fill, Morrison acknowledged. “I think this is a prime opportunity for groups like AAHPM to step up and play a role in developing serious illness research scientists and being an advocate for their work.”

THE FUTURE OF SERIOUS ILLNESS RESEARCH

The future of this field, Morrison said, lies with the next generation of serious illness research scientists. Many of these research scientist have been supported by NPCRC, PCRC, and other facilities or organizations. Morrison mentions researcher Abby R. Rosenberg, MD MS MA, as an example of that future. Rosenberg is chief of pediatric palliative care at the Dana Carver Cancer Institute and director of palliative care at Boston Children’s Hospital.

Rosenberg said pediatric palliative care research—compared to adult-focused palliative care research—can be difficult because of the small populations of both patients with serious illnesses and investigators trying to help them.

“What I love about our smaller community, though, is that we’ve quickly come together to collaborate and advance the field,” she said. Her own research has emphasized programs to address stress, resilience, and quality of life for people with serious illness and their families, including a resilience intervention called PRISM.

“Palliative care research faces significant challenges, which have been exacerbated by the looming end of the NPCRC and PCRC,” Rosenberg said. “Those programs have been critical to launch countless palliative care research careers, including mine—and still, we have too few scientists and too few training opportunities to support the next generation.”

Many of the people who identify primarily as “researchers” were trained in other fields, such as oncology or critical care, she said. “It would be great if there were more subspecialty palliative care clinician-scientists. That will require a research home for all of us.”

Another challenge is the methodology of serious illness research. “What are we measuring; and how do we interpret the results?” she asked. “For example, we can’t consistently find measurable impact from advance care planning (ACP), even though a patient who has been part of an organized ACP process will say it mattered. What can we do about that as researchers? We need to show robust value for our interventions, and that’s incredibly difficult.”

Rosenberg said that palliative care researchers also are looking at past research and identifying “gaps” that may require additional study. “For example, we need to better include folks in marginalized communities and address the paucity of long-term palliative care outcomes,” she said. “We are also starting to understand that our interventions need to meet people’s needs in the moment. How do we tailor our programs to be both person-specific and widely generalizable?”

She quotes Morrison in identifying a goal. “Sean Morrison muses: what’s in our syringe that is scalable, reproducible, and measurable? We want to partner with the larger palliative care community to determine how to answer that question, and we need platforms to share what we’re learning.”

For Rosenberg, those challenges point to the need for more than an office overseen by NIA.

“I love that NIA is helping, and yet—as a pediatrician—I worry it is not enough. I think we need a special institute for palliative care within NIH, dedicated to seriously ill patients across the entire lifespan,” she explained, mentioning the National Institute for Minority Health and Disparities, which cuts across other NIH institutes and populations. “I speak for those of us who have built our careers on studying serious illness. In the current federal research space, we feel homeless. An institute of our own would be great.”

Larry Beresford is a medical journalist in Oakland, CA, with a strong interest in hospice and palliative care.
Welcome to AAHPM Quarterly’s inaugural Roadblocks column. Each quarter, this column will use a clinical case to focus on a specific scenario faced by hospice and palliative care teams. Two or more interdisciplinary team members will comment on the specific regulatory, operational, ethical, or clinical “stuck points” highlighted in the case, opening doors for follow-up discussion and debate on AAHPM Connect. No author will take sides; instead, authors will be asked to lean into the gray areas to move our collective knowledge base forward.

**THE CASE**

You work for a community-based hospice agency and are asked to comment on the appropriate site for end-of-life care for a 70-year-old woman admitted to a local acute care hospital.

She has a medical history of ovarian cancer. Despite an initial excellent response to chemotherapy and abdominal debulking surgery, she has developed a malignant small bowel obstruction that was complicated by a small perforation of her intestine. After a course of critical care, including antibiotics, placement of a decompressive gastrostomy tube, pressor support, and percutaneous drainage of an intra-abdominal abscess, she has stabilized.

The patient, in consultation with her family, has elected to elect the hospice benefit. At this time, she is able to drink small amounts of fluid, makes a moderate amount of urine, and has waxing and waning mental status. The inpatient team estimates a prognosis of days to a few weeks. Though she was initially uncomfortable, complaining of nausea and abdominal pain, the palliative care team at the hospital adjusted her oral morphine concentrate and haloperidol dosing and she is now comfortable, with minimal dose changes for several days.

The inpatient team mentions that due to her religious beliefs, her family is strictly opposed to a death at home, and the hospital utilization review committee is pressuring the inpatient team to “discharge the patient and have them admitted to inpatient hospice (General Inpatient [GIP] Level of Care, at the hospital itself).” The primary attending confides in you that she feels conflicted, as she wants to honor the patient’s wishes, satisfy the hospital stakeholders who are pressuring her, and ensure the patient’s disposition is in line with hospice regulations.

**How do you navigate this situation? How would you mediate this tension, where the patient’s family and primary attending are “stuck” in the middle?**

Read how two interdisciplinary team members would handle this situation. Then, we want to hear from you!

**Ready to discuss this issue’s Roadblocks case?** Start a post on Connect or look to see if another reader already has, then get engaged!

If you are interested in suggesting a topic or contributing to a future Roadblocks column— or if you have written a piece that you think might be a good fit for this column—please reach out to us! Email Leah Rosenberg, MD, incoming Roadblocks senior section editor, at lbrosenberg@partners.org.
Because I am a chaplain, my priority would be to obtain clarity from the family about their apparent unwillingness to let the patient die at home on religious grounds. In 40 years of healthcare chaplaincy, I have never heard of a religion which would have this objection, nor did a search identify one.

However, it is not uncommon for patients and families to misunderstand the beliefs of their faith group. If this turns out to be the case, the normal procedure would be to identify a faith leader from their community whose opinion they would trust and have that leader talk to them.

Even if the family belief turns out to be sincerely held, it may be specific to certain circumstances that can be overcome. Is the room the patient would die in an issue? Who will need to be with them? How long will the body stay in the house after death?

Would discharging the patient to the house of a relative who would welcome her solve the problem?

One possibility in circumstances like this is that religion is used as a justification for what is really a psychological barrier. This possibility does not seem likely in this case since the family has consented to hospice, but it needs to be considered in case this issue is psychological instead of religious.

If it turns out that the religious objection is firmly and sincerely held—even if it is not part of the belief of a particular faith community—it must be respected. I would represent to the team and administration that the patient cannot go home without seriously violating the family's beliefs, which would constitute unethical care. I would support the team in efforts to find another solution, even if that solution stretches normal procedure.

While it might appear that the stakeholders are stuck between the proverbial rock and hard place, my assessment is that there is only a “hard place”: the hospital that wants the patient out.

Many might hold the conventional wisdom that the hospice GIP level of care is only for patients who have acute, ongoing symptoms that need management, and it is clearly described that this patient currently has her symptoms managed with appropriate medications, that there have not been dosing changes, and that she is able to take small sips of fluid.

However, this patient is far from a stable “custodial” situation. She likely has abdominal carcinomatosis, has already had one bowel obstruction, and is at high risk for another obstruction, which is painful despite the gastrostomy tube. It has been shown that in women with ovarian cancer, a bowel obstruction is a preterminal event, and median survival after the obstruction is 93 days.1

In addition, the patient’s alertness waxes and wanes, and this will complicate her oral intake, leading to dehydration and further clinical decline. So, while this patient may be “stable” at this time, her risk of rapid deterioration is high.

The Centers for Medicare & Medicaid Services (CMS) has acknowledged that GIP care may be appropriate when a patient needs medication adjustment, observation, or other stabilizing treatment after hospital discharge,2 and this patient clearly falls into that category: she needs observation for the high likelihood of rapid onset of symptoms and deterioration.

If she were to stabilize, not need adjustments in medication or other interventions, then she could transition to a skilled facility. If the logistics of this transition are expected to take time, then the billing status of the patient could change; the hospice would bill for Routine Home Care instead of GIP, which would take the patient off CMS’s radar.

References
After 3 long years of connecting via Zoom, we were so excited to meet in Montréal in person this year at the Annual Assembly of Hospice and Palliative Care. This year’s meeting included plenty of opportunities for celebrating, embracing, and learning about justice, diversity, equity, and inclusion with our peers. This year’s DEI activities included the following:

**DEI PRE-CONFERENCE WORKSHOP**

On Wednesday, March 22, we helped to kick off the assembly with ACTION: Anti-Racism Conversations and Thoughts in Our Neighborhoods, a 4-hour session led by seven faculty, including members of the AAHPM DEI Committee. This interactive session explored racial identity development and encouraged participants’ thoughts about their own identity and how it differs from that of the people they care for.

The conversation expanded with scenarios about cultural and religious humility and allyship. Participants learned how to exercise allyship as an active practice of utilizing positions of privilege and power to operate in solidarity with marginalized communities.

Participants also learned practical strategies and tools to dissect conversations with diverse patients and families, with colleagues, and even within their neighborhoods. The session included facilitator-guided experiential learning within small groups using videos, role-play, and discussions.

Attendees shared racism they experienced growing up in their own communities and its impact on them. Data outlining structural racism and race inequities were leveraged to demonstrate the imperative to address issues of race while also addressing one’s own racial identity development. Intentionally recognizing, evaluating, and addressing implicit biases, practicing cultural humility, and developing allyship were demonstrated as strategies that can promote access to high-quality, patient-centered, and more equitable care.

The seven faculty members who led ACTION: Anti-Racism Conversations and Thoughts in Our Neighborhoods are (from left) Corey Tapper, MD MS; Aziz Ansari, DO SFHM FACP FAAHPM; Heather Harris, MD FAAHPM; Sonia Malhotra, MD MS FAAP FAAHPM; Ruth Thomson, DO MBA HMDC FACOI FAAHPM; Arshia Madni, MD FAAP; and Shellie Williams, MD FAAHPM.
The session also explored transectionality, provided information about gender and sexual identity development, and focused on inclusion within the LGBTQ+ community. Faculty discussed how misgendering causes significant harm and can lead to gender dysphoria and worse. This segment helped to explain why affirming practices are vital.

The faculty did an outstanding job of creating an environment that focused on identifying, learning, and being empathetic to issues that are racially motivated. They explored ways to be an ally and provided useful tips for putting allyship into action.

**DEI-FOCUSED SESSIONS**

Attendees at the 2023 Annual Assembly of Hospice and Palliative Care participated in more than 30 DEI-focused educational sessions throughout the conference. View the DEI educational track list.

**DEI HOMEROOMS**

DEI Homerooms are new networking sessions that enabled attendees to meet with faculty and peers to reflect and discuss DEI track sessions presented that day. Participants shared “Aha!” and “Oh no!” moments from the day’s sessions, actions steps needed to advance what they learned, and more. Attendees could participate in the DEI Homerooms in person or virtually on Thursday, March 23, and Friday, March 24.

These sessions were well received, and attendees recommended hosting them again next year. If you are interested in becoming a volunteer faculty member for the 2024 DEI Homerooms, please contact Linda Sterling, DEI and membership engagement manager, at lsterling@aahpm.org.

**OBSERVING RAMADAN**

**Prayer Room**

The Annual Assembly was held during Ramadan. In observance, we provided a dedicated room for prayer and reflection that was open to all. The room also served as a meditation room for individuals with other religious backgrounds or for anyone seeking space to reflect or pray. Disposable prayer mats were provided, and signage included a link to learn more about Ramadan.

**Acknowledgement**

Dr. Arshia Madni, chair of the AAHPM East and South Asian Professionals, Patients, and Families in HPM Forum, delivered remarks from the podium at the end of Thursday’s keynote session. She acknowledged our Muslim colleagues and friends observing Ramadan and provided an explanation of Ramadan and how it is observed.

**DEI RECEPTION**

On Thursday, March 23, the AAHPM DEI Committee and Hospice and Palliative Nurses Association hosted more than 50 guests from 7-8 pm for a Breaking Fast with Your Muslim Colleagues During Ramadan reception. This event focused on celebrating and embracing all our differences, backgrounds, and what makes us unique. Guests enjoyed a “getting to know you” bingo game, delicious halal appetizers, good music, drinks, and a lot of fun and laughter!

**COMMUNITY MEETINGS**

Four identity-based AAHPM communities held in-person meetings at lunch time on Thursday, March 23, to discuss goals and activities for the year. Participating forums included

- Black Professionals, Patients, and Families in HPM Forum
- East and South Asian Professionals, Patients, and Families in HPM Forum
- Latinos Professionals, Patients, and Families in HPM Forum
- LGBTQI+ Special Interest Group

These were the groups’ first in-person meetings since 2019, and they were very well attended and full of rich conversation and engagement.

Heather A. Harris, MD FAAHPM, and Sonia Malhotra, MD MS FAAP, are the 2023 AAHPM DEI Committee chairs.
Membership and Communities Committee Update

Expand and Enhance Engagement
Lindsay Ragsdale, MD FAAHPM, Chair

AAHPM membership remains steady at 5,582 with an 83% retention rate and 1.3% growth. AAHPM membership comprises 72% physicians; 10% interprofessional (nurses, nurse practitioners, physician assistants, pharmacists, chaplains, social workers); 16% fellows, residents, and students; and 1% international members.

The Communities Committee continues to provide strategic direction for all the activities of the more than 40 Academy communities. The committee welcomed new leaders for Academy special interest groups (SIGs) and forums and hosted Community Leader Town Hall calls in May. AAHPM communities continue to meet virtually; these events are open to all members and are posted on AAHPM Connect.

AAHPM Connect is an active online platform for members to share articles, post presentations, and participate in discussions. In the first quarter of 2023, there were more than 330 discussion posts, 98 new discussion threads, and more than 207 unique contributors to the Open Forum. To join a community, add it to your demographic profile by going to your Member Profile page. Learn more at connect.aahpm.org.

The Diversity, Equity, and Inclusion (DEI) Committee worked to recruit a section editor for AAHPM Quarterly, working with staff to ensure that the DEI LAB column will contain content related to health equity, share information on current training programs and resources, provide updated info on AAHPM DEI efforts and work, and highlight the activities of our members.

Next Gen Scholars for Equity in Hospice and Palliative Medicine (HPM) Program, our new equity scholars’ program, is looking for eight postgraduate medical residents who

• are interested in hospice and palliative medicine
• are from communities that are underrepresented in the profession’s workforce and leadership.

These residents will be essential as our professional community works together toward centering the needs of those historically marginalized and minoritized in HPM.

Information on the program was shared at the annual assembly in Montréal, and we have already received interest from potential scholars and sponsors. Learn more about the Next Gen Scholars program on our website and in the fall issue of AAHPM Quarterly.

The LGBTQI+ SIG held its first June Pride Webinar, The Power of Pride: Challenges and Victories on LGBTQI+ Rights to Health Care in 2023 was presented at 2 pm CDT on June 8 by Dr. Kimberly Acquaviva, a professor from the University of Virginia School of Nursing. The live webinar was not recorded.

The DEI Strategic Planning Subcommittee met April 26 to determine priorities and finalize an action plan. The goal is to update the 3-year DEI strategic plan and submit an implementation plan for AAHPM to the DEI Committee and board of directors.

Workforce and Career Development Committee Update

Build and Sustain a Diverse Workforce
Bethany Snider, MD HMDC FAAHPM, Chair

AAHPM recognizes the importance of promoting diversity in the workforce and is actively working toward this goal. By expanding the leadership training program and improving accessibility to training, AAHPM aims to cultivate a diverse group of leaders in the field of hospice and palliative care. Collaboration between committees also focuses on advancing DEI in daily practice and training through development of replicable educational tools and strategies.
The Assessments Work Group hosted a preconference workshop at the Annual Assembly in Montréal that provided tool kits for fellowship programs to improve fellow assessments and faculty development. The tool kits aim to improve the overall assessment process for fellows and promote consistent and effective evaluation of fellows’ competencies in the field.

AAHPM held a career fair April 27, and has set dates for two more this year: August 25 and December 14. Please contact Mickey Martin, AAHPM’s senior manager of sales, at mmartin@aahpm.org if you would like your institution to participate.

**Education and Learning Committee Update**

**Engage, Develop, and Sustain Expertise**  
*Lynn O’Neill, Chair*

The 2023 Annual Assembly of Hospice and Palliative Care Planning Committee successfully hosted our hybrid 3-day event March 22-23, bringing together more than 2,900 colleagues to share research, clinical best practices, and practice-related guidance to advance the specialty of hospice and palliative care. Content for the on-demand component of the Assembly continued until April 24, and content was available available until April 30, 2023.

The Annual Assembly is designed for physicians, advanced practice nurses, registered nurses, pharmacists, physician assistants, researchers, social workers, fellows, residents, chaplains, students, professionals in training, and other members of the healthcare team interested in acquiring, maintaining, or expanding skills needed to function effectively in the field of hospice and palliative care.

Our 2023 Annual Assembly brought together a wide diversity in disciplines to learn together to improve the care of patients and families with serious illness.

AAHPM Learn, the Academy’s learning platform, had an exciting lineup of premiere continuing medical education (CME)-accredited activities, including the following:

- **April 18:** AAHPM hosted a free webinar, *Pain Management and Opioids: Balancing Risks and Benefits*, presented by Kathleen Broglio, DNP ANP-BD, and Joe Shega, MD. The course
curriculum is fully compliant with the Food and Drug Administration Opioid Analgesic REMS Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain and the 2022 Centers for Disease Control and Prevention Clinical Practice Guideline for Prescribing Opioids for Pain. In addition, this course met the Drug Enforcement Administration (DEA) and the Substance Abuse and Mental Health Services Administration Medication Access and Training Expansion (MATE) Act. The MATE Act requires new or renewing DEA registrants, as of June 27, 2023, to have completed at least 8 hours of training on opioid or other substance use disorders.

• **April 27:** AAHPM hosted Escape to the Museum: Finding Connection and Meaning webinar presented by Laura Morrison, MD, and Gordon Wood, MD and a panel of national faculty experts. This unique virtual session invited participants to experience art museum teaching, refining observation skills and connecting to meaning while considering how to learn and apply these teaching strategies in their home settings.

• **May 25:** Part of the Grand Rounds Clinical Series, “Is There a Pharmacotherapy Specialist in the House?” was presented by Mary Lynn McPherson, PharmD MA MDE BCPS. Participants in this Grand Rounds session gained a deeper understanding of the role of a pharmacotherapy specialist in palliative care and how an evidence-based practice (the old three-legged stool) is implemented.

• **June 2023:** AAHPM released an on-demand recording with active learner engagement activities on Pain Management and Opioids: Balancing Risks and Benefits presented by Kathleen Broglio, DNP ANP-BD and Joe Shega, MD. See the April 18 activity description to learn more about the presentation.

• **June 2023:** AAHPM released an on-demand microlearning flight CME on surgical palliative care entitled Demystifying Complex Mechanical Support and Other Surgical Equipment and Devices Hanging Out of your Seriously Ill Patient, presented by Drs. Ana Berlin and Allyson Cook Chapman and their faculty support team. Developed by national palliative surgery content experts, this four-part microlearning flight demystifies complex mechanical support and surgical equipment and devices commonly seen in hospice and palliative care. Content presents a provider’s guide to maintaining, caring for, and withdrawing these often-intimidating devices, with a focus on surgical outcomes, palliative care utilization, and communication in surgical decision making.

• **July 2023:** Palliative Wound Care, a webinar presented by Erika Ketteler, MD, and her team of WOCN-certified nurses, was designed to enhance the palliative and hospice provider’s knowledge and performance in the management of palliative wounds and offers a framework using case studies to abate patient, family, and team suffering utilizing a systematic and patient-centered approach to care.

Save the date for AAHPM’s 2023 Advanced Clinical Course on November 3 in Chicago. This full-day intensive is designed to strengthen and expand the knowledge base of primary psychiatric skills that palliative providers need to enhance treatment planning and develop clinical interventions for the emotional distress associated with serious medical illness. Drs. Alex Gamble, David Buxton, Allison Jordan, and Paul Riordan and PharmD Christie Kahlon will be the faculty experts conducting this intensive training on the intersection of mental health and palliative care. More information will be coming soon.

**Quality and Research Committee Update**

**Promote Quality of Care, Research, and Translation of Evidence into Practice**

Rebecca Aslakson, MD PHD FAAHPM, Chair

The Quality Committee has reviewed and recommended the EMS Care of Adult Hospice Patients – a Position Statement and Resource Document of NAEMSP and AAHPM, which has been endorsed by the AAHPM Board of Directors. In collaboration with the Public Policy Committee, the Quality Committee has submitted comments pertaining to the quality provisions of the Centers for Medicare & Medicaid Services (CMS) FY 2024 Hospice Wage Index and Payment Rate Update proposed rule.

The Research Committee reviewed 22 applications for the Research Scholars Program to select six outstanding applicants to receive funding. These recipients will attend the 2023 Kathleen M. Foley Palliative Care Retreat and Research Symposium October 24-26 in Jackson Hole, WY. The scholarship recipients are Zhimeng Jia, MD CCFP (PC); Whitney Kiker, MD; Jessica Ma, MD; Gina Piscitello, MD MS; Rebecca Rodin, MD MSc; and Keisha White Makinde, MD MPH. AAHPM congratulates them.
The committee also is investigating the most effective strategies for AAHPM to promote the growth and development of a skilled group of investigators in serious illness.

Health Policy and Advocacy Committee Update

Advance Health Policy and Advocacy
Kyle P. Edmonds, MD FAAHPM, Chair

• AAHPM responded to a request by U.S. Rep. Earl Blumenauer (D-OR) for policy recommendations to improve hospice program integrity and improve the Medicare hospice benefit.
• AAHPM joined stakeholder partners in urging Congress to pass legislation providing an annual inflation-based physician payment update based on the full Medicare Economic Index.
• AAHPM responded to a U.S. Senate Committee on Health, Education, Labor, and Pensions request for input on healthcare workforce shortages. The Academy discussed existing and projected HPM workforce shortages and pointed to policies needed to support specialty training as well as supplement the specialty workforce caring for patients with serious illness—including passing the Palliative Care and Hospice Education and Training Act (S 4260).
• AAHPM submitted written testimony for the U.S. House of Representatives Appropriations Subcommittee on Labor, Health and Human Services, and Education, requesting $20 million in new spending to expand and intensify the strategic coordination of palliative care research efforts.
• AAHPM weighed in on the Centers for Medicare & Medicaid Services proposals to advance interoperability and improve prior authorization processes within Medicare Advantage.

Development Update

At the recent Annual Assembly of Hospice and Palliative Care, we achieved remarkable fundraising success. Members generously donated $6,907, a 128% increase from last year, to support programs providing vital resources for medical professionals in hospice and palliative care.

This accomplishment reflects the dedication and generosity of our members. We are immensely grateful for their contributions, as the Academy proudly continues to advance the field.

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HMDCB is excited to announce the launch of a new Continuing Certification Program (CCP) in 2024. This new program will eliminate the high-stakes recertification exam and provide certificants with ongoing learning through a longitudinal assessment.

The goals of this new program are to accurately assess the competency, skill, and judgment of certified physicians on a continuous basis while also providing opportunities for professional development.

More information, including the full program requirements and an FAQ document, can be found at www.HMDCB.org/ccp.

2023 CCP Exam Dates
If your credential expires in 2023 or 2024, you are eligible to recertify this year!

• Application Deadline: November 1, 2023
• CCP Testing Window: July 6–November 14, 2023

To ask questions about the new CCP or find out when your credential expires, contact HMDCB staff at info@hmdcb.org or call 847.375.6740.

HMDCB Community Events
All HMDCB certificants are encouraged to attend these upcoming HMDCB Community Events:

• HMDCB and AAHPM Webinar: September 12 at 1 pm CT
• October Coffee Chat: October 19 at 12 pm CT
• Hospice Physician Documentation Clinic: November 3, 10, and 17 at 1:30 pm CT

These are great opportunities to connect with your certified peers throughout the country and gain new knowledge in hospice medicine! To learn more and register for these events, visit www.HMDCB.org/community.

Learn more and register for these events at www.HMDCB.org/community.
CONGRATULATIONS TO THE NEW LEADERS OF
OUR SPECIAL INTEREST GROUPS AND FORUMS

These individuals were elected by their special interest groups (SIGs) and forums and began their terms at the close of the 2023 Annual Assembly of Hospice and Palliative Care. Thank you for providing your leadership to these groups.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Leaders</th>
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</thead>
<tbody>
<tr>
<td>Cancer and Cancer Treatments SIG</td>
<td>Stephanie Terauchi, MD FAAHPM</td>
</tr>
<tr>
<td>Early Career Professionals SIG</td>
<td>Gregg Robbins-Welty, MD MS</td>
</tr>
<tr>
<td>Early Investigators Forum</td>
<td>Amy Porter, MD PhD</td>
</tr>
<tr>
<td>East and South Asian Professionals, Patients, and Families in HPM Forum</td>
<td>Eriko Onishi, MD MCR</td>
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<tr>
<td>Education SIG</td>
<td>David Harris, MD</td>
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<tr>
<td>Ethics SIG</td>
<td>Michael Nisco, MD MBA HMDC FAAFP FAAHPM</td>
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<tr>
<td>Fellowship Directors SIG</td>
<td>Shireen Heidari, MD</td>
</tr>
<tr>
<td>Global SIG</td>
<td>Hedieh Matinrad, MD</td>
</tr>
<tr>
<td>Grief, Bereavement, and Resiliency Forum</td>
<td>Allie Shukraft, MSW MAT APHSW-C</td>
</tr>
<tr>
<td>Humanities and Spirituality SIG</td>
<td>Katie Mechler, MD</td>
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<tr>
<td>ICU SIG</td>
<td>Gilles Chemtob, MD CM HEC-C</td>
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<tr>
<td>Integrative Medicine SIG</td>
<td>Augustin Joseph, MD</td>
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<tr>
<td>Latino Professionals, Patients, and Families in HPM Forum</td>
<td>Marieberta Vidal, MD</td>
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<tr>
<td>LGBTQ+ SIG</td>
<td>Michael Danielewicz, MD</td>
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<tr>
<td>Long-Term Care/Geriatrics SIG</td>
<td>Thanmayi Kaza, MD</td>
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<tr>
<td>Medical Aid in Dying SIG</td>
<td>Susan Wilhoit, MD</td>
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<tr>
<td>Neuropalliative SIG</td>
<td>Rita Crooms, MD MPH</td>
</tr>
<tr>
<td>Outpatient Palliative Care SIG</td>
<td>Catherine Pham, MD HDMC</td>
</tr>
<tr>
<td>Pharmacotherapy SIG</td>
<td>Alifia Waliji-Banglawala, PharmD MBA</td>
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<tr>
<td>Primary Care SIG</td>
<td>Jennifer Skorupa, MD</td>
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<tr>
<td>Program Chiefs SIG</td>
<td>Kristina Newport, MD</td>
</tr>
<tr>
<td>Psychosocial and Mental Health SIG</td>
<td>Keri Brenner, MD MPA</td>
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<tr>
<td>Research SIG</td>
<td>Steven Smith, MD</td>
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<tr>
<td>Rural SIG</td>
<td>Agron Ismaili, MD MBA DABPM CMD FACP FASAM FAAHPM</td>
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<tr>
<td>Safe Use of Psychedelic-Assisted Therapies Forum</td>
<td>Caitanya Min, NP-C ACHPN</td>
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<tr>
<td>Safety Net SIG</td>
<td>Marla Rejbi, DO</td>
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<tr>
<td>Self-Care Forum</td>
<td>Emily L. Cotter, MD MPH</td>
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<tr>
<td>Substance Use Disorder and Diversion SIG</td>
<td>Katrina Nickels, MD</td>
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<tr>
<td>Surgical and Perioperative Care SIG</td>
<td>Elizabeth Lilley, MD MPH</td>
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<tr>
<td>Veterans SIG</td>
<td>Shayna Rich, MD PHD</td>
</tr>
<tr>
<td>Wellness, Wellbeing, and Burnout Forum</td>
<td>Christie Mulholland, MD</td>
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AAHPM News
AAHPM 15-Minute Podium Abstract Awards

AAHPM congratulates the authors of the following award-winning 15-Minute Podium abstracts from the 2023 Annual Assembly of Hospice and Palliative Care. These awards recognize the top 5% of 15-Minute Podium abstracts submitted, as determined by the 2023 Annual Assembly Planning Committee during abstract review and scoring. To be eligible for these awards, abstracts had to have at least one author who is a member of AAHPM.

Case Study Award
Beyond Bystanders: Training Palliative Care Clinicians in “Upstander” Allyship
Sarah Winawer-Wetzel, MBA
Niharika Ganta, MD MPH FAAHPM

Inequality and Irony: Barriers Associated with Missed Palliative Care Telemedicine Visits
Paul D. Farah, DO
Renato V. Samala, MD MHPE HMDC FACP FAAHPM
Wei Wei, MS
Ruth Lagman, MD MPH MBA
Melanie Robins-Ong, DO

Early Career/Professional in Training Scholarly Work-in-Progress Study Award
Adoption of an Innovative “Patient Values Tab” in the Electronic Health Record (EHR) Across Varied Care Provider Roles and Clinical Contexts
Anjali V. Desai, MD MSCE
Andrea Knezevic, MS
Gregory Jordan, BS
Alla Levy, BS
Afshana Hoque, BA
Camila Bernal, MPH
Andrew Epstein, MD FAAHPM
Judith Nelson, MD JD

A Culturally Grounded, Community-Engaged Approach to Understanding Palliative Care Needs in a Reservation-Based Community
Katie E. Nelson, MSN RN PhD(c)
Kathleen Adams, BSN RN
Patricia M. Davidson, RN PhD
Mumtahana Meah, BS
Claire Petchler, BA RN CCRN
Alicia Werk, BSN RN
Rebecca Wright, PhD BSc (Hons) RN
Teresa Brockie, PhD RN FAAN

Scientific or Quality Improvement Award
“Little Seeds of Information”—Perspectives from Home Health Aides and Palliative Care Research Cooperative (PCRC) Community Hospice Partners to Address Information Needs Related to COVID-19 Vaccination
Stacy Fischer, MD
Hillary Lum, MD PhD
Matthew DeCamp, MD PhD

Engaging Seriously Ill and Vulnerable Older Adults in a Nurse-Led Telephonic Intervention: The Emergency Medicine Palliative Care Access Trial (EMPallA)
Rebecca L. Yamarik, MD MPH HMDC FAAHPM
Mara Flannery
Kaitlyn Van Allen, MPH
Allison Cuthel, MPH
Jennifer Curtis, BSN RN CHPN
Laraine Ann Chiu, MSN RN
Inez Brandon, RN MSN CHPN CNL OCN
Keith S. Goldfeld, DrPH MS MPA
Corita R. Grudzen, MD MSHS FACEP
Also honored and deserving of congratulations are the recipients of the poster abstract awards. These awards recognize the top 5% of poster abstracts submitted, as determined by the 2023 Annual Assembly Planning Committee during abstract review and scoring. To be eligible for these awards, abstracts had to have at least one author who is a member of AAHPM.

**Case Study Poster Award**

Exploring the Ethical and Moral Implications of Requiring Informed Consent to Determine Death by Neurologic Criteria

Matthew J. Hibbs, MD
Morgan Coleman Arnold, DO
Mark S. Beveridge Jr., MD

**Early Career/Professional in Training Scholarly Work-in-Progress Study Poster Award**

Referral-Based Versus Embedded-Based Palliative Care Consultation Models Among People Hospitalized with Heart Failure: Improving the Flow

Anup Bharani, MD
Ankita Mehta, MD
Karen Hiensch, ANP-BC
Li Zeng, MS
Anuradha Lala, MD
Nathan E. Goldstein, MD FAAHPM
Emily Chai, MD
Laura Gelfman, MD MPH

**Scientific or Quality Improvement Poster Award**

Using the NCP Guidelines as a Framework for an Interprofessional Cancer Communication Training

Haley Buller, MSHSC
Betty Ferrell, PhD MA CHPN FAAN FPCN
Judith Paice, PhD RN
Myra Glajchen, DSW MSW BSW ACSW APHSW-C
Trace Haythorn, PhD
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