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COMMUNICATING
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A MESSAGE FROM THE PRESIDENT

AAHPM'S STRATEGIC PLAN IS GROUNDED IN OUR VALUES

I don't think it is lost on any of us in hospice and palliative care that health care is undergoing seismic shifts related to workforce, reimbursement, and its very structure. At the urging of our CEO, we chose to engage in a strategic planning process earlier than planned to meet the challenges of this time. It is with great enthusiasm I share with you the American Academy of Hospice and Palliative Medicine's (AAHPM) new strategic plan for 2024-2027.

This plan is the result of nearly a year of extensive work by dedicated Academy volunteer leaders and our outstanding staff.

Our commitment to excellence and innovation was intentional, and the following goals will serve as a blueprint for our operations in the years ahead.

1. Advance the Field
2. Support Professional Success
3. Build a Vibrant Community
4. Ensure a Strong Organization.

Grounded in our values, the new strategic plan will guide the Academy's efforts and programming in objectives that will ensure AAHPM remains at the forefront of hospice and palliative care.

Commitment to High-Quality Care

At the heart of our mission is a steadfast dedication to providing the highest-quality care to patients and their families. We will continue to set and uphold the highest standards, leverage evidence-based practices, and foster a culture of continuous improvement.

Advocacy for Equity and Inclusion

AAHPM is committed to advocating for equitable access to hospice and palliative care for all individuals, regardless of their background or circumstances.

Interprofessional Collaboration and Membership Sustainability

Our strength lies in our diverse and dedicated membership. We will enhance interprofessional collaboration to foster a more integrated and supportive network of professionals. Ensuring the sustainability of our membership base is crucial, and we will implement initiatives that support and engage our members at all stages of their careers.

Professional Development and Support

Supporting the professional growth and development of our members is a key priority. We will provide robust educational resources, mentorship opportunities, and pathways for career advancement, ensuring that our members are well-equipped to meet the evolving challenges of our field.

Community Engagement and Growth

Engaging with our community is essential for fostering growth and innovation. We will strengthen our outreach efforts, build meaningful partnerships, and create opportunities for members to connect, collaborate, and share their expertise.

Organizational Strength and Innovation

We must ensure that AAHPM remains a solid and innovative organization to achieve our goals. We will implement forward-thinking strategies that position us for long-term success.

As I reflect on this bold and forward-thinking strategic plan, I want to highlight that this is the culmination of work done by our shared governance and informed by the voices and perspectives of members, volunteer leaders, and collaborators in the field. Active participation and transparency ensured the ideas that built this plan were inclusive, equitable, diverse, and ambitious. I find myself most excited about the ways in which we can support our members' individual and collective needs, whether that is in creating leadership development opportunities, advocating at the national level for hospice policy reform, building a diverse workforce, or supporting the research community. This plan works to meet the needs of our membership so you all can do the important work of improving care for patients and families living with serious illness.

Implementation planning is underway, and the Academy understands the need to be nimble and prepared to adjust to a changing healthcare landscape. I encourage you to read the strategic plan in its entirety so you can look for ways that you may contribute to its execution. Your engagement and support are vital as we embark on this exciting journey together.

With gratitude,

Vicki Jackson

Vicki Jackson, MD MPH FAAHPM
AAHPM President

CLINICAL PEARLS

DEPRESCRIBING FOR HOSPICE

Sarah Stayer, MD MPH, and Paul Tatum, MD MSPH AGSF FAAHPM

At the time of transition to hospice, emotions run high. Families and patients may not be ready, but change can occur quickly in terms of care settings and clinical status. Medical staff are challenged during this time with the act of deprescribing medications. It can be a time of trust-breaking between the hospice team and the family if not handled carefully. Potential benefits and burdens of treatments must be balanced with the patient's goals. Conceptualizing this process as goal-concordant prescribing rather than deprescribing may help team members move away from a process that might over-emphasize stopping medications before patients and family members are ready.

The initial determination of whether the medication is related to the terminal diagnosis determines how the medication is paid for. The hospice interdisciplinary group must complete a comprehensive assessment within 5 calendar days of admission, including "a review of all the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes… identification of the following: effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring."[1] Because of the tight timeline and potential changes in coverage, this can become a time of mistrust.

Those who make the initial referral to hospice can ease families' burdens by having explicit conversations with patients and families about the medications. In 2022, documentation of patient or family participation in medication decisions only occurred in 22% of discharges from acute care to hospice care.[2] Palliative providers, using their established relationship, can help their hospice partners by implementing specific interventions to address deprescribing before hospice admission.

The following are tips to help you support patients and families through this change.

1. **Expect emotions.** The act of medication deprescription is emotionally charged. Patients have emotional attachments to their medications. Many identify as being a "good" patient through their medication compliance. Since doctors reiterate messages of the importance of these medications, patients may feel like their physical safety is threatened by stopping medications. Consider questions such as "Would it be okay if we talk about your medications and look at which ones will be most helpful to you now and consider which may not be helping?" When emotions arise, stop the medical side of the discussion. Be prepared with supportive statements, such as "I know this is hard to think about" or "I know you have been taking this medication for so long; it must feel strange to think about not needing it anymore."
2. **Come prepared with information.** Prior to meeting the patient, carefully evaluate the medications for any interactions, particularly those with the potential to precipitate withdrawal. For instance, there is increasing literature supporting the stopping of statins as a safe option with improved quality of life.[3] Have a list of medications felt to have potential harm, to no longer provide benefit (such as preventive medications), and those requiring taper. Use the Beers List to help guide your choices. Ask your patients, "which medications are you most worried are causing harm?"
3. **Negotiate.** Understanding your stakeholders' (ie, the patient's and family's) perspectives is critical for good negotiations. Lead with questions that will help you understand their priorities, such as "Which medications do you think are not helping—or even causing unwanted side effects?" and "Which medications do you feel help you the most?" Ask about pill burden, which can decrease quality of life. Time-limited trials of either stopping or continuing medications can be helpful. Listen to their priorities and look for common ground.
4. **Provide guidance for your staff.** As the medical provider in charge of guiding nurses around deprescribing, know this is a skill that nurses can

develop. Train nurses to include patients and their families and open communication between the family and the physician, when necessary, so as to support patients and families through this transition and avoid division. Model these conversations and consider role-play. Reviewing the VitalTalk framework of NURSE statements[4] for how to respond to emotions provides a great foundation of various methods to support patients and families in these charged moments.

Transitions of all kinds are filled with challenges. With the right attitude and preparation, change can occur in a way that maintains confidence and trust. ●

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Sarah Stayer, MD MPH, focuses on providing compassionate, personalized care to patients and families, helping them choose the care most accordant with their own values. Her interest lies in improving communication between patients and medical teams and teaching these vital skills to future generations of physicians. She is a lifelong learner and a passionate teacher.

Paul Tatum, MD MSPH AGSF FAAHPM, is a geriatrician and palliative care physician who came to palliative medicine through a series of wonderful hospices where he had the good fortune to be medical director. He has served on the Medical Director Advisory Board of Compassus: Hospice and Palliative Care. He currently works with hospice patients with the VA St Louis and delights when deprescribing helps a patient feel better.

ART OF CARING

PORTRAYALS

Justin Maxon, Photographer, and Michael Fratkin, Physician

These images are meant to open a window to the lives of people within their natural habitats as those lives are completed. The words are meant to bring meaning and context—a doctor's flourish.

1.

There comes a moment
when there is nothing
around the corner.

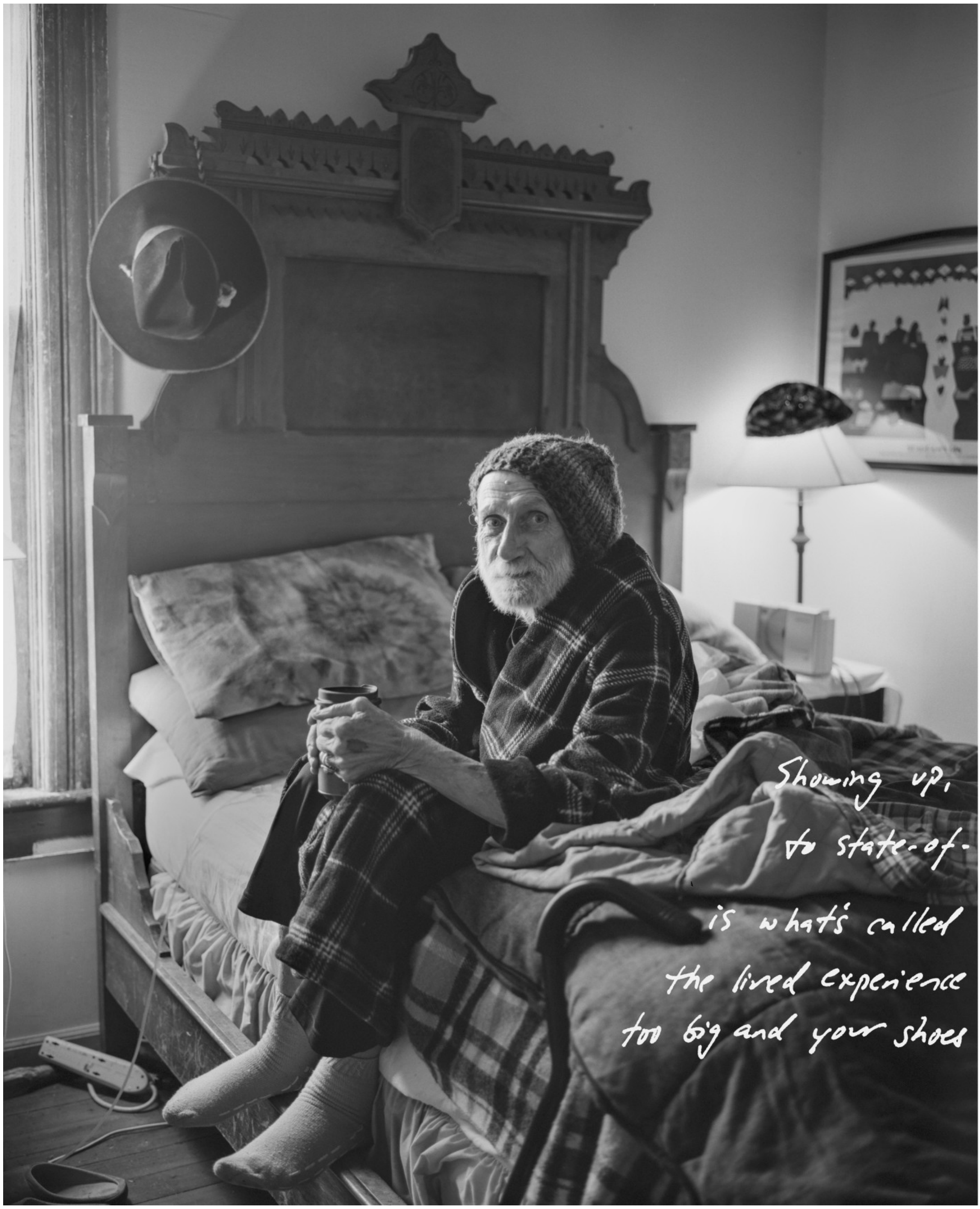
Hope appears when
the waiting is over.

2.

To envision & create a sustainable future, the infrastructure we build to care for people who care for people with serious illness must be centered on what people need.

The blueprints must be drawn from the bedside outward, not from the institutions inward.

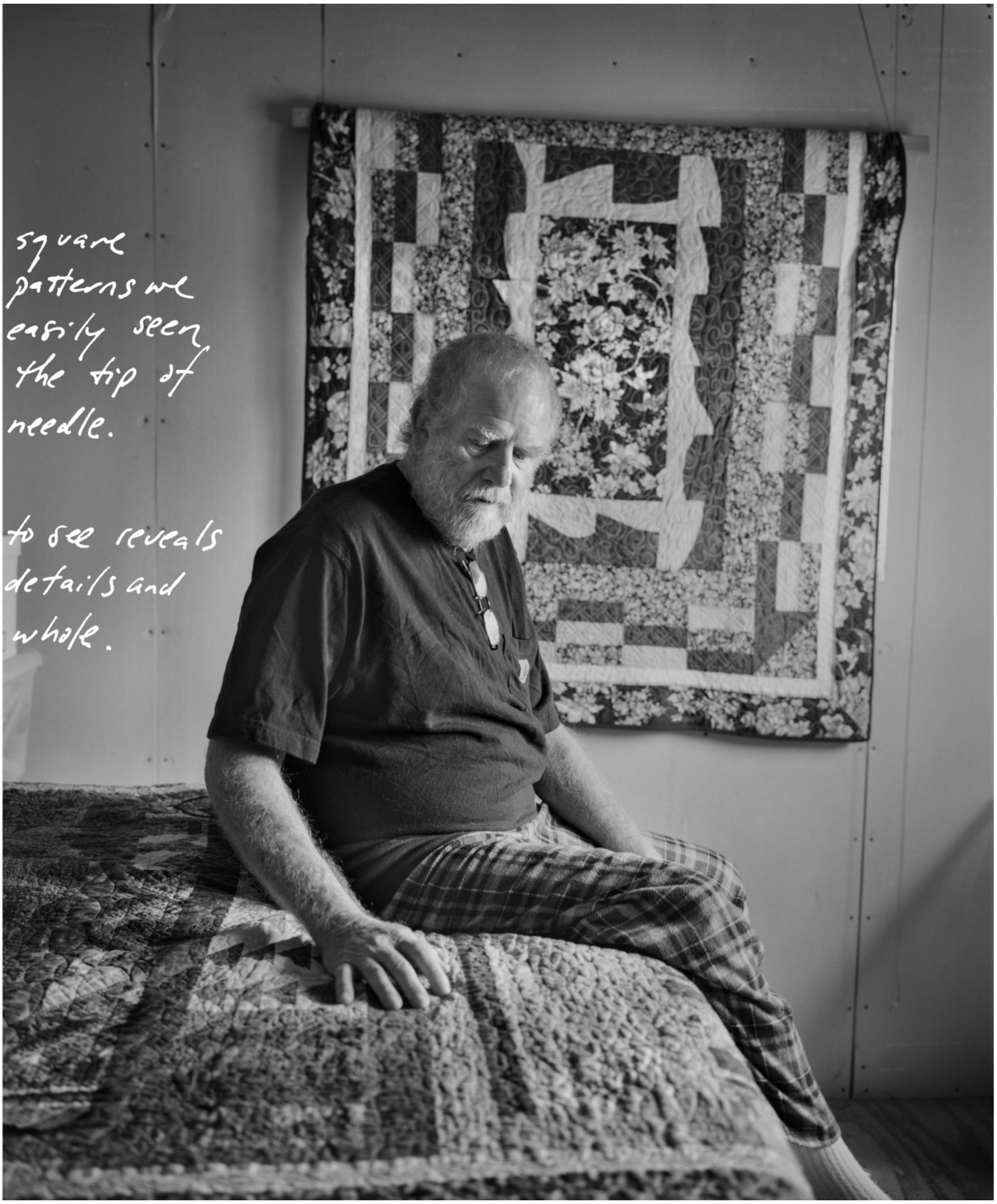
3.



Showing up, in addition
to state-of-the-art medicine,
is what's called for in response to
the lived experience of when your hat's
too big and your shoes are too small.

Moment by moment, square
by square, the patterns we
weave are not easily seen
while squinting at the tip of
the needle.

A last step back to see reveals
the imperfect details and
the perfect whole.



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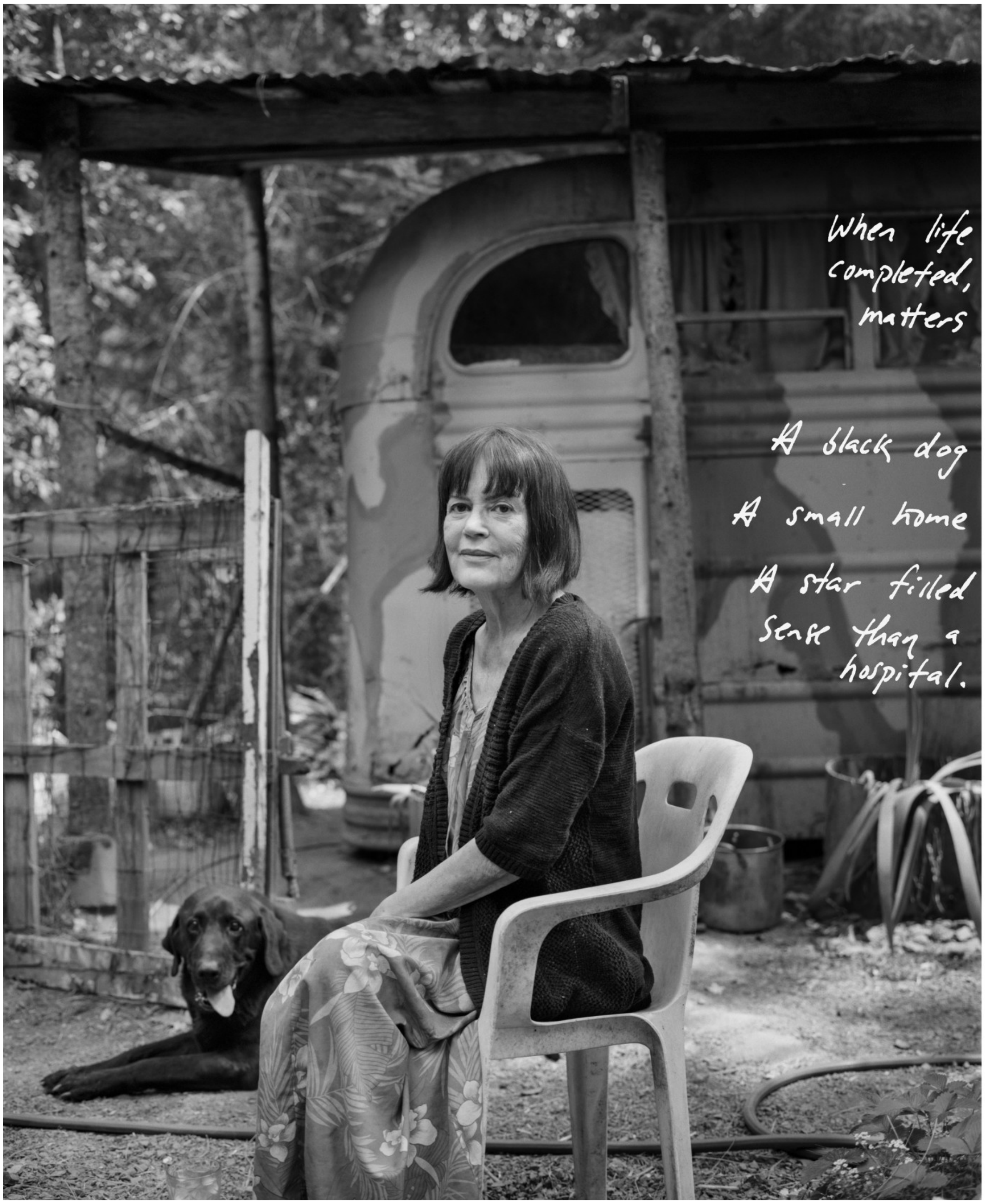

5.

When life is being
completed, who we are
matters more than what we
have.

A black dog is family.
A small home is freedom.
A star filled sky makes more
sense than a university
hospital.

Want to see your creative writing, photography, art, or illustration in *AAHPM Quarterly*?
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ADVOCACY UPDATE

RESEARCH FUNDING, PCHETA, CONCURRENT CARE: AAHPM ADVOCACY AGENDA MOVES FORWARD

Wendy Chill

AAHPM continues to accomplish significant policy and advocacy work. We want to ensure members are kept informed of this valuable work impacting the practice of hospice and palliative care as well as patients, families, and caregivers.

AAHPM Secures Federal Funding for Palliative Care Research

The federal appropriations package for fiscal year (FY) 2024, which passed on March 24, included $12.5 million for the National Institute on Aging to implement a transinstitute, multidisease strategy to expand and intensify national research programs in palliative care. AAHPM, in active partnership with the Patient Quality of Life Coalition (PQLC), strongly advocated for this increased funding for palliative care research. This victory brings to fruition countless hours of advocacy efforts by the Academy and others.

The money appropriated in the current federal budget marks the first time that funds have been explicitly dedicated to the purpose of researching palliative care.

For the FY 2025 appropriations package, AAHPM continues to advocate for maintaining this important funding. In addition to advocating for this funding in partnership with PQLC, AAHPM also submitted its own written testimony to the House Committee on Appropriations, Labor, Health and Human Services, Education, and Related Agencies Subcommittee. These requests highlight the importance of increasing the evidence base for palliative care and ensuring that patients with serious illness, as well as their families and caregivers, receive the high-quality care they need and deserve.

Lobby Day in Support of PCHETA

On April 17, 2024, AAHPM, in partnership with PQLC, participated in a lobby day in support of the Palliative Care and Hospice Education and Training Act (PCHETA). The goal of the day was to both increase bipartisan Senate support of the legislation and to ensure the Health, Education, Labor, and Pensions (HELP) Committee takes action to move it forward.

PCHETA would expand opportunities for interdisciplinary education and training in palliative care, including through new education centers and career incentive awards for physicians, nurses, physician assistants, social workers, and other health professionals. The bill would also implement an awareness campaign to inform patients and healthcare providers about the benefits of palliative care and hospice and the services available to support individuals with serious illness, as well as provide direct funding toward palliative care research to strengthen clinical practice and health care delivery.

AAHPM members Gregg VandeKieft, MD FAAHPM, and Paul Tatum, MD FAAHPM, traveled to Washington, DC, to take part in meetings with their senators to ask for support and passage of PCHETA. In total, PQLC volunteers met with 48 different Senate offices and 2 House offices.

Session on Concurrent Care Held During AAHPM Annual Assembly

To ensure that people with serious illness always receive the right care at the right time, we need policies that support concurrent disease-directed and palliative care. During a public policy forum ("Why Can't I Have Both? The Imperative for Concurrent Disease-Directed and Palliative Care") at this past Annual Assembly, hospice, pediatric, and public policy experts from AAHPM, the National Coalition for Hospice and Palliative Care (NCHPC), and the National Hospice and Palliative Care Organization (NHPCO) discussed the benefits, challenges, and policy implications of concurrent care. Speakers discussed how the benefit works for children, highlighted opportunities for adults in innovative hospice and palliative care programs, and reported on the proceedings of a national stakeholder convening to define concurrent care, hosted by NCHPC and NHPCO on February 6, 2024.

The panel was moderated by Phil Rodgers, MD FAAHPM, chair, department of family medicine, University of Michigan, and included Benjamin Moresco, MD FAAP, medical director, Rainbow Kids Pediatric Palliative Care; Bethany Snider, MD FAAHPM, senior vice president and chief medical officer, Hosparus Health; Rory Farrand, MSN APRN-BC, vice president, palliative and advanced care, NHPCO; and Jessica Hausauer, PhD, executive director, NCHPC.

Payment rules that make patients quit disease-directed treatments to get palliative care, such as dialysis restrictions for hospice patients, put those who aren't ready for the trade-off in a bind and may extend their suffering. Lack of concurrent care options contributes to disparities in hospice care. Concurrent care is now mandated under the Affordable Care Act for children and supported in the Veteran's Administration system. New alternative payment models may allow concurrent care, but access remains limited. Lack of clarity in terminology used to describe concurrent care poses a policy challenge, although a recent convening of national stakeholders focused on finding common language.

Wendy Chill is AAHPM's director of health policy and government relations. For more information or questions about the Academy's advocacy efforts, e-mail info@aahpm.org.

COMMUNICATING PALLIATIVE CARE'S TRUE VALUE

LARRY BERESFORD

At a time when many palliative care managers are busy trying to find their footing in value-based models of managed healthcare delivery for covered populations (see "How Can Hospice and Palliative Care Clinicians Find their Home in Population Health," AAHPM Quarterly Newsletter, Fall 2023), Academy member Sandra Gomez, MD FAAHPM, president of Symptom Management Consultants in Humble, TX, was gratified for a chance to speak at the national conference of the American College of Healthcare Executives (ACHE) on March 26, 2024, in Chicago.

There, she and colleagues Rodney Tucker, MD FAAHPM, of the University of Alabama at Birmingham and Tom Gualtieri-Reed of Spragens & Gualtieri-Reed presented palliative care concepts to the assembled leadership of a healthcare system in transition. They were invited by Chuck Stokes, FACHE, ACHE's past chair and a retired healthcare executive who served as executive in residence at the University of Alabama at Birmingham. [*Editor's Note:* Stokes passed away on July 23, 2024.]

When participants at her session were asked if their networks and organizations had palliative care programs, most hands went up. When asked if they knew whether their network's palliative care program was healthy, robust, or well-staffed, most hands went down. "Those leaders affirmed that they have little idea what palliative care does," Dr. Gomez reported. Most were unaccustomed to speaking about care at the end of life. "We had a good session," she says. "The room wasn't empty. They asked a lot of good questions." But clearly there were gaps in understanding.

If palliative care advocates are trying to advance what they do best—managing the most medically complex and seriously ill patients at home, protecting them from avoidable emergency room visits and hospitalizations, managing distressing symptoms to prevent crises, clarifying these patients' goals of care, offering medical care plans in accord with those goals, avoiding unnecessary and unwanted treatments, and supporting family caregivers—then they would seem to be facing a communication problem. That is, a gap in understanding about what palliative care offers, confusion about what value-based care entities might desire from this field, and lack of clarity about how their respective languages differ, overlap, or might need to be reconciled.

CEOs need to know that home-based palliative care can meet seriously ill patients' needs, Dr. Gomez said. "It works beautifully as a wraparound service. But we need to know who is at financial risk for that patient. We need to look at the conversation with a different lens: Who am I trying to convince?" Where are they getting their information about palliative care?

Hospital systems have created palliative care programs, she said, "but they're losing money on them. It's expensive to deploy the full palliative care team." There are demo projects at the Centers for Medicare and Medicaid Services (CMS), with people working with hospices to build community-based programs for seriously ill patients but without an appreciation for how expensive it is to actually care for such patients.

Leaders in palliative care, even at the highest levels, "usually only talk at each other's conferences. We need to be talking to different groups, not just to each other," Dr. Gomez said. "We need to be sharing our articles about cost savings with CEOs. We need to get in front of those folks in their venues. Chuck Stokes had challenged us to put together a palliative care model and value proposition for healthcare organizations and value-based care organizations. We needed a sponsor, and so we are aligning with Chuck['s work]."

THE VALUE PROPOSITION

In her career, Tara C. Friedman, MD FAAHPM, past president of AAHPM and chief medical officer (CMO) of Chapters Health System in Temple Terrace, FL, has gone from building inpatient palliative care programs in academic and community hospitals to Aspire Health, an early example of community-based palliative care as a direct contracting entity, to a large multistate hospice organization. "When I first got into the field, we were very focused on hospital-based care. We had no idea that the next big change in health care would be to push back into the community," Dr. Friedman said.

"Our field is still very young. Twenty years ago, we were shouting from the mountaintop, 'Look at us!' With rapid growth in the field, we quickly realized we didn't have enough people to do everything the system wanted from us. And now we need to refocus on how palliative care is important in this new context. In many ways we are still struggling with our own identity now that the need is to take care further upstream," she said. "We also have to think about what resonates with a health plan or other risk-bearing entity."

> *"CEOS NEED TO KNOW THAT HOME-BASED PALLIATIVE CARE CAN MEET SERIOUSLY ILL PATIENTS' NEEDS. IT WORKS BEAUTIFULLY AS A WRAPAROUND SERVICE."*

Palliative care advocates need to learn a new language, understand a slew of unfamiliar acronyms, and appreciate a new set of key performance metrics, keeping members healthier and well-informed and providing goal-concordant care for the sicker members, Dr. Friedman said. "We need to translate that into vocabulary risk-bearing entities understand, like days at home, medical loss ratio, hospital admissions and ER visits per thousand, and the like."

With more than 40 years of experience delivering on full-risk care delivery, hospice has more experience in this type of care delivery than other sectors of health care. "We might consider how to leverage that experience into innovation, rather than waiting in the wings to see what happens," Dr. Friedman said.

Dana Lustbader, MD FCCM FAAHPM, professor of medicine at Zucker School of Medicine at Hofstra/Northwell in New York and national medical director at Humana, started her palliative care career more than 20 years ago by creating an inpatient consult service, first in one hospital, then spread across eight hospitals and an entire health system. "We also built a hospice and palliative medicine fellowship. Then we started a supportive oncology clinic in a bricks-and-mortar cancer center and a palliative care clinic within a large provider group."

She built out tele-palliative care 10 years ago, using video visits long before the pandemic, and then joined Optum, the clinical care arm of the health plan giant UnitedHealthcare, to scale up home-based primary care for frail seniors and those with advanced illness enrolled in Medicare Advantage, before moving on to Humana.

As Dr. Lustbader looks back on that experience, she is concerned that the hospital-centric way of delivering health care isn't what many seriously ill patients or their families want today. Instead, they would prefer to receive reliable care where they live. "How do we think about preparing our workforce to pivot to where the puck is going—which is to provide care in the home, leveraging AI and remote patient monitoring, with a workforce that can manage medically complex patients at home—when nearly all medical training occurs in the hospital or clinic setting?"

> *"HOW DO WE THINK ABOUT PREPARING OUR WORKFORCE TO PIVOT TO WHERE THE PUCK IS GOING—WHICH IS TO PROVIDE CARE IN THE HOME, LEVERAGING AI AND REMOTE PATIENT MONITORING, WITH A WORKFORCE THAT CAN MANAGE MEDICALLY COMPLEX PATIENTS AT HOME."*

Palliative care advocates should be asking how their own boss pays the bills and what is keeping the boss awake at night, she said. "What are the headwinds we might be facing" with Medicare Advantage and other risk-bearing entities?

Payment for home-delivered care is complicated, Dr. Lustbader said. "It's hard, and one reason why is because it's like the Wild West out there right now—essentially unregulated." Palliative care is not a home health agency benefit and it's not hospice care. It is difficult to sustain in a fee-for-service model and nearly always requires some sort of per member per month payment or shared financial risk arrangement.

WHEN HOME-DELIVERED CARE SAVES

Recent data from the CMS Innovation Center's Independence at Home pilot showed that the most frail individuals with the most impairments in their activities of daily living saved the most money from home-delivered care. Dr. Lustbader was lead author of a 2017 *Journal of Palliative Medicine* study showing reductions of $12,000 in the last 3 months of life for patients receiving home-based palliative care implemented within an accountable care organization.[1] Both pilot and study demonstrated improved outcomes and significant reductions in total cost of care for the most functionally impaired or seriously ill subgroups, she said.

Kimberly Bower, MD, palliative care physician at Rady Children's Hospital–San Diego and former medical director at Blue Shield of California, said healthcare executives make decisions based on finances. A major financial driver for health plans is the number of members enrolled in the plan, which is closely linked to the satisfaction of members with the plan and its benefits package. Palliative care, through its whole-person, patient-centered approach, can be leveraged as part of a strategy to improve member satisfaction and the health plan's net promoter score.

Palliative care providers need to remind plans of the power of high-touch care that is integrated with other interventions that health plans are investing in, such as hospital at home and home monitoring, she said. "We know how to do this. We have been doing it for a long time. We can create value by aligning patient values and preferences with their treatments and educating them on how to manage their disease and avoid the hospital."

When it comes to palliative care's role, generally payers are open to covering a doctor's visit but not the whole palliative care team—which we believe is crucial to achieving optimal outcomes. And that's probably not going to change until the overall financial model changes, Dr. Bower said. Groups like Sharp and Kaiser in California, where the payer and provider are closely related, are now significantly ramping up their palliative care programs because they realize the financial benefits of team-based, proactive, patient-centered care.

But value-based care elsewhere is slow in coming. "If you're paying for care fee-for-service and not realizing the cost savings of avoidable hospitalizations and ED visits and unwanted treatments, it's hard for palliative care to make sense fiscally. Additionally, we don't have consensus on the best ways to measure quality in palliative care, making the implementation of value-based payment models challenging," she said. "At Blue Shield we found that patients who received home-based palliative care were referred to hospice sooner. This resulted both in the patients receiving more benefit from their hospice care and overall cost savings."

VALUE-BASED OR FEE-FOR-SERVICE

Charles von Gunten, MD, a hospice and palliative medicine veteran who is now CMO of Elizabeth Hospice in San Diego, CA, wonders if the field is overemphasizing the role of value-based care and the need to take on risk contracts, given the uneven and incomplete dissemination of value-based models into the population. Most hospitals, he said, still operate largely under fee-for-service reimbursement. And if they are only 60% to 70% full, a pitch by palliative care to keep their patients out of the emergency room and avoid readmissions may not be well-received.

"Value-based care is an interesting innovation, and it's being talked about a lot. But who has actually successfully implemented it?" Dr. von Gunten asks, adding that he believes all health care, just like all politics, ultimately is local. "You need to know your audience and know your market. My suggestion: start your conversations with inquiry—not advocacy. Find out what they know and what they want."

> *ALL HEALTH CARE, JUST LIKE ALL POLITICS, ULTIMATELY IS LOCAL. "YOU NEED TO KNOW YOUR AUDIENCE AND KNOW YOUR MARKET. MY SUGGESTION: START YOUR CONVERSATIONS WITH INQUIRY—NOT ADVOCACY."*

He said that when he was talking about palliative care recently to senior health system leaders, he found out that one of their biggest concerns was a 50% turnover rate among their oncologists, who were burning out from trying to manage difficult, complex patients without the right resources. And that is something palliative care should be able to help with.

"People in health care are enthusiastic for what we have to offer. They're not opposed to palliative care. They're eager to collaborate. Engaging with humility is first as you reach out in the larger environment of health care," he said.

Dr. Friedman thinks it's important to dip a toe into the pool of value-based care, no matter how slightly. "It's being a partner with someone. It's going to your C-suite and asking: 'What kinds of value-based approaches is our health system involved in? And how come palliative care isn't included in that?'" When the next CMS Innovation Center model comes along, is your hospice or palliative care service considering being part of it?

"We need to start talking about being involved now, proving that we can be part of it and can learn along the way. As a field, we have continued to evolve. But now we need to be nimble in navigating the changes, not just as consultants, but taking risk and considering novel reimbursement and payment strategies for sharing that risk," Dr. Friedman said.

No one should be in a position of overseeing a home-based palliative care service until they have gone on a home visit to see how palliative care patients are really managed in the home—and what all that entails, Dr. Gomez said. "I took my CEO on a home visit and have asked his boss on one." But also, find the palliative care team in the hospital and ask to round with them and learn. She encourages palliative administrators with a clinical background to keep one foot in clinical practice, if possible.

BUILDING A BETTER MODEL

For Chuck Stokes, the field's next step is to make its contributions easier to understand by putting together new and better "models" for palliative care (and for hospice, which is just as important)—models that can be replicated in different communities and different parts of the healthcare system. Stokes's hospice model proposes a more consumer-centric language and approach to how hospices present themselves to their community and how this image could be aligned with consumer expectations.

> *"I'D LIKE TO SEE THE HOSPICE PROGRAM DEVELOP TO ANOTHER LEVEL," STOKES SAID. DEVELOP A PALLIATIVE CARE AND HOSPICE SCORECARD AND SHARE THE DATA TRANSPARENTLY WITH HEALTHCARE ORGANIZATIONS AND CONSUMERS.*

"I'd like to see the hospice program develop to another level," he said. Develop a palliative care and hospice scorecard and share the data transparently with healthcare organizations and consumers. "You'll have a higher probability of getting that value proposition through to healthcare executives," Stokes explained.

Make sure everyone is clear on the distinction between palliative care and hospice and the point of appropriate transition and transfer between the two. "Can you bundle and package all of that into a model program for the home environment and then implement as much as your hospital or healthcare system can afford to implement, managing and caring for patients in the home, with greater use of telemedicine and other new technologies?" he poses. This reduces readmissions to the emergency department, the hospital, and the ICU, thus reducing overall costs of care.

Stokes thinks there are four or five things that people particularly care about at the end of life. That list could include the patient's spiritual well-being; getting financial affairs in order with a visit from the hospice financial counselor; unresolved relationships; the control of discomfort; even the patient's bucket list of things they wanted to accomplish before they transition from this life.

The goal of palliative care and hospice programs should be to help people live their highest quality of life and to be fully prepared for their ultimate, eventual transition. "The message is: we are going to put you in this hospice program, and we are going to try to create an exceptional experience as you transition, living fully for whatever time you have left. We're going to try to create an experience for your family that you're leaving behind."

He also recommended a similar set of consumer-centric goals for palliative care to meet, "with the problems we will solve for the person. That should be attractive to the people who are responsible for the costs of caring for seriously ill patients," he said.

"We could ask healthcare system foundations to help support and fund development of these models," Stokes said. "Let's enlist eight or 10 national leaders in hospice and palliative care—your best and brightest—who agree to spend the next 6 to 8 months creating these models of consumer-oriented best practices, asking what can be learned from other healthcare systems and from other countries, and then putting together a white paper of best practices." Then quantify what hard dollar savings result from providing palliative care and how it improves patients' quality of life.

Such a model may also improve engagement for doctors and other health professionals, bringing them back to their "why" in choosing a career in health care in the first place, he said. But these models have to be easily understood, easily communicated—and easily quantifiable. That is just essential in today's healthcare industry. ●

Reference

1. Lustbader D, Mudra M, Romano C, et al. The impact of a home-based palliative care program in an accountable care organization. *J Palliat Med.* 2017;20(1):23-28.

Larry Beresford is a medical journalist in Oakland, CA, with a strong interest in hospice and palliative care.

A friend of the Academy, Chuck Stokes died suddenly on July 23, 2024. Our hearts are with his family and friends in their time of grief.

PATHWAYS TO PALLIATIVE CARE

MELANIE BIEN: "STREET MEDICINE IS PALLIATIVE CARE"

Joy C. Liu, MD MPH

At the entrance to the hotel lobby, three security guards ushered visitors through an airport metal detector before a check-in table. Melanie Bien took out a badge identifying her as a social worker with the San Francisco Department of Public Health and then climbed up the narrow flight of stairs. After several unanswered knocks at one of the doors, her colleague loudly announced, "We are coming in for a wellness check," and keyed in.

The room was overcast with gray light filtering in from two large windows facing a brick wall. On the center bed, a man opened his eyes and raised his head. Melanie introduced herself and her colleague Shannon Ducharme as members from the palliative care outreach team. A colleague referred him to her. Could she come in and talk with him? He nodded. Since there was nowhere to sit among the scattered clothing and belongings, she asked to sit on the bed.

On their sides, they each formed a different edge of an obtuse angle. Her side was a slight frame with short curly hair dyed blonde at the tips, a beige plaid jacket over a black Department of Public Health zip-up, dark blue jeans, black Doc Martens, and a cross-body bag printed with sunflowers. Her large wooden earrings dotted with butterflies fluttered when she moved.

The conversation started with his love of a good burger with fries (McDonald's or Wendy's, nothing fancy), meandered to his family, then paused at his inability to be independent after he received his medical diagnosis. Together, they sat in silence, laughed, asked and answered questions that turned into stories. Besides a brief interjection to ask if he was in the process to get permanent supportive housing, they barely talked about his housing situation at all.

Melanie makes visits like these as a social worker on the Street Medicine Palliative Care project. The Street Medicine team delivers care to people experiencing homelessness, often in shelters, hotels, or the streets. The Street Medicine Palliative Care project stemmed from an experience caring for a patient experiencing homelessness who didn't want dialysis and wanted to learn about other options for care. Today, the team consists of three physicians, three nurses, two nurse practitioners, two social workers, two health workers, two volunteers, and an AmeriCorps staff. They care for some of the most medically and socially complex patients from the Street Medicine team.

Melanie's own path to this work was more circuitous. She grew up in the unrest of Baltimore in the 1960s and 1970s. "There was just conflict everywhere, inside the house and outside the house." After a difficult period in her life during which she lived in an abandoned warehouse, she found art. "Whoever was in that warehouse before had left all this big paper, in chunks. And I just started drawing to kind of heal myself."

She spent a year and a half in Africa, often creating art spontaneously with others. She studied art therapy in New Mexico before moving to California. One of her first jobs was working with Indigenous peoples living with HIV/AIDS. "A lot of deaths," she observed, "a lot of end-of-life care, a lot of seeing what's important."

Melanie describes her art therapy education as one for her soul and the social work degree she received later for broadening her potential impact: "My art therapy training really taught me how to have a presence with human beings and to exchange information in a nonhierarchical way. Like really listening, paying attention." After cobbling together various jobs as an art therapist, she moved to a full-time position at Zuckerberg

Melanie Bien is a social worker on the San Francisco Department of Public Health's Street Medicine Team who provides palliative care to patients experiencing homelessness.

San Francisco General Hospital as a medical social worker on the palliative care team. From there, she went into street medicine.

Homelessness has changed since Melanie first started. It has been on the rise nationally since 2017.[1] California has been hit particularly hard and is now home to 30% of the country's population experiencing homelessness.[2] This population is also aging. Adults over age 55 are one of the fastest growing groups,[3] many experiencing homelessness for the first time in their lives. What's more, "people tended to not use [the] kind of substances that we're seeing now. This is a different landscape," observed Melanie.

That means the nature of distress has also changed. The best way Melanie can describe it is "straddling." Many of her patients say they want to go to their medical appointments or get treatment, but they do not follow through. "When our patients can't be whole while they try to hold these two opposing things, they just end up being fragmented," she said. They lose whatever power they had as default decisions are made for them by people who do not know their stories.

"Maybe given the national economic landscape, people are going to be homeless for a while. But the whole point is that we use the wisdom to come back up and not be stuck in homelessness permanently," said Melanie. Now, many cannot get unstuck because they are dying on the streets. People experiencing homelessness die at higher rates, with ranges between 3 to 16 times greater, depending on the study. For some, that means at least their death will be seen and mourned by the communities they have in the streets. Dying while housed—what if they are not found for days? What if no one recognizes that their story ended? Invisibility in death is not the same as near invisibility in life.

As the suffering of the people they care for has changed, street medicine has moved toward the pathos it shares with palliative care. "When you're dealing with people experiencing homelessness, you're always dealing with palliative care, whether there's a diagnosis or not, because you're always trying to figure out what's important, and you're always trying to improve the quality of people's lives," said Melanie. "It forces you to connect with people in their most intimate moments of suffering and death. You can't not care about humanity when you're close and personal."

As Melanie left the hotel room after her visit finished, she felt something tugging at her back. Out of her plaid jacket, she pulled out a brown belt. "Are you sure that's not yours?" Shannon asked. Melanie looked at the belt, then looked at her waist before they both realized that it was his belt. As Melanie turned back and disappeared around the corridor to return it, Shannon called after her, "You've gotten all tangled up in each other." ●

Back row, left to right: Barry Zevin, MD, medical director of street medicine; Vivian Yip, health worker; Jeffrey Tyler, health worker; Shannon Ducharme, health worker extraordinaire and leader; Jessica Naugle, RN; Trevor Lee, MD. First row, left to right: Adrien Barbas, NP; Tanya Majumder, MD, co-creator and leader; Melanie Bien, social worker, co-creator, and leader; Cassandra Smith, RN; Lauren Sir, RN, leader.

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3. Skiba K. The graying of America's homeless: an alarming trend. AARP. Published December 16, 2022. Updated December 20, 2022. Accessed August 1, 2024. https://www.aarp.org/home-family/your-home/info-2022/americas-homeless-over-50.html.

DEI LAB

MEET THE 2023-2025 AAHPM NEXT-GEN SCHOLARS

Arshia Madni, MD FAAP; Noelle Marie Javier, MD; Linda Sterling, and Jon P. Furuno, PhD

***Alexandria Hoy,** MD, Augusta University/UGA Medical Partnership, Internal Medicine, PGY-3*

***Bruno A. Costa,** MD, Mount Sinai Morningside/West, Internal Medicine, PGY-3*

***Jenay A. Powell,** MD, University of Tennessee, Internal Medicine, PGY-3*

***Rahee M. Nerurkar,** MD, Montefiore Medical Center, Primary Care/Social Internal Medicine, PGY-2*

***Michael A. Walker,** Meharry Medical College, MS2*

The AAHPM Next Gen Scholars for Equity in Hospice and Palliative Medicine program sponsors residents from underrepresented communities who are interested in hospice and palliative medicine (HPM). Data suggest that a lack of culturally effective HPM services in marginalized communities may contribute to disparities. Data further suggest that health outcomes and patient satisfaction are significantly better when physicians represent the populations they serve, yet African American and Hispanic physicians represent less than 5% and 8%, respectively, of HPM fellows. AAHPM has developed this program to introduce and promote hospice and palliative medicine to a broader community of resident physicians.

DEI LAB

LEARNING • ACHIEVING • BELONGING

AAHPM welcomed its first cohort of eight scholars in August 2023, when the 2-year program commenced. We interviewed several of the scholars to learn what drew them to apply for the program and their expectations and experiences with the program thus far.

What drew you to this opportunity?

Bruno Costa: The program's goal to cultivate leaders from diverse backgrounds in the palliative care field deeply resonated with me. As a first-generation Latino physician and Brazilian immigrant, I'm aware of the challenges and biases that can affect different parts of a medical career—from academic opportunities to patient care and professional relationships. By providing structured sponsorship for underrepresented minorities, the Next Gen Scholars program emerged as the ideal platform for advancing my dedication to health equity and culturally competent care.

Alex Hoy: I was drawn to the Next Gen Scholars for Equity in Hospice and Palliative Medicine opportunity by my ambition to become a leader in the field and my need for mentorship where I lacked experience. Additionally, the emphasis on equity in the workplace resonated with me deeply, as diversity and inclusivity are vital in supporting individuals, especially in such a compassionate field. This program aligns perfectly with my professional goals and values, offering a platform to grow, connect, and contribute to advancing

Applications for cohort two of the AAHPM Next Gen Scholars for Equity in HPM program will open late March 2024. This exciting new program will sponsor eight post-graduate medical residents interested in hospice and palliative medicine from communities that are underrepresented in the profession's workforce and leadership, and who will be essential as our professional community works together towards centering the needs of those currently marginalized in HPM.

Julie Childers and Alex Hoy

Bruno Costa and Tammie Quest

hospice and palliative care while fostering a more inclusive healthcare environment.

Jenay Powell: Having been consistently thrust into predominantly White spaces as an underrepresented minority, a focus on diversity and equity has always been fairly intertwined with my interest in medicine. I have always imagined a career in which I would integrate health equity and my specialty of choice. Once I settled on palliative care during my first year of internal medicine residency, a program such as this one really stood out as an opportunity for more growth and development.

What do you hope to gain from the program?

Bruno Costa: I hope to gain fresh insights into addressing healthcare disparities, enhance my leadership skills, build effective career pathways, and strengthen my network within the palliative care field. I also hope to feel equipped to apply the knowledge acquired to successfully guide other trainees from underrepresented minorities, thereby continuing the cycle of support and encouragement.

Alex Hoy: I hope to gain support and mentorship from the program as a medical resident from an underrepresented minority community. Being a leader in representation is crucial for fostering workplace inclusivity, and I deeply appreciate the significance of this role. Cultural diversity is essential in hospice and palliative medicine, as it allows for the integration of practices and the respectful consideration of traditions. With aspirations to advance my career in this field as an upcoming HPM fellow, the support and mentorship offered by this program are invaluable. The sponsorship provided will serve as stepping stones toward achieving my objectives, and I genuinely value the guidance and insights that my sponsor can offer as I endeavor to make my mark in this impactful field.

Michael Walker: I aim to deepen my understanding of hospice and palliative care while exploring avenues for research, advocacy, and community engagement as a minority voice in the field. Through this program, I hope to gain insights and skills that will empower me to make meaningful contributions.

What has been the biggest benefit to being a scholar in the program?

Jenay Powell: In general, I feel that being one of the Next Gen Scholars has allowed me to get involved with the American Academy of Hospice and Palliative Medicine earlier than I probably would have on my own. It seems likely that I would not have had the opportunity to dip my toe into AAHPM happenings until probably after fellowship [which began this summer at MedStar Washington Hospital Center] is complete. Even just from being able to attend the Annual Assembly virtually this spring with the support of the program, I have already picked up so many nuggets of knowledge and new perspectives that I found to be valuable and have already integrated into my patient care and teaching experiences.

Michael Walker: The invaluable mentorship provided by Dr. Khaliah Johnson, a leader in pediatric palliative care, has been transformative. Having a mentor who shares my values of advocacy and spirituality, while also being a minority leader in the field, has been incredibly inspiring and enriching.

Rahee Nerurkar: As I hoped, I was matched with a mentor who has not only guided me in this program but has shared her perspective on… her career in medicine [and] her life as well. Her wisdom has been invaluable, and we likely would not have crossed paths had it not been for the Next Gen Scholars program.

The full interview including detailed responses from the scholars will be shared on our website soon. The Next Gen Scholars for Equity in HPM program closed its call for applications in the summer. Visit the webpage for more information. ●

Arshia Madni, MD FAAP, is an assistant professor of pediatrics and associate program director of the hospice and palliative medicine fellowship at the University of Tennessee Health Sciences Center/Le Bonheur Children's Hospital. She also is chair of AAHPM's DEI Committee.

Noelle Marie Javier, MD, is an associate professor in the Brookdale Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mount Sinai in New York. She also is chair-elect of AAHPM's DEI Committee and past-chair of AAHPM's LGBTQI+ special interest group.

Linda Sterling is AAHPM's DEI and Membership Engagement Manager.

Jon P. Furuno, PhD FSHEA, is a professor in the department of pharmacy practice at Oregon State University College of Pharmacy.

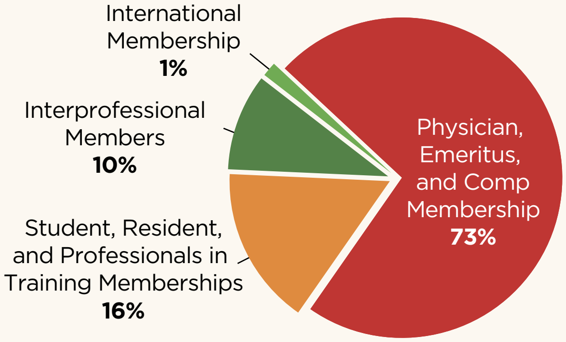
QUARTERLY PROGRESS REPORT

AAHPM POINTS OF PROGRESS

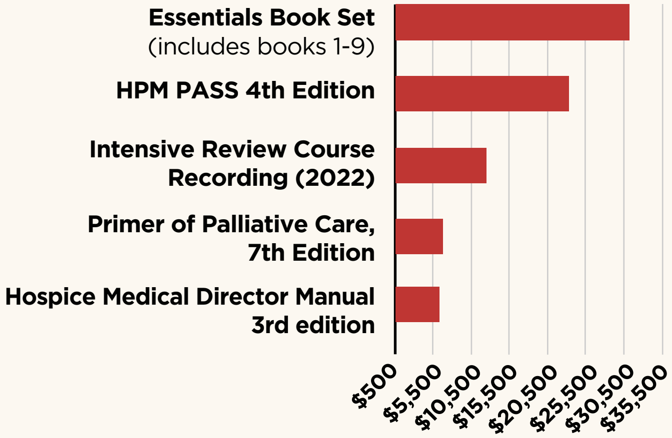
Expand and Enhance Engagement

AAHPM membership is holding steady, with a 1% increase in physician, emeritus, and complimentary membership compared to February.

March 31, 2024, Active Members by Member Type



Top 5 Product Sales Quarter One 2024



The best-selling AAHPM products in Q1 were the Essentials book set followed by the newly released HPM PASS 4th Edition.

Connect Engagement

190+ MEMBERS WHO CONTRIBUTED TO POSTS ON CONNECT BETWEEN JANUARY 1 AND MARCH 10

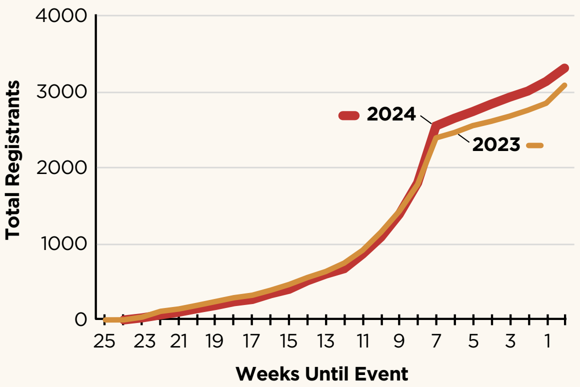
260 NEW DISCUSSION THREADS WERE STARTED, WITH OVER 170 REPLIES (438 TOTAL POSTS!)

14 COMMUNITY MEETINGS OCCURRED IN Q1 2024, INCLUDING THE PEDS JOURNAL CLUB

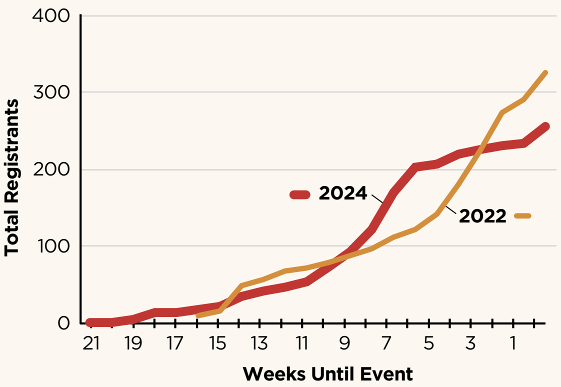
Engage, Develop, and Expand Expertise

Final Annual Assembly registration numbers reached 3,318, which is 214 more than 2023. Total attendance was 3,278. In-person attendance increased this year, too: 76% of attendees were in person in 2024 compared to 65% in 2023

Annual Assembly Total Registration by Weeks Until Event



State of the Science Total Registration by Weeks Until Event



AAHPM POINTS OF PROGRESS (CONTINUED)

2024 Annual Assembly: Thank YOU!

300+	INTERDISCIPLINARY VOLUNTEERS AND STAFF WHO PARTICIPATED IN THE PLANNING, DEVELOPMENT, AND IMPLEMENTATION OF OUR 2024 ANNUAL ASSEMBLY
1,000+	FACULTY AND AUTHORS WHO CONTRIBUTED TO THE ACCEPTED ACCREDITED ASSEMBLY EDUCATIONAL CONTENT
3,000+	IN-PERSON AND VIRTUAL ATTENDEES WHO CHOSE TO JOIN WITH COLLEAGUES AND PEERS TO SHARE RESEARCH, CLINICAL BEST PRACTICES, AND PRACTICE-RELATED GUIDANCE TO ADVANCE THE SPECIALTY OF HOSPICE AND PALLIATIVE CARE

2024 State of the Science Symposium: Thank YOU!

80+	INTERDISCIPLINARY VOLUNTEERS WHO PARTICIPATED IN THE PLANNING, DEVELOPMENT, AND IMPLEMENTATION OF OUR STATE OF THE SCIENCE (SOTS) SYMPOSIUM
150+	UNIQUE FACULTY AND AUTHORS WHO CONTRIBUTED TO THE ACCEPTED ACCREDITED SOTS EDUCATIONAL CONTENT

Summer Courses 2024

Our summer course offerings were held in Louisville, KY, from August 8 to 10.

The **Striking a Balance: Understanding Pain Management and Opioids** REMs grant-funded half-day course covered the CO*RE 2023-2024 curriculum. Course content thoughtfully balanced the risks and benefits of opioid prescribing, providing the latest insights in this vital healthcare area.

The 2.5-day **Intensive Review Course** was designed to advance the knowledge, diagnostic reasoning, and clinical judgment skills, attitudes, and strategies of physicians and advanced practice providers practicing hospice and palliative medicine.

AAHPM offers a wide range of on-demand learning resources in the AAHPM Learn platform. Discover and explore AAHPM products, including books, assessments, subscriptions, course recordings, and more. Our content encompasses all aspects of hospice and palliative care, allowing you to enhance your clinical knowledge.

Visit AAHPM Learn to advance your understanding in this field.

AAHPM POINTS OF PROGRESS (CONTINUED)

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

Research

1 NEW SCIENCE ADVISOR

Welcome to our new science advisor Stacy Fischer, who is consulting with AAHPM along with the support of Laura Hanson and Areej El-Jawahri!

- In the News: HomeCare Magazine

28 APPLICATIONS RECEIVED FOR THE RESEARCH SCHOLARS PROGRAM

Six scholars attended the annual Kathleen M. Foley Palliative Care Retreat and Research Symposium in September.

The Serious Illness Research Consultancy Center (SIRCC) is now up and running.

Quality

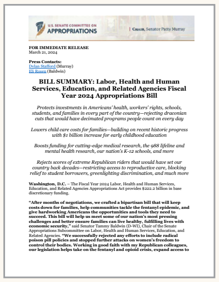
The Quality Committee is preparing comments for the Hospice Proposed Rule.

CMS asked AAHPM to add “Feeling Heard and Understood” to four Merit-based Incentive Payment System specialty measure sets: cardiology, geriatrics, hospitalists, and nephrology. AAHPM staff have initiated calls with each specialty to discuss use of the measure.

AAHPM will appoint a member of the Pediatric Council to the Society of Critical Care Medicine’s “Neonatal and Pediatric End-of-Life Care in the ICU” guideline work group.

Advance Health Policy and Advocacy

The federal appropriations package for FY 2024 included $12.5 million for the National Institute on Aging (NIA) to implement a transinstitute, multidisease strategy to expand and intensify national research programs in palliative care. AAHPM, in active partnership with the Patient Quality of Life Coalition, strongly advocated for this increased funding for palliative care research.



U.S. SENATE COMMITTEE ON APPROPRIATIONS | CHAIR, Senator Patty Murray

FOR IMMEDIATE RELEASE
March 21, 2024

Press Contacts:
Dylan Stafford (Murray)
Eli Rosen (Baldwin)

BILL SUMMARY: Labor, Health and Human Services, Education, and Related Agencies Fiscal Year 2024 Appropriations Bill

Protects investments in Americans’ health, workers’ rights, schools, students, and families in every part of the country—rejecting draconian cuts that would have decimated programs people count on every day

Lowers child care costs for families—building on recent historic progress with $1 billion increase for early childhood education

Boosts funding for cutting-edge medical research, the 988 lifeline and mental health research, our nation’s K-12 schools, and more

Rejects scores of extreme Republican riders that would have set our country back decades—restricting access to reproductive care, blocking relief to student borrowers, greenlighting discrimination, and much more

Washington, D.C. – The Fiscal Year 2024 Labor, Health and Human Services, Education, and Related Agencies Appropriations Act provides $222.2 billion in base discretionary funding.

“After months of negotiations, we crafted a bipartisan bill that will keep costs down for families, help communities tackle the fentanyl epidemic, and give hardworking Americans the opportunities and tools they need to succeed. This bill will help us meet some of our nation’s most pressing challenges and better ensure families can live healthy, fulfilling lives with economic security,” said Senator Tammy Baldwin (D-WI), Chair of the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. **“We successfully rejected any efforts to include radical poison pill policies and stopped further attacks on women’s freedom to control their bodies. Working in good faith with my Republican colleagues, our legislation helps take on the fentanyl and opioid crisis, expand access to**

AAHPM signed onto a letter requesting the US Drug Enforcement Agency release a new proposed rule allowing the prescribing of controlled substances through the use of telehealth. This request is in conjunction with previous advocacy from AAHPM on this issue. The timely and effective management of pain and other distressing symptoms is central to providing high-quality palliative care to patients with serious illness, and opioid analgesics and other controlled substances are critical tools in alleviating their suffering.

April 2, 2024

The Honorable Anne Milgram
Administrator
United States Drug Enforcement Administration
8701 Morrissette Drive
Springfield, VA 22152

Dear Administrator Milgram:

Thank you for your leadership and engagement in public listening sessions last fall related to telemedicine flexibilities and for your actions to ensure continued patient access to care delivered through telemedicine in advance of final telemedicine regulations this year.

Now that the first quarter of 2024 has passed, we write to request that DEA expedite the release of a revised proposed rule to permit and regulate the prescribing of controlled substances through telehealth. This rule is crucial for access to mental health, substance use disorder, and other telehealth care. As you know, the current flexibilities for telehealth expire at the end of this year; we request the updated rules be proposed immediately for the following reasons:

- Given the complexity of these issues and the significant stakeholder interest (as demonstrated through more than 38,000 public comments received by DEA on proposed rules), DEA must plan to ensure stakeholders have adequate time to provide feedback on any policy proposal.
- If DEA were to create a special registration process for telehealth prescribers, as proposed by both DEA and many stakeholders, significant operational lead time would be needed for DEA, practitioners, pharmacies, and other related service providers to implement the new special registration process and comply with other potential operational requirements and guardrails.
- Given widespread provider shortages, particularly in the mental health and substance use disorder treatment spaces, a rulemaking late in the year that makes significant policy changes would affect the ability of patients and clinicians to make appointments and ensure consistent access to care. While we hope the final rulemaking preserves patient access, any policy change that requires patients to seek in-person care would be extremely disruptive due to long scheduling lead times and in-office wait times.
- In addition to operational and implementation challenges for clinicians, there will be significant operational and staff training needs for pharmacies and other parts of the healthcare delivery system to ensure patients uninterrupted access to needed medical treatments offered through telehealth.
- Finally, DEA’s national leadership is needed to set a clear path forward for the nation and to encourage more consistent definitions and aligned requirements from state regulatory bodies. Alignment of requirements is needed to simplify compliance for healthcare providers and encourage telehealth providers to offer care in our nations most underserved areas – without geographic barriers such as state lines limiting access to care.

Thank you for your consideration of this request. We looking forward to working with you to ensure continued access to needed telehealth services for all Americans while protecting against diversion and inappropriate use.

Sincerely,

1

AAHPM members Gregg VandeKieft, MD FAAHPM, and Paul Tatum, MD FAAHPM, participated in the Palliative Care and Hospice Education and Training Act (PCHETA) Lobby Day. Both took part in meetings with their US Senators to ask for support and passage of PCHETA, which would expand opportunities for interdisciplinary education and training in palliative care, including through new education centers and career incentive awards for physicians, nurses, physician assistants, social workers, and other health professionals. ●

HOSPICE
MEDICAL
DIRECTOR
CERTIFICATION BOARD

AAHPM PARTNER UPDATE

HMDCB UPDATE

Board of Directors Announcement

HMDCB is excited to announce our 2024-2025 Board of Directors:

President
Todd Cote, MD HMDC FAAFP FAAHPM

Past President
David Wensel, DO HMDC FAAHPM

Secretary/Treasurer
Bernice Burkarth, MD HMDC FAAHPM

Member at Large
Thomas Caprio, MD MPH MS HMDC

Member at Large
Lisa Hobbs Ellis, MD HMDC FACP

Member at Large
Michael Nisco, MD MBA HMDC FAAHPM

AAHPM Liaison
Michael Barnett, MD MS FAAP FACP FAAHPM

Public Member
Lisa Sallstrom, MS CAE PMP

We look forward to the leadership each member will provide the organization, and we thank them for their continued support and service on the board.

Renew Your Credential by October 31

If your HMDC credential expires in 2024, register now for the Continuing Certification Program (CCP) to remain certified and stay part of the HMDCB community. The new CCP uses a longitudinal assessment that is open book, is untimed, and can be retaken as needed to help assess and expand your hospice knowledge. Act now so that you can continue to highlight your expertise in hospice medicine and enjoy HMDCB community benefits, including webinars, coffee chats, and discounts on CME opportunities! Complete the longitudinal assessment by **October 31, 2024,** to remain certified. Renew today by visiting www.HMDCB.org/ccp.

Advertise with HMDCB

HMDCB invites you to promote your organization, educational activities, and jobs to more than 1,200 dedicated hospice physicians and medical directors through our advertisement program. Popular options include webinar sponsorship, sponsored emails, and newsletter ads. Visit www.HMDCB.org/advertising to learn more.

Become Certified in 2025

The next opportunity to take the HMDCB initial examination is in 2025, and the application will open in January. Start preparing now by reviewing the eligibility requirements and exam prep resources available at www.HMDCB.org/info.

HMDCB Community Events

All certificants are invited to attend the 2024 HMDCB community events. These events are a great place to connect with your hospice peers and expand your hospice knowledge. Events include free webinars and Coffee Chats, as well as discounts on CME opportunities hosted by our partners. To learn more and register for all upcoming events, visit www.HMDCB.org/community.

Contact HMDCB

HMDCB staff are happy to answer your questions or assist you with renewing your credential or registering for an event. Contact HMDCB staff at info@hmdcb.org or call 847.375.6740. ●

Learn more and register for all upcoming events at www.HMDCB.org/connect.

DONOR SPOTLIGHT: DONNA ZHUKOVSKY, MD FACP FAAHPM

My passion for this profession and my firm belief in its transformative power is what keeps me giving to AAHPM every year. Reflecting on a poignant moment that reinforced my commitment to giving, I recall a recent donation I made to the Alyssa L. Bogetz Educational Fund. Mental health, an area often clouded by stigma, resonates deeply with me. I believe that understanding and addressing mental health issues is crucial for providing holistic care.

The impact I aim for with my donations is best captured by a song:

> "If you save a life, you save the world."
> – *“Save a Life” by Debbie Friedman (derived from Talmudic text)*

I believe that by empowering even just one person with knowledge or resources, we set off a ripple effect that can touch countless lives.

Investing in the Academy means investing in the betterment of our profession and, ultimately, in the well-being of those we serve. ●

GIVE A LASTING GIFT TO THE ACADEMY

AAHPM is dedicated to strengthening our future and creating a lasting legacy in the field of hospice and palliative medicine. Your donations create new opportunities for scholarships, mentoring, and the growth of new leaders to continue developing this amazing field.

Visit the AAHPM Giving Center to learn more and donate.
AAHPM Giving Center

AAHPM 15-MINUTE PODIUM ABSTRACT AWARDS

The 2024 Annual Assembly abstract awards recognize the highest scored, accepted peer-reviewed 15-minute podium abstracts, as determined by the 2024 Annual Assembly Planning Committee during the abstract review and selection process. To be eligible, faculty must include representation from at least one AAHPM member.*

Case Study Award

Using Transdermal Buprenorphine to Treat Chronic Pruritus in a Young Adult with Lymphoma and Anxiety

***Miranda Ravicz,** MD
Katharine Davidoff, MD
Stephanie B. Kiser, MD MPH

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

Enhancing Quality of Serious Illness Conversations: Is Communication Skills Training a Must?

***Amanda M. Hazeltine,** DNP MS CNP AGACNP-BC
***Vandana Nagpal,** FACP FAAHPM
Shawna Steadman, DNP ACNP-BC ACHPN

Scientific or Quality Improvement Awards

Perspectives on Aging and Illness by Homeless Adults Receiving Street Medicine

***Alexis Coulourides Kogan**
Anuva Mittal
Enya Lowe, MSc
Corinne Feldman, MMS PA-C

Spiritual Care Needs of Patients with Cancer Belonging to Dharmic Religions: A Mixed Methods Study

***Rushil V. Patel,** MD
***Judith Nelson,** MD JD
Jill Bowden, MDiv BCC
Danielle Boselli, MS
Sydney-Evelyn Gibbs, MSGH
Ashley Strahley, MPH
Ritesh Kotecha, MD
Komal P. Murali, PhD RN ACNP-BC

AAHPM NEWS

AAHPM POSTER ABSTRACT AWARDS

The 2024 Annual Assembly abstract awards recognize the highest scored, accepted peer-reviewed poster abstracts, as determined by the 2024 Annual Assembly Planning Committee during the abstract review and selection process. To be eligible, faculty must include representation from at least one AAHPM member.*

Case Study Poster Award

“What Do They Mean They Can’t Do It?”: A Jehovah’s Witness’ Journey for a Bloodless LVAD

***Alexandria Hoy,** MD

***Balakrishna Vemula,** MD

***Lauren Berninger,** DO MBE

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

A National Survey Describing Management Patterns for Pediatric Paroxysmal Sympathetic Hyperactivity

***Hitoshi G. Koshiya,** MD

***Julie Hauer,** MD

***Justin A. Yu,** MD MS

Laura Kirkpatrick, MD

Alyssa Zuziak, DO

Scientific or Quality Improvement Poster Award

Improving Pediatric Residency End-of-Life Education: A Quality Improvement Approach

***Kaitlin Spratt,** MD

***Ami Mehta,** MD

***Jaxon Vallely,** DO

Daniel Cirotski, MD MPH

AAHPM NEWS

EMERGING LEADERS IN HOSPICE AND PALLIATIVE CARE

Thirty-six individuals were selected as AAHPM's 2024 class of Emerging Leaders in Hospice and Palliative Care for their career accomplishments, involvement in the Academy, mentoring of residents and students, and participation in charitable work. The emerging leaders are recognized on the **AAHPM blog** and will be celebrated at the 2025 Annual Assembly of Hospice and Palliative Care in Denver, CO. Congratulations!

Toluwalase Ajayi, MD FAAP FAAHPM
Prasanna Ananth, MD MPH
Jennifer M. Barker, DO FAAHPM
Kara Bischoff, MD
Keri O. Brenner, MD MPA
L. Emily Cotter, MD MPH
Dustin Dillon, MD HMDC FAAP
Laura Dingfield, MD MSEd FAAHPM
Niharika Ganta, MD MPH FAAHPM
Eric Goodlev, MD
David Harris, MD
Michael Huber, MD MS HEC-C
Katie Jones, PhD ACHPN CARN-AP
Sachin Kale, MD MBOE FAAHPM
Vishal Kapadia, DO
Christine Khandelwal, DO MHPE HMDC FAAHPM
Andrew Lawton, MD FAAHPM
Ana Luisa Leech, MD MS FAAHPM
Richard Leiter, MD MA
Elizabeth Dawn Trice Loggers, MD PhD FAAHPM
Dominic Moore, MD FAAP FAAHPM
Alexis Morvant, MD MA FAAP
Sudha Natarajan, PhD NP MSN
Katrina Nickels, MD FASAM
Rex Alvin Paulino, MD
Amy Porter, MD PhD
Leah Rosenberg, MD
Jared Rubenstein, MD
Daniel Shalev, MD
Milagros Silva, MD FAAHPM
Sarah Stayer, MD MPH
Benjamin Thompson, MD
Lauren Treat, MD
Finly Zachariah, MD FAAFP FAMIA FAAHPM
Carly Zapata, MD MPH
April Zehm, MD FAAHPM

Learn more about the Emerging Leaders program.

AAHPM NEWS

VISIONARIES IN HOSPICE AND PALLIATIVE CARE

Twenty-three individuals were selected as AAHPM's 2024 Visionaries in Hospice and Palliative Care. This award honors individuals who have made or are making exemplary contributions to the field of hospice and palliative care. All awardees had to be nominated by their peers and represent influential leadership and unparalleled advancement of the field. This new class of visionaries is further recognized on the **AAHPM blog** and will be celebrated at the 2025 Annual Assembly of Hospice and Palliative Care in Denver, CO. Congratulations!

Rabia Atayee, PharmD BCPS FAAHPM

Justin Baker, MD FAAP FAAHPM

Gary T. Buckholz, MD HMDC FAAHPM

Elise Carey, MD FACP FAAHPM

Elizabeth Glazier, MD MPH FACP

Elizabeth Balsam Hart, MD

Vicki Jackson, MD MPH FAAHPM

Daniel Johnson, MD FAAHPM

Tammy Kang, MD MSCE FAAHPM

Jenni Linebarger, MD MPH FAAP FAAHPM

Dale Lupu, PhD MPH

Laura Morrison, MD FACP FAAHPM

Steven Pantilat, MD FACP FAAHPM

Vyjeyanthi Periyakoil, MD FAAHPM

Karin B. Porter-Williamson, MD FAAHPM

Michael Rabow, MD FAAHPM

Steven Radwany, MD FACP FAAHPM

William E. Rosa, PhD MBE ACHPN FAAN

Abby R. Rosenberg, MD MS MA FAAHPM

Drew Rosielle, MD FAAHPM

Tressia Shaw, MD FAAP FAAHPM

Barbara M. Sourkes, PhD

Brad Stuart, MD

Note: AAHPM is continuing to update its blog with the 2024 Visionaries interviews.
Check back throughout the remainder of the year as new posts are shared.

Learn more about the Visionaries program.

NEW

ARTIST IN RESIDENCE

CORY INGRAM, MD

Katie Mechler, MD

Affiliation
Mayo Clinic

Years in Hospice and Palliative Medicine
15

AAHPM Activities
AAHPM Quarterly Editor in Chief

Medium
Photography

Artist Q&A

How did you get started with your art, and describe if it has changed over your hospice and palliative care career?

My dad is a wonderful family photographer, and I saved my money and bought my first camera in 1984. My Nikon FG-20 film camera arrived from a shop in New York to my rural Iowa home about 8 weeks later. I started taking pictures and over time became the photographer for my town newspaper, and the rest is history.

What is your creative process?

Many of my photos are from bringing a camera with me wherever I am. If you see me at conferences, you will most often see me with my small camera. My camera helps me to slow down, to really see things. I took pictures around Montreal at the 2023 AAHPM conference, such as streetscapes, people, my favorite bagel shop. Even when I photograph intentionally for sports or senior photos, I try to capture atypical viewpoints and elements that tell a story.

Describe your art in 7 words or less.

Emotional archaeology, experiences through story and imagery

What do you want people to take away from your art?

I think of artistry in general as a gift that keeps on giving, and so I would love it if they took away a sense of story. During the pandemic I really thought a lot about how we were masked and were distant from our patients and other people in the community—that was such a challenging time and why I captured that photo of the gaze over the mask: to capture that emotion. And the landscapes where the emptiness is striking.

“I’m trying to capture images that stand out, and I guess the camera in hand slows me down enough to stop and watch.”

"This was…from driving down the road and thinking that [it] really captures this idea of harvest: …harvesting being in the moment, harvesting everyday presence, harvesting just what's around you."

What are future plans for your art?

I'll be working with a photographer from London named Richard Cranefield. Together we'll work with bereft family members to capture still-life images in honor of the loved one who died. Like a farmer and a widow with his empty boots at the edge of a plowed field, a radio announcer's microphone with an empty desk. And I'm working on a display at the art guild in my community.

How do you deal with perfectionism and the inner critic in your art?

I think I am honestly not necessarily great at this. I'm just your average photographer. In fact, on my journey with photography I think technology and perfection got in the way. Lane Kennedy advised: just capture what you see and what you feel—just take the picture. Don't worry about the light being perfect, just shoot.

What advice do you have for your younger self, or what do you want our readers to know?

Just do it. Just take pictures. Another photographer's slogan is "wear a camera." So, I try to do just that. You will have people tell you, "That doesn't resonate with me." Well, that's ok! That's one thing about art: you just have to put it out there, and there will be some people it does resonate with. You'll be amazed at what comes out. All of us have something to say. All of us have a certain sort of artistry about us. I encourage every person who feels compelled to explore that.

Be on the lookout for a post on AAHPM's blog featuring a short video interview with Dr. Ingram and more photos from his portfolio. ●

CALLING ALL AAHPM MEMBER ARTISTS: PAINTERS, PHOTOGRAPHERS, SCULPTORS, POTTERS, QUILTERS, DIGITAL ARTISTS, CARTOONISTS, EVEN DOODLERS—CASUAL OR SERIOUS CREATORS OF ANY KIND!

Artist in Residence is a new column that seeks to highlight AAHPM members who create art as part of their professional or private lives and wish to share said art with the AAHPM community to encourage connection and healing. Email info@aahpm.org if you would like to be considered for the next Artist in Residence.