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PALLIATIVE CARE and PALLIATIVE MEDICINE

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It has been twenty-nine years since Congress passed the Medicare Hospice Benefit, and despite the increase in hospice utilization over those years, still only four of every ten persons dying in the United States is benefiting from hospice.

This is understandable, for it is very difficult for patients facing death, for their families, and for their physicians to give up trying for a cure. Having to choose between hospice and continued aggressive care can be hard.

Often this disproportionate focus on continued treatment and tests results in little effort to reduce symptoms affecting the patient and the family, whether those symptoms are physical, emotional, socio-economic, or spiritual.

This dissatisfaction with care at the end-of-life resulted in a broad consensus in the 1990s that change was necessary, and would require the support of the community, philanthropic organizations, the entire healthcare team, and eventually, the federal government.

Since doctors control how medicine is practiced to a large degree, it soon became apparent that no meaningful improvement in palliative, end-of-life care would happen without their active participation. The multicenter SUPPORT study in the mid-90s, designed to use trained social workers and nurses to change outcomes in hospitalized dying patients, demonstrated no improvement in outcomes without a change in doctor's attitudes and practices.

Palliative Care, as originally defined by the World Health Organization and the Institute of Medicine, seeks to provide the total active care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social, and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. It affirms life, and regards dying as a normal process. It neither hastens nor prolongs death. Using an interdisciplinary approach, palliative care can be applied not only to those dying or in a hospice program, but can also serve those patients undergoing active and aggressive treatment for cancer or other life-threatening conditions.

CMS has Redefined Palliative Care:

Palliative Care Improves Quality and Helps Relieve Suffering

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

73 FR 32204, June 5, 2008
Medicare Hospice Conditions of Participation – Final Rule

Palliative Care is NOT only End-of-Life Care and is not dependent on prognosis. Physicians are encouraged to think about palliative care earlier to relieve suffering and improve quality of life rather than wait until death appears near and inevitable. Why is it important to differentiate end-of-life and hospice from palliative care?

1) We really don't know whose dying until the last few days of life, hence very late referral to hospice in the U.S.
2) Most people with palliative care needs are chronically ill and not dying anytime soon, and people have an abiding desire not to be dead!

Palliative Medicine, a new subspecialty of medical practice, was begun in the mid-90s when academic and hospice physicians expanded the national hospice organization to embrace palliative care. This became the American Academy

of Hospice & Palliative Medicine, which now has over 4000 members. Board certification by AAHPM in this specialty began in 1995. In 2008 with the sponsorship of ten medical specialties, the sub specialty of Palliative Medicine and Hospice received accreditation by the American Board of Medical Specialties. There were over 1,200 physicians certified by ABMS in 2008.The majority of these physicians are internists, family practitioners, and oncologists, many of whom are in academic and tertiary-care centers. Fellowship training programs, one or two year, have been established in many of the large treatment centers and medical schools. After 2012 a one-year fellowship will be required for candidates to be eligible for certification. There are approximately 4,000 palliative care physicians, many of whom work part-time. There is a shortage of palliative care physicians, estimated at between 6,000 and 18,000. Advanced practice nurses, also in short supply, will play a large role in the delivery of services in both hospital-based and outpatient palliative care and in hospice care.

End-of-life education was not part of the medical school curriculum in the past, and little emphasis has been given to this subject during a doctor's graduate education. This large gap in education was finally addressed in 1997 by Dr. Linda Emanuel, who developed the EPEC Project with the support of the AMA and Northwestern Medical School. By the next year she and her co-principals, Drs. Charles vonGunten and Frank Ferris. had produced the 12 modules which comprise the series, Education of Physicians on End-of Life Care. The three day training course is presented at least twice annually, with special courses targeted to oncologists and to neurologists. There are over 1500 doctors who are certified EPEC trainers now teaching end-of-life care in their communities. A similar program, ELNEC, is training nurses in the same educational material. In 2008, 41% of medical schools had palliative care teaching programs, and there were palliative care services in 1027 of 4000 hospitals in this country.

Quality gaps and challenges

WHAT PATIENTS WANT

- Pain and symptom control
- Avoidance of inappropriate prolongation of the dying process
- A sense of control
- To relieve burdens on family
- Strengthening relationships with loved ones

Singer et al. JAMA 1999 281(2): 163-168

Family Satisfaction with Hospitals as the Last Place of Care

2000 Mortality Followback (Survey:n= 1578 decedents)

1. Not enough contact with MD:	58%
2. Not enough emotional support of patient:	51%
3. Not enough explanation what to expect during the dying process:	50%
4. Not enough emotional support of family:	38%
5. Not enough help with pain/shortness of breath:	19%

Teno et al.JAMA 2004 291: 88-93

WHAT PATIENTS GET / PALLIATIVE CARE ROLES

- Expert symptom management – pain, dyspnea, constipation, nausea
- Address issues of emotional distress and existential and spiritual suffering
- Expert at family meetings and establishing consensus re: goals of care and a treatment plan matched to these goals
- Improve patient-family-professional communication and decision-making
- Assure safe sustainable discharge plans with services matched to meet needs of complex patients and their family caregivers.

QUALITY ROADMAP FOR PALLIATIVE CARE

- National Consensus Project
- Coalition of CAPC, NHPCO, AAHBM, HPNA, Last Acts
- Identifies core precepts of palliative care in 8 domains

www.nationalconsensusproject.org

NATIONAL QUALITY FORUM

- Established 38 preferred practices associated with quality palliative care

http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_Preferred_Practices_for_Palliative_and_Hospice_Care_Quality.aspx

- CAPC Metrics
- Operationalizes the NQF Framework
- 12 domains with "must have" & "should have" recs
- Starting point for strategic planning & gap analysis
- Developed by consensus panels of PCLC experts, CAPC staff, and CAPC consultants led by David Weissman, MD

Weissman & Meier, J Palliat Med 2008

USEFUL WEBSITES

www.capc.org (CAPC)
www.hpna.org (Hospice & Palliative Nurse Association)
www.aahpm.org (American Academy of Hospice and Palliative Medicine)
www.swhpn.org/ (Social Work Hospice & Palliative Care Network)
www.aacn.nche.edu/ELNEC/ (ELNEC Nursing curriculum)

SOURCES OF ARTICLES:

The Impact of Palliative Care teams on Quality and Cost: Tools and Strategies for Success: Diane E. Meier, MD Director, Center to Advance Palliative Care, Mount Sinai School of Medicine, New York, New York diane.meier@mssm.edu ; www.capc.org ; www.getpalliativecare.org www.palliativecare-la.org (the website of the Palliative Care Institute of Southeast Louisiana)

Capitol Hill Day 2011 *was an overwhelming success. More than 450 participants made nearly 1500 contacts on the Hill in a single day. Attending Capitol Hill Day from LA and MS were Jamey Boudreaux - LMHPCO Executive Director, Nancy Dunn - LMHPCO Education Director, Stephanie Schedler - Glendale Healthcare (LMHPCO President), Belinda Patterson - Hospice Ministries (LMHPCO President-Elect), and John Sullivan – Executive Director Alliance for the Advancement of End of Life Care.*

John Sullivan discusses hospice care with Adam Buckalew, Legislative Assistant to Congressman Gregg Harper

Jamey Boudreaux and Aaron Smith, legislator director for Congressman Jeff Landry (Third District-LA) discuss Senate bill.722

Belinda Patterson, Congressman Alan Nunnelee, Nancy Dunn and John Sullivan

Jamey Boudreaux, John Sullivan, Nancy Dunn, Rep. Bennie Thompson, Belinda Patterson and Stephanie Schedler

LIST OF BLOGS:

American Academy of Hospice and Palliative Medicine
http://www.aahpm.org/apps/blog/?cat=54

This blog has an entry on PC initiative: http://www.aahpm.org/apps/blog/?p=1093

GeriPal: A Geriatrics and Palliative Care Blog: http://www.geripal.org/

PALLIMED: A Hospice and Palliative Medicine Blog: http://www.pallimed.org/

RESOURCES:

Palliative Care Links

http://www.aahpm.org/ The American Academy of Hospice and Palliative Medicine: The American Academy of Hospice and Palliative Medicine is a physician specialty society for hospice and palliative medicine. The Web site provides information on professional education, board certification, fellowship training, and health policy and advocacy relevant to hospice and palliative medicine.

http://www.capc.org/ Center to Advance Palliative Care: The Center to Advance Palliative Care Web site offers a multitude of palliative care resources, tools, training, and technical assistance.

http://www.cunniffdixon.org/ Cunniff-Dixon Foundation: Foundation exists to improve the art of medicine and surgery for patients who are near or at the end of their lives

http://www.dartmouthatlas.org/ Dartmouth Atlas: The Dartmouth Atlas Web site permits creation of customized reports looking at geographic differences in end-of-life care costs and utilization (US).

http://www.aacn.nche.edu/ELNEC/factsheet.htm End-of-life Nursing Education Consortium (ELNEC)\: ELNEC is a national nursing education initiative to improve palliative care. ELNEC is at train-the-trainer project that offers four curricula designed for specific populations; Core, Critical Care, Geriatric and Pediatrics.

http://www.eperc.mcw.edu/ End-of-Life / Palliative Education Resource Center (EPERC): educational resources for the community of health professional educators involved in palliative care education

http://www.getpalliativecare.org/ Get Palliative Care.org: Get Palliative Care.org is a consumer-oriented Web site that defines palliative care and provides links to local resources.

http://www.hpna.org/ Hospice and Palliative Nurses Association: The Hospice and Palliative Nurses Association is the United States' largest and oldest professional nursing organization dedicated to promoting excellence in hospice and palliative nursing care.

http://www.nationalconsensusproject.org/guidelines_download.asp National Consensus Project: Link to the Clinical Practice Guidelines for Quality Palliative Care

http://www.nhpco.org National Hospice and Palliative Care Organization: The National Hospice and Palliative Organization is a membership organization of hospices that provides educational, organizational, and advocacy resources related to hospice and palliative care.

http://www.palliativedoctors.org/ Palliative Doctors: Public-oriented Web site providing information about and links to palliative care resources

http://www.swhpn.org/ Social Work in Hospice and Palliative Care Network: Links to information, education, training, and research for social workers

http://www.socialworkers.org/practice/bereavement/standards/default.asp NASW Standards for Social Work Practice in Palliative and End of Life Care

Association of Hospice Palliative Care Chaplains:
http://www.ahpcc.org.uk/

This is a link to a on Center for Advancement of Palliative Care to a discussion forum for Chaplaincy in Palliative Care Setting:
http://www.capc.org/forums/chaplaincy

This link is to The National Association of Catholic Chaplains:
The page is Chaplain Tools: Palliative Care and Hospice
http://www.nacc.org/resources/palliative.asp

Hospital Chaplain page:
http://www.hospitalchaplain.com/htm/r-palliative.htm

United Methodist Church resource Page:
http://www.umc.org/site/apps/nlnet/content3.aspx?c=lwL4KnN1LtH&b=2789393&ct=8738915

Louisiana Palliative Medicine Physicians: (www.AAHPM.org)

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National Palliative Care Data – Cautiously Optimistic

Cordt. T. Kassner, PhD
Hospice Analytics, Inc.

Can we track palliative care consults nationally through Medicare claims data? Palliative care was approved as a medical subspecialty 10/6/06. Since then, there has been discussion of using CMS billing V-code 66.7 as a way to systematically track palliative care consults across hospitals and Medicare. V66.7 is labeled as an "encounter for palliative care", with subheadings of "end-of-life care", "hospice care", and "terminal care". V66.7 is always a secondary diagnosis, with the underlying disease coded first; and its use is not tied to reimbursement of any kind.

Strengths of V66.7: Currently, V66.7 is the only palliative care billing code able to be used easily and consistently to track palliative care consults, outcomes, and costs across all Medicare providers. And in fact, some hospitals have implemented automated processes to include V66.7 on all palliative care consultations and this V-code is being used exactly for these purposes.

Weaknesses of V66.7: There is only a V-code label for V66.7 – "encounter for palliative care" – there is no general or specific definition of the code or regulation stipulating when this code should or should not be used. Therefore, we do not know whether V66.7 is being used consistently or appropriately. Further, Medicare claims are limited to one primary diagnosis field and 10 secondary diagnosis fields. So if V66.7 is included on a claim, but not included in one of these first 11 diagnosis fields, then we cannot use Medicare claims to track this information.

Conclusions for using V66.7: We cannot verify the reliability of V66.7 in terms of consistent or appropriate use – anecdotally there is evidence of both correct and incorrect use of the code. Therefore, we must be cautious in drawing conclusions or implementing change based on this information alone.

A Peek at the Data: So balancing the strengths and weaknesses of using V66.7 to identify palliative care consults, how often was V66.7 used across 2009 Medicare hospital, hospice, skilled nursing facility, and home health agency claims? What does this information tell us?

Summary: Preliminary analysis of V66.7 has strong face validity – the results are surprisingly close to what might be expected. The vast majority of "palliative care encounters" occurred in hospital and hospice settings (>90%), and over 80% of those who received a "palliative care encounter" in 2009 died during the same year – suggesting application of this code might be accurate. If use of V66.7 is an accurate indicator of palliative care consultations, then further exploration using this code may be warranted. Possible uses might include comparing mortality, hospice referral, and total health care expenditures of those receiving palliative care consultations to those who do not, etc.

How often was V66.7 used?

2009	# Beneficiaries	# PC Consults	# Died (%)	# Died in Hospital (%)	# Died in Hospice (%)
Medicare Total	131,696	134,904	110,512 (84%)	40,661 (30%)	58,956 (45%)
Louisiana	763	770	655 (86%)	301 (39%)	315 (41%)
Mississippi	1,191	1,194	1,003 (84%)	420 (35%)	446 (37%)

Where was V66.7 used?

2009	# INPT Hospital (%)	# Hospice (%)	# SNF (%)	# HHA (%)
United States	84,614 (63%)	42,845 (32%)	4,896 (4%)	2,549 (2%)
Louisiana	724 (94%)	* (*%)	35 (4%)	* (*%)
Mississippi	1,030 (86%)	153 (13%)	* (*%)	* (*%)

* Indicates CMS protected fields where cell size <11

Effective Communication near the End of Life

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Each year over 2 million American's will die with 75 percent of these deaths occurring in an institutional setting often after receiving care in an intensive care unit.1With the technological advances available today, choices associated with death and dying have become complex. Patients and families are presented with options for care, which in the best situation, results in a peaceful, dignified death. However at times, dying can be prolonged, accompanied with needless suffering and costly or ineffective treatments. Facing an advanced or life threatening condition is a stressful and fearful experience for the patient and their family. Difficult health care decisions further exacerbate stress and fear. Patients and families need information presented in an honest straightforward manner to allow them to make informed choices. Effective communication plays an essential role in how these discussions unfold and how decisions are made. So we are left asking ourselves how can these patients be served best?

Many times, these patients and families will benefit from the clinical expertise and skills of a palliative care team. Palliative care is a comprehensive approach to compassionate, holistic patient and family-centered care for patients of any age with an advanced or life threatening condition. Palliative care can assist in the care of a patient at any point during an illness. It is not reserved for those who are terminally ill. Frequently, palliative care is asked to assist in the care of the sickest most complex patients who may be nearing the end of their life. This makes palliative care a crucial resource in the acute care hospital setting.

Palliative care is typically provided by an interdisciplinary team that may be comprised of physicians, nurse practitioners, nurses, social workers, and chaplains. This team works in collaboration with the medical team already caring for the patient. Frequently, the palliative care team is asked to assist in the care of patients who are receiving care from multiple providers. This can result in care being fragmented along with a lack of ongoing communication among care providers, the patient and family. Many times, these patients are at a crossroad with complex needs requiring difficult decisions. Decision making is a difficult, emotional, and complex process. Research indicates that the patient and family may experience depression, anger, fear, hopelessness, helplessness, and/or anxiety. 2 These emotions may interfere with the patient and family being able to understand the impact of the situation, making it challenging for them to make decisions. The patient and their family need a supportive, caring environment where they can ask questions, as well as share information and concerns. A family meeting is a useful forum for the palliative care team to facilitate these conversations.

The family meeting is the cornerstone procedure for palliative care. The palliative care team has the skills and resources to facilitate the discussions needed to assist patients and families with making crucial health care decisions. The members of the palliative care team can provide information about the patient's diagnosis, treatment options, and prognosis as well as what support and outcomes can reasonably be anticipated. This team can assist patients and families with clarifying the goals of care based on the values and beliefs of the patient leading to development of a plan of care. Time is required for patients and families to understand the information. The clinical expertise of the palliative care team will support them during this decision making process. Effective communication at this time can result in improved management of symptoms and a better quality of life.

Nurses, whether the palliative care nurse or the nurse providing bedside care, are a pivotal member of the palliative care team. This is best illustrated by the role the nurse has in supporting patients and families following the family meeting when they continue the conversation. It is the nurse who spends an extended amount of time listening to the patient's psychosocial concerns, expressions of loss and grief, need to know that their life had meaning and purpose, responses to suffering, desire to maintain a sense of control and any unmet spiritual needs. At the same time, the nurse is able to hear the concerns of the family as they come to grips with the impending decline in health and ultimate death of their loved one. This places the nurse in a position to develop a supportive, trusting relationship with the patient and family. The nurse can assist them with interpreting bad news, clarifying information, answering questions, and deciphering medical terms. In addition, the nurse can directly support the patient by expressing the patient's wishes to the physician, healthcare team, and their family; to advocate on behalf of the patient and make certain the patient's voice is heard. The manner in which nurses communicate with patients and their families at this time can either facilitate or block open discussion of the patient's preferences regarding their care and needs.

Effective and compassionate communication is the basis of the nurse-patient relationship. The need for strong communication skills is universal to nursing care in any setting but takes on special importance during times of serious illness and end of life care. The American Nurses Association reminds nurses that they have an important role in helping patients participate in discussions about their care, especially end of

life care, and that the patient has the responsibility and right to make healthcare decisions for her/himself.3 As a result, one of the challenges for nurses caring for these seriously ill patients is being able to understand and honor the patient's wishes regarding care.

Communication at this time needs to be straightforward, open and sensitive, reflecting a desire to understand of the patient's needs, wishes, and priorities. This type of communication is not a simple, naturally occurring process. It requires therapeutic communication skills. Whether

speaking with the patient or family, nurses need to be familiar with the principles of good communication when undertaking this complex endeavor. The following have been identified as principles to guide conversations at this time: (a) be honest and truthful, (b) ask the patient about their goals and values, (c) help the patient explore options within the context of their goals and values, (d) encourage questions, (e) do not interrupt, (f) ask yourself "if this was my family member, what would I do," and (g) take time to listen.4

Some appropriate, gently probing questions that can be used to get the conversation started are: (a) Tell me what the doctors have told you about your/your family member's condition? (b) How do you see things going? (c) Are you surprised by the information you have been given? (d) Do you have any questions about what the doctor told you? If during the discussion, they indicate the doctor stated that "there is not much more we can do" it is important to discern how they feel about this, acknowledge their feelings, seek clarification, and use silence with active listening. A response to this may be "this must be very hard for you to hear." This is also an excellent opportunity to discuss what can be done for the patient at this time how to make the most of each day, the importance of aggressive pain and symptom management, as well as identifying any spiritual needs.If the patient or family asks "why is this happening?" an appropriate response is "I do not know. I wish I had an answer." At the same time, if they ask "what would you do?" offer a reflective statement such as "this must be a difficult experience for you" or "what are your greatest concerns or fears now?" 5

Effective communication with patients and families regarding wishes for care is a significant determinant in patients receiving care that is consistent with their values and wishes. Nurses need to be mindful that their interactions with patients and families can either facilitate or impede these discussions. These discussions provide the patient and family with an opportunity to express hopes and fears, needs, wishes, and priorities. When patients have the opportunity to participate in end of life care discussions, their preferences and wishes can be identified so they may receive care they desire in the setting they desire.

References:

1. U.S. Department of Health and Human Services, (2010). *Health, United States, 2010 with special feature on death and dying*. Retrieved from http://www.cdc.gov/nchs/data/hus/hus10.pdf
2. March, P.D. and Strayer, D.A., (2010). *Evidence-based care sheet: End of life care and decision making*. Glendale, CA: Cinahl Information Systems
3. American Nurses Association. (2006). Nursing and End-of-Life Decision Making. Retrieved December 8, 2009 from http://www.nysna.org/practice/positions/endoflife.htm 4. Barclay, J. S., Blackhall, L. J., and Tulsky, J. A., (2007). Communication strategies and cultural issues in the delivery of bad news. Journal of Palliative Medicine, 10(1), 958-977
5. Gauthier, D. M., (2008). Challenges and opportunities: Communication near the end of life. *MedSurg Nursing*, 17(5), p. 291-296

LOUISIANA~MISSISSIPPI
HOSPICE AND PALLIATIVE CARE ORGANIZATION

Monday, April 11, 2011

Tulane University IRB Committee
New Orleans, LA

RE: *Hospice Emergency Medication Kit Content and Utilization: A Survey of Regional Practices*

To whom it may concern:

LMHPCO is pleased to submit this letter of support and cooperation to Tulane University's Institutional Review Board, pledging our assistance to Dr Dominique Anwar's research project entitled "*Hospice Emergency Medication Kit Content and Utilization: A Survey of Regional Practices*."

The Louisiana-Mississippi Hospice and Palliative Care Organization (LMHPCO) is a non-profit, 501(c)(4) educational corporation that seeks to improve hospice care and services in the two-state area through research, professional education, public awareness and advocacy. In 2010 LMHPCO networked 76 Louisiana and 68 Mississippi hospice providers for this purpose and we have every reason to believe that our membership will be supportive of our efforts in this project.

LMHPCO will provide Dr Anwar with contact information for all our membership and will publicize and encourage our membership to cooperate with her investigation.

LMHPCO is very interested in Dr Anwar's research into palliative care and practice and believes her current investigation: *Hospice Emergency Medication Kit Content and Utilization: A Survey of Regional Practices,* will provide our membership and the global hospice community with greater insights into quality patient care.

Sincerely

Jamey Boudreaux
Executive Director

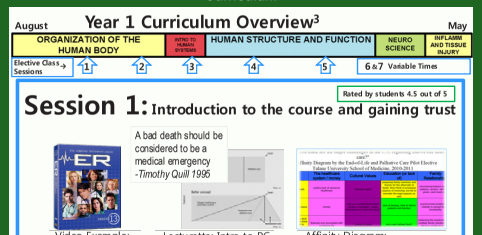
717 Kerlerec St. • New Orleans, LA 70116 • (504) 945-2414 • Fax (504) 948-3908 • www.LMHPCO.org

A Pilot Preclinical Elective on Aspects of Palliative Care and End-of-Life Care

Benjamin M. Azevedo*, Kathleen W. Azevedo, RN, MSN, Dominique M. Anwar, MD***

*Tulane University School of Medicine, **University of California, Berkeley, Extension

Curriculum



Session 1: Introduction to the course and gaining trust

Rated by students 4.5 out of 5

Video Example: Defining the need

A bad death should be considered to be a medical emergency
-Timothy Quill 1996

Lecturette: Intro to PC and EOL Care

Affinity Diagram: Barriers to good EOL care

Session 2: Our First Dead Patient: Anatomy and Cadavers

Rated by students 4.7 out of 5

It is commonly known that medical students dissect the bodies of the dead; it is less commonly realized that these same dead do a great deal of cutting, probing and pulling at the minds of their youthful dissectors.
-Alan Gregg, MD 1957

"Reverence"
Elective Student (2011)
Crayon on Paper

Now I'd like to *reintroduce* myself as a future Tulane Medical School cadaver.
-Hill Riddle, guest speaker

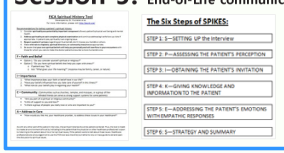
My mom willed her body to an anatomical gift program in California five years ago.
-Jessie Kittle, T2 and guest speaker

Session 3 and 4: Exploration of Media Views on Death

Rated by students 4.4 out of 5

Session 5: End-of-Life communication

Rated by students 4.9 out of 5



Dr. Chad Miller teaches a group

Session 6: Ethics Committee Meeting

Rated by students 4.9 out of 5

- All students attended one Ethics Committee Meeting during the course
- Topics discussed: patient consultations, new policies or laws, new research
- Activity: Ask questions and participate
- Goal: Familiarize students with resources available to physicians

Session 7: Hospice Visit: exploring a multidisciplinary view

Rated by students 4.9 out of 5

- Shadow a hospice team member
- Observe techniques of communication
- Understand the culture of hospice
- Introduce resources available to patients

Abstract

Context: Medical education does not adequately cover end-of-life (EOL) care and palliative care (PC). Physicians must have an understanding of the best care for patients at the end of life, including palliative care. The preclinical years of medical school offer an environment to explore these topics.

Objectives:

- To teach medical students some basic end-of-life care competencies
- To instill confidence in addressing EOL care issues with patients and families
- To examine the effectiveness of this intervention

Design: Twenty students voluntarily enrolled in a student-designed elective taking approximately 10 hours in their first year. All first-year students responded to a survey to compare outcomes.

Results:

- Elective students felt they knew more about PC, hospice, and health care advanced directives.
- Elective students feel better prepared to speak to patients about EOL choices

Conclusions: Simple, low-cost, well-timed sessions can decrease the barrier to effective communication and lead to better care for patients and more confident students.

Background

Medical students in the US and at Tulane feel unprepared to provide aspects of quality care for the dying[2]. With the growth of the aging population in the coming years, the ability of doctors to care for patients at the end of life is increasingly important.

Although Tulane students feel that physicians are responsible for helping patients to prepare for death (fig.1), they feel that the teaching in this area has been inadequate (figs.2&3)[2].

Fig. 1

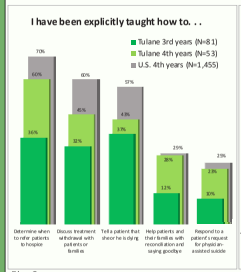


Fig. 2

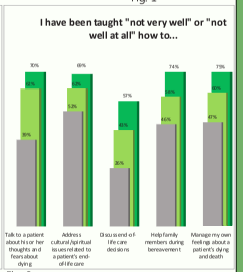


Fig. 3

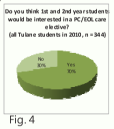


Fig. 4

This need, as well as anecdotal requests and strong student support (fig.4), led to the development of the elective course *Aspects of Palliative and End-of-Life Care* at Tulane Medical School to be taught in the 2010-2011 academic year.

We hypothesized that an elective undergraduate medical education course would increase self-perceived preparedness among undergraduate medical students to speak with patients and their family members about end-of-life issues compared to students who did not enroll.

Methods

Selection of Students:

Students self-selected by expressing interest through email.

- 30 students responded with interest
- 24 students attended the first session
- 20 students finished the elective
- 18 students completed the survey

Study procedures:

A survey including peer reviewed published questions[2] was administered in the 2009-2010 school year to all Tulane medical students to gauge interest and collect baseline data. The same survey was administered to the first-year class in 2011, with different collectors assigned to compare students who took the elective with those who did not.

Results

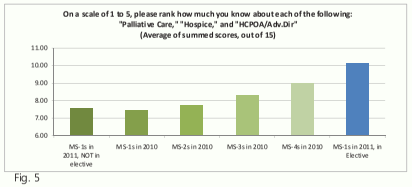


Fig. 5

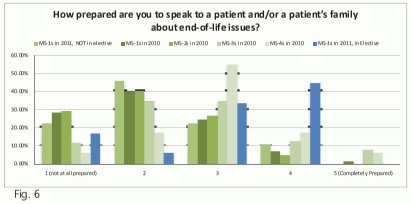


Fig. 6

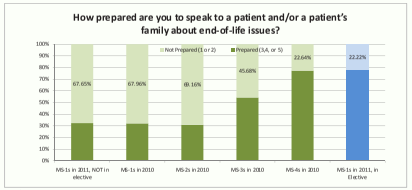


Fig. 7

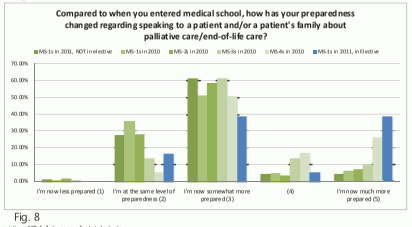


Fig. 8

Abbreviations: MS-1, first-year medical student; etc.

Contact information

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Discussion

Limitations to this study include the possibility of a selection bias due to the voluntary nature of the elective. Students who participated may have already been knowledgeable and comfortable with these topics but with the absence of a pre-course survey, we will not know. Also, we did not evaluate their knowledge or their abilities in an objective way with a pre-test and post-test, so the data is self-reflective and subjective.

There was significant interest from other students who did not get the opportunity to take the course as well as continued interest by those enrolled in the elective. Those subjects that students expressed interest in learning more about include: (n = 86)

• How to break bad news to patients or their families	74.4%
• Pathophysiology of the end of life	66.3%
• Clinical diagnosis/presentation and management of symptoms at the end of life	62.8%
• Pharmacology of palliative care and end of life	59.3%
• Ethical and legal considerations at the end of life	59.3%
• Advance planning for end-of-life: Learning to fill out Advanced Directives and Health Care Power of Attorney	47.7%
• A visit to a hospice to shadow a doctor or nurse	43.0%

Possible future continuations of the course:

- Implementation into the mandatory course work for MS-1 students
- Adding more subjects from the list above to MS-2 opportunities
- Continuing to study these same students as they progress through school
- Funding opportunities in order to include standardized patients
- Part of a larger beginning to a Tulane Research Group on Palliative and End-of-Life Care

Conclusion

These encouraging results demonstrate that in the preclinical years of medical school, students have the potential to learn and grow in areas that are underrepresented in the medical curriculum. We believe that it is representative of the enthusiastic nature of the first year of medical school that this low-cost, 10-hour elective was able to show such results.

Literature Cited and Acknowledgements

1. Bertman, S. (2009). *One Breath Apart: Facing Dissection*. Amityville, New York: Baywood Publishing Company, Inc.
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3. *Tulane OME Courses*. (n.d.). Retrieved March 18, 2011, from Tulane Office of Medical Education: http://tulane.edu/som/courses/courses.cfm

Many generous people offered their support of this project. Father Don Owens' enthusiasm encouraged us from the beginning. Dr. Theresa Dise, Dr. Marc Kahn, and Dr. Kevin Krane guided us in the planning stages, and the Tulane Hospital Ethics Committee welcomed the students and applauded our efforts. We are grateful to Dr. Amy Sullivan at Harvard for permitting us to use her well-thought-out survey questions to be able to compare Tulane to the national averages. Dr. Jennifer Gibson tirelessly helped us to perfect our surveys. Dr. Stephen Azevedo and Elaine Hicks helped with editing our abstract and poster. Our guests, Hill Riddle, Jesse Kittle, Dr. Sean Ransom, and Dr. Chad Miller folded true humanism into the lessons of the course. Most of all, this could not have taken place without the trusting enthusiasm of the students who volunteered for this elective and the positive energy they brought to make it so engaging.

Hospice and Palliative Care Community Celebrates Contributions of Volunteers during National Volunteer Week, April 10 – 16

(Alexandria, Va) – National Hospice and Palliative Care Organization salutes the estimated 468,000 trained hospice volunteers that provide more than 22 million hours of service every year to our nation's hospice programs. National Volunteer Week is April 10 through 16 and those dedicated individuals offering support, companionship and hope to those facing a life-limiting illness deserve special recognition for the difference they make in America.

"Hospice volunteers play an indispensable role in enabling hospice and palliative care organizations to offer the best care possible for patients living with life-limiting illness, their families and caregivers," said J. Donald Schumacher, NHPCO president and CEO. "By sharing their time, energy, and expertise, volunteers bring compassion and caring to the lives of those in need.

"It is federally mandated under Medicare that five percent of all patient care hours be provided by trained volunteers. This regulation reflects the vital role that volunteers play in the hospice philosophy of care and ensures that a hospice program has roots deep in the community.

A special group of volunteers were honored on April 9 at NHPCO's 26th annual Management and Leadership Conference at the Gaylord National Convention Center in National Harbor, Maryland. The dedicated volunteers of the hospice program at the Louisiana State Penitentiary at Angola were honored – despite the most difficult of circumstances – for their commitment to caring for those in their community with compassion, dignity and respect. On behalf of the men working with the hospice program at Angola, Nancy Dunn, education director of the Louisiana-Mississippi Hospice and Palliative Care Organization, presented the "Seasons of Caring" quilt created by hospice volunteers at Angola to the nation's hospice and palliative care community. LMHPCO has been a supporter of the Angola hospice program that has grown into a national model of care for the dying in corrections facilities. Upon accepting the quilt, Schumacher remarked, "The care provided by the men at Angola reminds us all of the powerful gift that hospice volunteers make – and this quilt, that will hang in the National Center for Care at the End of Life, will be a tangible symbol of the hope integral to hospice."

NHPCO issued a proclamation honoring volunteers, available at NHPCO's website.

Nancy Dunn, LMHPCO Education Director presented NHPCO's President, Don Schumacher with a quilt created by the inmate volunteers at LSP Hospice at Angola, LA at the recent NHPCO management & Leadership Conference, held in National Harbor, MD. The quilt was made possible by Warden Burl Cain, Sandy Roberts, RN Program Manager, Courtney Washington, Hospice Social Worker, and the leadership & handwork of inmates Steven Garner and Scott "Chief" Meyers (both serving Life sentences). NHPCO issued the following press release on April 11, 2011

face to face

2011 LMHPCO Conference

Conference Keynote Speaker

"A View from Washington"

This presentation will highlight the many issues impacting the hospice and palliative care industry.

PRESENTATION OBJECTIVES:

- List the components of health care reform that impact the hospice industry
- List three regulatory changes that will impact how hospice care is delivered in the future
- Describe the U-shaped payment model and how MedPAC is progressing with implementation of the model
- Identify 3 critical issues that hospices will need to address to be successful in 2011 and beyond.

Dr. Schumacher has more than 30 years' experience in hospice and palliative care administration. Since 2002, he has served as the President and Chief Executive Officer of

J. Donald Schumacher, PsyD
President and CEO
National Hospice and Palliative Care Organization

The National Hospice and Palliative Care Organization (NHPCO), which is the largest nonprofit membership organization representing hospice and palliative care programs and professionals in the world. In 2003, he was appointed as the President and CEO of NHPCO's subsidiary organization, the National Hospice Foundation. He became the President of the Foundation for Hospices in Sub-Saharan Africa in 2004. He also became the President of The Hospice Advocacy Network in 2007.

Thursday Morning Plenary

Gary M. Golden

Gary was a walk on athlete at Louisiana Tech University where he received his undergraduate degree. After graduation Gary went to work for a global training organization and his responsibilities were to sell training programs and instruct various topics.

Gary has a Master's Degree in Health Care Administration and has written and customizes a large variety of seminars to meet the clients' needs.

In 1999, Gary founded **G**olden **O**pportunities, which is a training and development company designed to help corporations excel. **G**olden **O**pportunities goes beyond improving the bottom line by delivering top quality performance while giving people the opportunity to develop to a higher level. Gary is a dynamic presenter speaking to diversified groups on many topics and works with all types of industry.

THE COACH

This presentation is a fresh perspective on how to motivate and inspire others by focusing on behavior. Participants will better understand the art of developing and instilling the desire to want to perform in others, and become familiar with the concept of linking performance to gratification.

face to face 2011 LMHPCO Conference

Mark your calendar for the LMHPCO 2011 Leadership Conference

July 27-29, 2011

at the Loews Hotel, New Orleans

CONFERENCE HOTEL

The LOEWS NEW ORLEANS HOTEL has again been selected as this year's conference site. Conveniently located in the heart of the New Orleans business district at 300 Poydras Street, the conference site is easily accessible to numerous tourist attractions, great shopping and fabulous food!

Registrants can book rooms on line or by calling 866-211-6411. The LMHPCO Conference Rate of $109.00 per night is guaranteed through June 25, 2011.

Hotel Reservation & Cancellation Policy
The cancellation of guaranteed reservations must be received 72 hours prior to arrival in order to avoid a charge equal to one night's room and applicable taxes. All "no show" reservations will be billed to each individual's account.

Check in and check out time
Check-in time for all attendees is 4:00PM. Attendees may be checked in earlier depending on occupancy levels and availability. Check out time is 12:00PM. Any guests checking out after 12:00PM may be assessed a fee equal to one night's room and tax.

http://www.loewshotels.com

Heart of Hospice Nominations Being Sought

Do you know of someone who has attained repeated outstanding achievements in hospice and end-of-life care? Why not take the time to nominate them for the LMHPCO Annual Heart of Hospice Award? The Heart of Hospice Award will be presented to one LA recipient and one MS recipient on Thursday, July 28, 2011 at the lunch meeting of the LMHPCO Annual Leadership Conference in New Orleans.

Deadline for nomination is Wednesday, June 1, 2011.

LOUISIANA~MISSISSIPPI
HOSPICE AND PALLIATIVE CARE ORGANIZATION

Heart of Hospice Award
2011 Nomination Form

Deadline for Nomination is Wednesday, June 1, 2011

The Heart of Hospice Award recognizes an individual from each of the two states who has attained repeated outstanding achievements in hospice and end-of-life care. This award will be presented on Thursday, July 28, 2011 at the Lunch Meeting of the LMHPCO Annual Leadership Conference in New Orleans.

Information requested includes all of the following:

- Name of **Nominee**
- Hospice/Palliative Care Program Affiliation:
- Mailing Address:
  City:
  State:
  Zip:
- Phone number:
- Fax:
- E-mail address:

Nominee's Curriculum Vitae/Resume

Narrative

Describe nominee's history and relationship to hospice/palliative care, including accomplishments and contributions to hospice/palliative care.

Reference Letters (at least 1)

- Name of **Nominator** (Your Name):
- Hospice/Palliative Care Program Affiliation:
- Mailing Address:
  City:
  State:
  Zip:
- Phone number
- Fax:
- E-mail address:

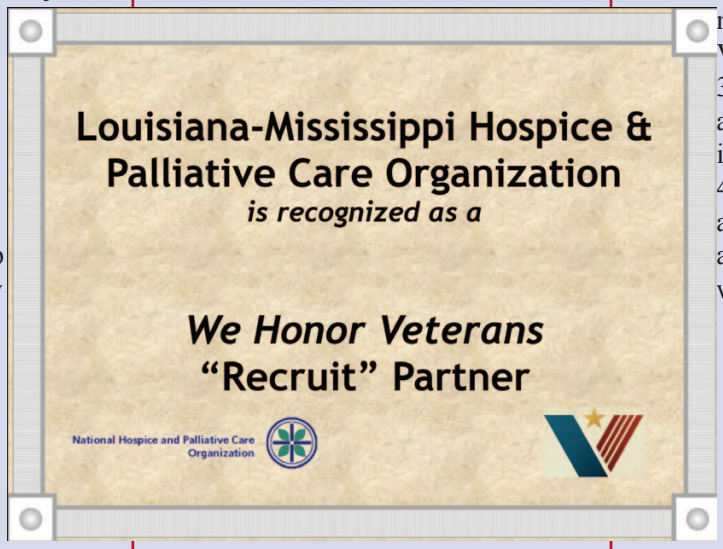
All requested materials must be e-mailed, faxed or postmarked by June 1, 2011 to:
E-mail: nancy@LMHPCO.org
Fax : 504-948-3908
Mail : LMHPCO PO Box 1999 Batesville, MS 38606

"WE HONOR VETERANS"

We Honor Veterans a program of the National Hospice and Palliative Care Organization (NHPCO) in collaboration with the Department of Veterans Affairs (VA) invites hospices, state hospice organizations, Hospice-Veteran Partnerships and VA facilities to join a pioneering program focused on respectful inquiry, compassionate listening and grateful acknowledgment. By recognizing the unique needs of America's veterans and their families, community providers, in partnership with VA staff, will learn how to accompany and guide them through their life stories toward a more peaceful ending.

Become a WHV Partner
Through this program, local community hospices can join hospice providers across the country in honoring our Nation's Veterans and be listed as Partners on the We Honor Veterans website.

By becoming a We Honor Veteran Partner, hospices will be better prepared to:
1. Build professional and organizational capacity to provide quality care for Veterans
2. Develop and/or strengthen partnerships with VA and other Veteran organizations
3. Increase access to hospice and palliative care for Veterans in their community
4. Network with other hospices across the country to learn about best practice models
www.WEHonorVeterans.org



Here are LMHPCO members in the process of building their competency with regards to Veterans.

Faith Foundation Hospice
Alexandria, LA • Recruit

Hospice Compassus
Monroe, LA • Recruit

Hospice Compassus - Slidell/New Orleans
Metairie, LA • Recruit

Hospice of Shreveport/Bossier
Shreveport, LA • Recruit

Hospice of South Louisiana
Houma, LA • Recruit

Lakeside Hospice
Metairie, LA • Recruit

Louisiana Hospice & Palliative Care
Opelousas, LA • Recruit

Louisiana Hospice & Palliative Care
Mamou, LA • Recruit

Louisiana Hospice & Palliative Care - Jennings
Jennings, LA • Level One

Odyssey Hospice of Lake Charles
Lake Charles, LA • Recruit

Odyssey Hospice of New Orleans
Metairie, LA • Recruit

Patient's Choice Hospice and Palliative Care
Tallulah, LA • Recruit

Premier Hospice, LLC
Bastrop, LA • Recruit

St. Joseph Hospice - Acadiana
Lafayette, LA • Recruit

AseraCare Hospice
Corinth, MS • Level One

Deaconess Hospice
Biloxi, MS • Recruit

Hospice Ministries, Inc.
Ridgeland, MS • Recruit

Hospice of Light
Gautier, MS • Recruit

Odyssey Hospice of Jackson, MS
Flowood, MS • Recruit

Patient's Choice Hospice and Palliative Care
Vicksburg, MS • Recruit

Quality Hospice Care, Inc
Philadelphia, MS • Recruit

LMHPCO Calendar Events of Interest (www.LMHPCO.org)

APRIL

April 26, 2011
318 Shreveport Area Code Meeting
Zocolo's
436 Ashley Ridge Blvd.
Shreveport, LA 71106
Details and Registration available at:
http://tinyurl.com/4z8n3hj

April 27, 2011
337 Lafayette Area Code Meeting
Abacus Restaurant
530 West Pinhook
Lafayette, LA
Details and Registration available at:
http://tinyurl.com/4grnmwx

April 28, 2011
Area Code 337 Lake Charles Area Code Meeting
Mazen's Mediterranean Foods
217 W. College St.
Lake Charles, LA
Details and Registration available at:
http://tinyurl.com/4grnmwx

April 28, 2011
Area Code 662 North Area Code Meeting
Ryan's
2210 S. Harper Road
Corinth, MS
Details and Registration available at:
http://tinyurl.com/695yb9j

April 29, 2011
Area Code 228 Meeting
Salute Restaurant
1712 15th Street
Gulfport, MS
Details and Registration available at:
http://tinyurl.com/459x86s

MAY

May 17, 2011
Hospice Aide Training
Gautier, MS

May 12, 2011
Education Committee Conference Call
10:15-11:15 am

JULY

July 27-29, 2011
LMHPCO Annual Leadership Conference
Main Conference: July 27-28, 2011
Post-Conference: July 29, 2011
Loews New Orleans Hotel

OCTOBER

October 6-8, 2011
NHPCO's 12th Clinical Team Conference and Pediatric Intensive
Town and Country Resort and Convention Center, San Diego, CA
Preconference Events:
October 4-5, 2011
Main Conference:
October 6-8, 2011
www.nhpco.org

October 20-21, 2011
SW End-of-Life Education Project
Jackson, MS
Location TBD

Winter 2012

SW End-of-Life Education Project
Shreveport, LA
Date and location TBD

face to face 2011 LMHPCO Conference

Become a 2011 LMHPCO Conference Exhibitor

For further information on exhibiting and sponsorship opportunities, please contact us at 888-546-1500, www.LMHPCO.org or by e-mail at jboudreaux@LMHPCO.org.

face to face 2011 LMHPCO Conference

JOURNAL ARTICLE SUBMISSIONS

LMHPCO accepts newsworthy items of interest from its membership for publication in the Journal. Submissions should be sent to Nancy@LMHPCO.org and should be received by the 20th of the month to be included in the next month's publication.

Members make the work of LMHPCO possible!

(2011 memberships received as of 4/25/2011)

2011 PROVIDER MEMBERS:

A& E Hospice, Inc, Olive Branch, MS
Agape Northwest Regional Hospice, Minden, LA
Angelic Hospice & Palliative care, Greenwood, MS
Aseracare Hospice, Corinth, MS
Aseracare Hospice, Senatobia, MS
Aseracare Hospice, Tupelo, MS
At Home Hospice Care, Fayette, MS
Brighton Bridge Hospice, Oberlin, LA
Camellia Hospice of East Louisiana, Vidalia, LA
Camellia Home Health & Hospice, Biloxi, MS
Camellia Home Health & Hospice, Bogalusa, LA
Camellia Home Health & Hospice, Hattiesburg, MS
Camellia Home Health & Hospice Jackson, MS
Camellia Home Health & Hospice, McComb, MS
Christus Hospice & Palliative Care – St Frances Cabrini, Alexandria, LA
Christus Hospice & Palliative Care Schumpert, Shreveport, LA
Circle of Life Hospice, Inc, Shreveport, LA
Clarity Hospice of Baton Rouge, LA
Comfort Care Hospice, Laurel, MS
Community Hospice, New Orleans, LA
Community Hospice, Inc, Batesville, MS
Community Hospice, Inc, Hattiesburg, MS
Community Hospice, Inc, Verona, MS
Continue Care Hospice, Cleveland, MS
Continue Care Hospice, Hollandale, MS
Continue Care Hospice, Yazoo City, MS
Crossroads Hospice, LLC, Delhi, LA
Deaconess Hospice, Biloxi, MS
Deaconess Hospice, Brookhaven, MS
Deaconess Hospice, Hattiesburg, MS
Delta Regional Medical Center Hospice, Greenville, MS
Elayn Hunt Correctional Center End of Life Care, St Gabriel, LA
Faith Foundation Hospice, Alexandria, LA
Forrest General Hospice, Hattiesburg, MS
Generations Hospice Service Corporation, Denham Springs, LA
Gentiva Hospice, Booneville, MS
Gentiva Hospice, Starkville, MS
Gentiva Hospice, Tupelo, MS
Grace Community Hospice, Cleveland, MS
Guardian Hospice Care, Alexandria, LA
Harmony Life Hospice, Shreveport, LA
Heart of Hospice, Lake Charles, LA
HL Haydel Memorial Hospice, Houma, LA
Hospice Associates, Baton Rouge, LA
Hospice Compassus, Alexandria, LA
Hospice Compassus, Baton Rouge, LA
Hospice Compassus, Lafayette, LA
Hospice Compassus, Mc Comb, MS
Hospice Compassus, Meridian, MS
Hospice Compassus, Monroe, LA
Hospice Compassus, Natchez, MS
Hospice Compassus, New Orleans, LA
Hospice Compassus, Shreveport, LA
Hospice Compassus, Slidell, LA
Hospice Care of Avoyelles, Alexandria, LA
Hospice Care of Avoyelles, Marksville, LA
Hospice Care of Avoyelles, Opelousas, LA
Hospice Ministries, Brookhaven, MS
Hospice Ministries, Mc Comb, MS
Hospice Ministries, Ridgeland, MS
Hospice of Acadiana, Lafayette, LA
Hospice of Caring Hearts, LLC, Dubach, LA
Hospice of Light, Gautier, MS
Hospice of Light, Lucedale, MS
Hospice of Many, LA
Hospice of Natchitoches, LA
Hospice of St Tammany, Covington, LA
Hospice of Shreveport/Bossier, LA
Hospice of South Louisiana, Houma, LA
Infinity Care Hospice of Louisiana, LLC, Gretna, LA
Jordan's Crossing Hospice, Shreveport, LA
Lakeside Hospice, Metairie, LA
LifePath Hospice Care Services, LLC, Shreveport, LA
Life Source Services, LLC, Baton Rouge, LA
Louisiana Hospice & Palliative Care, Jennings, LA
Louisiana Hospice & Palliative Care, Mamou, LA
Louisiana Hospice & Palliative Care, Opelousas, LA
Louisiana State Penitentiary Hospice, Angola, LA
Magnolia Regional Medical Center Home Health & Hospice, Corinth, MS
Mid-Delta Hospice of Batesville, MS
Mid-Delta Hospice of Canton, MS
Mid-Delta Hospice, Belzoni, MS
Mid-Delta Hospice, Charleston, MS
Mid-Delta Hospice, Clarksdale, MS
Mid-Delta Hospice, Cleveland, MS
Mid-Delta Hospice, Greenville, MS
Mid-Delta Hospice, Greenwood, MS
Mid-Delta Hospice, Indianola, MS
Mid-Delta Hospice, Lexington, MS
Mid-Delta Hospice, Yazoo City, MS
North Mississippi Medical Center Hospice, Tupelo, MS
Notre Dame Hospice, Slidell, LA
Odyssey Hospice, Flowood, MS
Odyssey Hospice, Lake Charles, LA
Odyssey Hospice, Mandeville, LA
Odyssey Hospice, Metairie, LA
Odyssey Hospice, Shreveport, LA
Odyssey Hospice of the Gulf Coast, Gulfport, MS
Patient's Choice Hospice, Tallulah, LA
Patient's Choice Hospice, Vicksburg, MS
Pax Hospice, Ridgeland, MS
Pointe Coupee Hospice, New Roads, LA
Paramount Hospice Acadiana, Lafayette, LA
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Providence Hospice South, Hattiesburg, MS
Quality Hospice Care, Philadelphia, MS
Regional Hospice & Palliative Services, SE, Lafayette, LA
Richland Hospice, Rayville, LA
River Region Hospice, LLC, River Ridge, LA
River Region Hospice House, River Ridge, LA
St Catherine's Hospice, LLC, LaPlace, LA
St Joseph Hospice of Acadiana, Lafayette, LA
St Joseph Hospice of CENLA, Alexandria, LA
St Joseph Hospice, New Orleans, LA
St Joseph Hospice , Shreveport, LA
St Joseph Hospice & Palliative Care Northshore, LLC, Covington, LA
St Margaret's Hospice, Gretna, LA
St Teresa's Hospice & Palliative Care, Lafayette, LA
Serenity Hospice Services, LLC, New Orleans, LA
Serenity Premier Hospice, Vicksburg, MS
Unity Hospice Care, Oxford, MS
Unity Hospice Care, Southaven, MS
Unity Hospice Care, Tupelo, MS

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