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QUARTERLY

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# TRACKING THE EVOLUTION OF HPM SCIENCE

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EDITOR'S MESSAGE

# A NEW LOOK & A NEW CONFERENCE

Welcome to the new-and-improved *AAHPM Quarterly*—and for those of you who joined us at the 2019 Annual Assembly in Orlando, welcome home!

You may have noticed that this issue of the *AAHPM Quarterly* looks a little different from past volumes. As the field changes and the Academy grows, the publications that help keep you informed and up-to-date about changes to the field of hospice and palliative medicine are evolving as well! Although the content will remain as robust as always, this streamlined new look reflects a fresher and more modern design and can help you find your favorite sections more easily—just check out the new section graphics at the top left of each article.

We're excited to present another exciting development in this issue's feature story: AAHPM's new scientific meeting, the State of the Science in Hospice and Palliative Care, to be held in conjunction with the 2020 Annual Assembly in San Diego. Born from the popular State of the Science plenary session, this meeting will give researchers, clinical scientists, and others working in hospice and palliative care research the opportunity to hear from leading researchers and network as a scientific community. To learn more about the history of the State of the Science and this new offering, read the feature story on page 14 and visit aahpm.org/stateofthescience.




*AAHPM covers from 2011 to today*

Other forward-looking content in this issue includes updates to the 2019 Medicare Physician Fee Schedule (see Advocacy Update on page 12) and a discussion about treating side effects when using the emerging treatment immunotherapy in palliative care (see Clinical Pearls on page 8).

We encourage you to share your thoughts on the new look and the new meeting with us or on the Connect platform. And as always, we hope the *AAHPM Quarterly* continues to pique your interest and provide insights that can help shape your practice.



Tara C. Friedman, MD

*Tara C. Friedman, MD FAAHPM*





*Joanne Wolfe and her husband Michael (above) and children Hannah, Ben, and Sam (right).*

## MEET AAHPM PRESIDENT

# JOANNE WOLFE, MD MPH FAAHPM

**What led you to the specialty of hospice and palliative medicine?**

I came to the specialty of hospice and palliative medicine through several formative experiences. For pediatric residents in the early 1990s, it was not uncommon to find oneself alone in the hospital in the middle of the night attending to a dying child without any advance preparation. In one instance, for example, through trial and error, I sought to relieve pain in a child dying of widely metastatic neuroblastoma, while he was clinging to his mother, screaming. Thanks to the experience and wisdom of the oncology nurses, we managed to capture his pain in his final hours. This and similar experiences left me wondering whether we could do better for seriously ill children in their final hours and throughout their lives.

When deciding what to investigate during the research portion of my hematology/oncology fellowship, I was inspired by the work of Drs. Joanne Lynn and Joan Teno and the worrisome results of the SUPPORT study showing poor quality of care for seriously ill adults in acute care hospitals. Under the sage guidance of my research mentor, Dr. Jane Weeks, I conducted a study of quality of care for children with cancer at end of life, which uncovered similar opportunities for improvement. At the same time, I was working as a pediatric medical director for a local hospice and again learned from the home-based interdisciplinary team how optimal end-of-life care could be provided.

Together, these experiences led me to focus my career on developing high-quality pediatric palliative care and training and on searching for interventions through research that would better the lives of seriously ill children and their families.



**Which aspects of providing palliative care do you consider most rewarding?**

At this stage I spend most of my time on administrative responsibilities and research. While clinical care is only a small part of what I do, it is an essential component and is most inspiring. As we accompany families along their child's illness experience, in partnership with the rest of the clinical team, I believe we are truly improving their well-being, and that is immensely rewarding. At the same time, each moment of clinical work fosters my own well-being through witnessing family courage and reminding me of my own life priorities. Furthermore, these interactions feed my curiosity, creativity, and commitment to improve our care through research.

If I could be afforded two most rewarding aspects of my work, the second would be seeing our field grow and watching the next generation of clinicians, teachers, and investigators emerge. It feels truly wonderful to know that our field of hospice and palliative medicine rests in the hands of highly qualified new leaders.

**How did your background prepare you to become president of AAHPM?**

Several aspects of my background prepared me to become president of AAHPM. One of my formative opportunities in the field was being accepted as a faculty scholar with the Project on Death in America. Through this experience, I met current and emerging leaders in the field of adult and pediatric care and across disciplines. I have learned so much from these career-long relationships.

Second, early in my career I identified AAHPM as my professional home. While I recognized the need to network within adult and pediatric oncology and across pediatrics, I realized that AAHPM's vision to improve the care of patients with life-threatening or serious conditions through the advancement of hospice and palliative medicine was fully aligned with my career goals. The Academy provides leadership in advancing clinical care, training, and advocacy, all essential to building a career. Thus, from early on, I focused my volunteer work within the Academy and, through many experiences over the years, became sufficiently qualified to become its president. Needless to say, I am deeply honored to have been selected.

**What would you like to see AAHPM focus on during your term?**

Remarkably, while our field is very young, we have made enormous strides over the past decade. I believe it is my role as president to continue to promote progress, and I believe this can be accomplished in the following ways:

1. My presidency coincides with AAHPM strategic planning, and it feels like a tremendous responsibility to get it right. I believe hospice and palliative medicine will continue on its disruptive path in transforming healthcare, and I look forward to working with the Academy membership and staff to anticipate our future impact and align our priorities.
2. Many of us in the field are concerned about sustaining and expanding our workforce, and this is clearly a top priority. Along with growing our workforce, we need to continue to build the next generation of leaders in hospice and palliative medicine. AAHPM fosters leadership in myriad ways—through trainings such as AAHPM Ignite, Ascend, and Elevate, and through mentored volunteer leadership opportunities such as SIG chair-elect, chair, and past-chair roles. I would like to see these programs expand their depth and reach to benefit a greater number of potential future leaders.
3. We need to continue to build the evidence base for our hospice and palliative medicine practices. AAHPM is fortunate to partner with other organizations, such as the National Palliative Care Research Network and the Palliative Care Research Cooperative, and is working toward a collaborative research meeting. In addition, with the support of the Gordon and Betty Moore Foundation, efforts are underway to unify our national registries in order to advance opportunities for quality measurement, benchmarking, and practice improvement, among others. It is critically important to our field to complete these projects, and I look forward to lending my support as president. Furthermore, I believe we need to expand and diversify National Institutes of Health research funding opportunities. In particular, while the National Institute of

**EDUCATION**

BS, Psychology, McGill University
MD, Harvard Medical School
MPH, Harvard School of Public Health

**SPECIALTIES**

Pediatrics
Hematology/Oncology
Hospice and Palliative Medicine

**YEARS IN HOSPICE AND PALLIATIVE MEDICINE**

21 years

**CURRENT AFFILIATIONS**

Dana-Farber Cancer Institute
Boston Children's Hospital
Harvard Medical School

**AAHPM ACTIVITIES**

**Current**

Member since 2003
Member, Pediatric SIG
Member, Research SIG
President, Board of Directors

**Past**

Board of Directors: Director, Secretary, President-Elect
Chair, Research Committee
Chair, Quality & Research Strategic Coordinating Committee
Chair, Publications Committee
Member, Development Committee
Member, Awards Committee
Associate Editor, *PC-FACS*
Annual Assembly: Scientific Subcommittee Member, Program Planning Committee Member, Presenter

**KEY AWARDS**

Pathfinder in Palliative Care Award
American Cancer Society

Excellence in Scientific Research
AAHPM

Outstanding Mentorship
Academic Pediatric Association

Frank A. Oski Lectureship Award
American Society of Pediatric Hematology/Oncology

Executive Leadership in Academic Medicine Fellowship Award
Drexel University College of Medicine

Visionary in Hospice and Palliative Medicine
AAHPM

Vittorio Ventafidda Award
Fondazione Maruzza

Nursing Research and the National Institute of Aging are highly committed to palliative care research, other agencies are not. In considering our youngest patients, I would like to work with the Eunice Kennedy Shriver National Institute of Child Health and Human Development to expand its prioritization of pediatric palliative care research.

4. From an advocacy perspective, AAHPM has spearheaded shepherding the Palliative Care and Hospice Education and Training Act through Congress. Last year the Academy saw great success with its passing in the House. I hope to work with the incredibly dedicated advocacy team to ensure this is the year it passes in both the House and Senate.

**What can be done to help others—physicians and medical professionals, patients and family, lawmakers, and the media—become more aware of palliative care?**

The ongoing success of our field depends on continued transformation of the public's view of the meaning of palliative care as an entity broader than end-of-life care. I believe the best way to accomplish this is through social media, the mechanism through which many disruptive innovations, such as palliative care, have affected change.

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

Up until this past September, much of my free time was spent at home, partnering with my husband to raise our three children. Understanding that parenting never truly ends, they are all, however, "out of the house," at least for now. I anticipated this change with excitement—imagining so much more free time. I must admit, I am a bit lonelier than expected, so it turns out to be a great time to take on the responsibility of the AAHPM presidency. Aside from parenting, I love to cook and wait expectantly every day for *The New York Times* cooking newsletter to arrive in my inbox. I find it especially joyful to cook for friends and family. In addition, I love the outdoors, including New England winters, and enjoy running, hiking, skiing, and snowshoeing. Finally, in a nod to a

former AAHPM president, I am a fair-weather sports fan and have grown to love our Boston teams. However, I remain deeply devoted to a sports team in the city where I grew up—the Montreal Canadiens!

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

As I mentioned, I entered the field of hospice and palliative medicine through pediatric hematology/oncology. When I first began practicing palliative care across all childhood illnesses, I was less familiar with the experiences of children with advanced neurological impairment, who make up about half of the patient population we serve. In fact, I have to admit, I came from a background where intellect was highly valued, and most of my clinical experiences were with developmentally typical children. And, I was biased toward intellectually disabled children and wondered why families were putting their children through so much medical intervention. My views began to change when I made a home visit to a 6-year-old girl with a neurodegenerative condition of unknown etiology. During the visit, I witnessed the love between this girl, her parents, and older brother. I learned about how her brother would regularly bring his buddies to his sister's special-needs classroom and how they would read to all the children. I saw a child giving and receiving love in a manner I could never have imagined, and I was transformed.

**What else would you like AAHPM members to know about you?**

I hope it is clear that I am immensely committed to fulfilling my responsibilities as president. I have learned that progress depends on collaboration and teamwork, and I look forward to working with the amazing Academy staff and volunteers to make this a highly productive year! ●


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CLINICAL PEARLS

# SIDE EFFECTS OF IMMUNOTHERAPY IN PALLIATIVE CARE

*Susan B. LeGrand, MD FACP FAAHPM*

The hope of immunotherapy was that it would be less toxic than cytotoxic chemotherapy by binding to specific receptors and using the patient's own immune system to treat the cancer. As the agents have been used more, we are discovering significant toxicities that are different from the normal chemotherapy side effects. Many agents have been approved for different hematologic and solid tumors. This article will only discuss solid tumor immune checkpoint inhibitor (ICI) therapies because they are the ones most likely to be seen in palliative medicine. The other class of agents that may be seen are the tyrosine kinase inhibitors, with predominantly skin toxicity, edema, nausea, hypothyroidism, vomiting, and diarrhea. Skin toxicity actually may help predict response. For practical reference, drugs ending in "ib" are inhibitors (of various receptors) whereas those ending in "mab" are monoclonal antibodies.

There are two major classes of ICIs currently in use: 1) ipilimumab-cytotoxic T-lymphocyte associated antigen 4 (CTLA-4) and 2) pembrolizumab and nivolumab-programmed cell death protein (PD-1) and its ligand PD-L1, IgG4 antibodies. CTLA-4 agents regulate T-cell activation in lymphoid organs where T-cells are primed and possibly by regulatory T-cell depletion. PD-1 agents work by suppressing T-cell activity within peripheral tissues and the tumor microenvironment. Although there are some side effects that are similar, CTL-4 agents have higher rates of toxicity and discontinuation of treatment. Current research is focusing on combinations of these medications or combinations with ICI and cytotoxic chemotherapy. Toxicity is typically increased in the combinations. Significant response rates are seen particularly with combinations, and these responses may be long lasting.

Ipilumumab is approved for treatment of melanoma and renal cell carcinoma. It also is approved in colon cancer that has specific genetic abnormalities. Nivolumab is approved for melanoma, metastatic non-small cell lung cancer (NSCLC); small cell lung, renal cell, squamous cell of head and neck, and urothelial cancers; colon cancer (with the genetic alterations); hepatocellular carcinoma; and classical Hodgkin's lymphoma. Pembrolizumab is approved for melanoma; NSCLC; squamous cell head and neck cancer; classical Hodgkin's lymphoma; primary mediastinal large B-cell lymphoma; and urothethial, gastric, cervical, and hepatocellular cancers. The combination of ipilumumab and nivolumab is approved for advanced melanoma. Other combinations with chemotherapies have been approved.

Immune-related adverse events (IRAE) usually are seen within the first 12 weeks of therapy, but they also may be seen as long as 6 months after discontinuation of treatment. Therefore, suspicion must remain high even if the medication has been stopped. Onset is usually acute. Treatment is moderate to high doses of steroids (0.5 mgs/kg–2.0 mgs/kg) depending on the severity of the complication. Response to steroids usually is seen 1–7 days after initiation; then the steroids are tapered over 4 weeks. There is a 10% relapse rate with hospitalization in 5% (anti-PD-L1 agent) to 35% in CTLA-4 agents. Overall toxicities, usually low grade, occur in up to 90% of patients, with higher grade in 40%–50%. Discontinuation rates for the combination of ipilimumab and nivolumab are as high as 35% seen in NSCLC. Although there is data that steroids do not interfere with therapeutic response, it is prudent to discuss with the primary oncologist prior to initiating them. ICI may be held or discontinued.

**Colitis:** 25% of CTAL-4 agents and 5% in anti-PD-1/PD-L1 agents. It may be life threatening. Presents with watery diarrhea in >90%, abdominal pain and lower gastrointestinal bleed. Mild (<6 stools/day) may be treated with hydration and anti-diarrheal agents. Severe (>6 stools above baseline) or lower grades persisting longer than 5–7 days should be treated with high doses of steroids (1–2 mgs/kg). Consider hospital admission. Colonoscopy

can be supportive of the diagnosis, but treatment should not be delayed waiting for procedures/results. Steroids are essential.

**Pneumonitis:** Potentially life threatening, occurring in 2%–5% of patients. Presents with dry cough, dyspnea, hypoxia. Infectious signs are uncommon and should lead to an investigation. CT typically shows a ground-glass appearance. Symptomatic patients should get high-dose steroids.

**Myocarditis:** This may be life threatening (20%–50%) and with pneumonitis is the most common cause of mortality. The most severe cases typically present in the first month of treatment. Fatigue, dyspnea, chest pain, and elevations of troponin are seen. EKG may show heart block and ventricular arrhythmias. Prompt steroids are needed, and other immunosuppressive therapies such as immunoglobulin or antithymocyte globulin may be required.

**Skin:** Occurs in up to 30% and can generally be managed with topical steroids and antihistamines. These typically present as pruritus, acneiform rash, or toxic epidermal necrolysis. While rare, bullous disorders or Stevens-Johnson syndrome should include dermatology consult and high-dose steroids.

**Endocrine:** Endocrine changes usually are not reversible. Ten percent of CTLA-4 patients may develop hypophysitis, but it is rare with other agents. They present with symptoms of adrenal insufficiency. Replacement dose hydrocortisone should be given. Hypothyroidism occurs in up to 20% and requires replacement therapy. A transient hyperthyroid state may be seen, but it always converts to hypothyroid.

**Hepatitis:** Asymptomatic enzyme elevations may be seen in 1%–10% of patients. Other symptoms, such as fatigue, jaundice, nausea, and edema, may be seen. High-dose steroids generally are effective.

**Neurotoxicities:** Although rare, Guillain-Barre syndrome, myasthenia gravis, and encephalitis have been seen. Disease-specific management is used. Encephalitis patients present with confusion with/without meningeal signs. Lumbar puncture should be done while steroids and antibiotics (for bacterial meningitis) are given. Evaluation to rule out metastatic disease is appropriate. In general, an autoimmune disorder of any organ system can be seen as a side effect of this treatment. The majority of these are managed with steroids in various doses. The exact dosage required and length of therapy is not well defined at this time. Early identification of these complications is important to begin therapy. Organ-specific consultations also may be appropriate, and sometimes biopsy procedures are needed to clarify etiology. ●

*Susan B. LeGrand, MD FACP FAAHPM, is a practicing oncologist and hospice and palliative medicine physician, and serves as director of education for The Harry R. Horvitz Center for Palliative Medicine at the Cleveland Clinic Taussig Cancer Center in Cleveland, OH. You can reach her at legrans@ccf.org.*

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ART OF CARING

# READING OURSELVES, READING OTHERS: TEACHING PERSPECTIVE TAKING IN PALLIATIVE MEDICINE

*Kathryn B. Kirkland, MD*

I've been surprised by how often new hospice and palliative medicine fellows are unprepared for the range of responses their patients have when they are the recipients of bad news. It seems self-evident that there are many ways of reacting to difficult situations, and yet, after years of medical school and clinical training, new fellows seem surprised when confronted by reactions that differ from what they expect. In response, they often speak of what their own emotional responses to such news would be. The fellows expect the patient to react the way they think they would, and when the patient doesn't, they are surprised and often have no idea how to proceed.

Until we can recognize and process our own responses to suffering, we cannot create space for the different responses of others. And until there is a capacity to hold and explore the experiences of others, we cannot practice effective or sustainable palliative care.

So what can be done?

The answer I have found lies in the incorporation of narrative medicine into the training of our fellows.

If you know what narrative medicine is, you can probably come up with several reasons why it is an integral part of our hospice and palliative medicine fellowship curriculum at Dartmouth. It seems obvious that the ability to receive and make use of the stories of illness is critical to delivering (or we might more aptly say co-creating) the individualized care that palliative care teams provide for patients with serious illness.

The narrative medicine exercises that I do with our fellows and other members of our interprofessional team twice a month provide opportunities for them to learn to read closely, carefully, for well more than plot. As they read and deconstruct the poems or short excerpts of fiction that I bring to our sessions, they often start with the story, but quickly we move to discuss the mood, the images, the cadence, even the look of the piece on the page. We are interested not just in what the writer has done, but in how she has done it. How do the words, the images and metaphors, the chronology and the rhythms, work to create a mood, or lay out a plot, or move us?

It's not hard to make the leap to our roles as readers in clinical situations. What might we miss if we fail to notice how our patients craft their stories of illness? How much more can we learn if we can hear their metaphors, feel the rhythms and pauses of their narratives?

When we write together, as Rita Charon has pointed out, we often discover what the psychoanalyst Christopher Bollas calls "the unthought known," things we don't know we know until we access them through writing. As we write, we often surprise ourselves or even defy ourselves: "I did NOT want to write about that, but something made me." When we share our writing with the group, we realize the gift of having readers—actually listeners—who sometimes see in our writing things we have not seen. The pieces come to life between writer and reader, teller and listener, just as the stories that our patients tell can do, when we give them space, and our attention.

These basic narrative competencies are central to palliative care and all health care—and even, some would say, to life.

The greatest contribution of these narrative sessions to our fellows' training is in the realm of developing their ability to recognize, accept, and be curious about a range of perspectives—in the room, in our clinical practice, and in the world.

I now deliberately start the year with two sessions in which I use texts and writing prompts to focus their attention on themselves. After reading poems on these subjects, the

fellows write the story of their name and the story of where they are from. I've found that being explicit in beginning to understand and question one's own innate perspectives is a prerequisite to opening to the perspectives of others.

After these introductory sessions, we turn to texts that take us in different directions. Sitting around a table with any poem or photograph or painting, people see different things, derive different meanings, sometimes even experience different moods. "How can this be?" I ask the group. Take me to the lines that support your way of understanding. As we confront inherent ambiguities in the texts, we are forced to engage with our own ways of seeing and those of others, justifying our own and listening to the justifications of others. As we face the unresolvability of the question "Whose perspective is right?" we grow in our comfort with the range of perspectives we will continue to encounter.

Jane Kenyon's short poem "Coats" is one of my favorite texts for teaching perspective. The poem describes a scene outside a hospital, a man leaving with a woman's coat over his arm. The tone darkens as we move from "bafflement" to the unambiguous "irremediable cold" where the last line leaves us. We notice how the single word "hospital" in the first line defines how we interpret the scene. Usually some, if not all, of the participants say that the story is about a woman who died and her grieving partner. I ask them where the poem talks about a death (it doesn't, explicitly). Usually they cite the third line, "Clearly she would not need it."

Is it clear? I ask. There often is a pause here as the participants consider this. Slowly it dawns on them that this statement is someone's opinion. Whose? This usually takes us back to the first line which opens with the words, "I saw." Someone watched this scene unfold and is now telling us about what she thought it meant. Do we trust her? What is the source of her authority? How do we know? We note how different the poem would read if it started, "He was leaving the hospital." Why does the narrator introduce himself as the first character in the poem? Our discussion continues with the group considering these questions, often offering very different opinions on the reliability of the narrator. We talk about the ways in which our own perspectives lead us to frame the stories we hear or see playing out in the hospital, the assumptions we make, the mistakes we make.

Another narrative exercise I use to develop perspective-taking competency involves the fellows writing in the first person about a family meeting in which they have participated. When they arrive for the session with this pre-work, I ask them to write again about the same family meeting, again in the first person, but this time from the perspective of one of the other participants in the meeting. Then they each read the companion pieces to the group. This exercise generates rich discussion about how differently people in different roles experience the same conversation, about the presumptuousness (and the power) of imagining what an experience might have been like for another, about the nature of fiction and nonfiction.

The capacity to receive the stories of others, to honor different perspectives and responses to illness and suffering, is critical for those who work with people facing serious illness. Narrative medicine offers a powerful approach to building this capacity in hospice and palliative medicine fellows and interprofessional teams both within specialty palliative care and outside it. ●

*Kathryn B. Kirkland, MD, is the Dorothy and John J. Byrne, Jr. Distinguished Professor and chief of palliative medicine at the Geisel School of Medicine and Dartmouth-Hitchcock Health. She integrates narrative medicine teaching into medical student, resident, fellow, faculty, and healthcare team education and helps facilitate cross-disciplinary activities with colleagues at Dartmouth College. She can be reached at kathryn.b.kirkland@hitchcock.org.*

ADVOCACY UPDATE

# 2019 MEDICARE PHYSICIAN FEE SCHEDULE: CMS DELAYS PROPOSED CHANGES TO E/M PAYMENT, ADVANCES VIRTUAL CARE

*Jacqueline M. Kocinski, MPP, and Phil Rodgers, MD FAAHPM*

For many years, payment policies finalized annually by the Centers for Medicare & Medicaid Services (CMS) under the Physician Fee Schedule (PFS) sparked little fanfare in the hospice and palliative care community. More recently, efforts by AAHPM and others to promote reimbursement for high-value "cognitive care" yielded changes beneficial to palliative care teams, including separate payment for advance care planning, complex chronic care management, and prolonged non-face-to-face services.

When CMS released its proposed rule for the calendar year (CY) 2019 PFS, Academy members took notice. The agency laid out plans for sweeping changes, including collapsing codes for office/outpatient Evaluation and Management (E/M) services and applying a single, blended payment rate for new and established patients for level 2 through 5 visits. The American Medical Association (AMA) estimated this change would cut payments to many specialties, reducing hospice and palliative medicine clinician reimbursement for office E/M visits by 20%. AAHPM joined others to oppose the move, maintaining it would decrease seriously ill patients' access to care.

## E/M Visits

Stakeholder disapproval of the E/M payment "reforms" was strong: CMS received more than 15,000 public comments on its 2019 proposed rule, compared to roughly 2,500 in 2018. This surely impacted CMS's decisions, as the agency ultimately finalized only some E/M documentation proposals, delayed some payment proposals, and abandoned several others altogether.

CMS delayed collapsing E/M payment rates until 2021, when a blended payment rate would apply for level 2 through 4 office/outpatient visits, leaving level 5 payment intact. Practitioners could then document level 2 through 5 visits on the basis of medical decision-making (MDM), time, or the current E/M documentation framework. In 2021, CMS also intends to implement new add-on codes for primary care services, complex nonprocedural specialty E/M visits (defined by a list of clinical specialties that omitted HPM, prompting ongoing advocacy by the Academy), and extended visits. CMS noted the 2-year delay will give the agency time to respond to AMA and other stakeholders' recommended changes to coding and valuation for E/M services, including through annual rulemaking.

The Academy has provided input to the AMA-convened Current Procedural Terminology (CPT)/Relative Value Scale Update Committee (RUC) Workgroup, which is working to build consensus across specialties regarding modernizing office/outpatient E/M CPT codes to simplify documentation requirements and better focus code selection around MDM and clinician time. AAHPM also is engaged with other specialties in a coalition led by the American Geriatrics Society, which is analyzing CMS's proposals and modeling alternatives to help participating societies gauge impact and develop joint feedback to CMS.

In the meantime, for CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits, and practitioners should follow existing documentation guidelines. For CY 2019 and beyond, CMS finalized the following policies:

- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed. They should still review and update prior data and note that they have done so.
- For new and established patient office/outpatient visits, practitioners need not re-enter information on the chief complaint

and history already recorded by ancillary staff or the beneficiary and may simply note it was reviewed and verified.

- For E/M visits furnished by teaching physicians, CMS no longer requires that the physician "personally document their participation in the medical record." Instead, it can be documented that the teaching physician was present at the time of the service in a note written by the physician, nurse, or resident.
- Practitioners no longer need to document the medical necessity of a home visit in lieu of an office visit.

CMS did not finalize its proposal to reduce payment when E/M office/outpatient visits are furnished on the same day as many procedures.

## Virtual Care

Under the 2019 PFS, CMS recognizes new "communication technology–based services" that fall outside the legal definition of Medicare telehealth services and are not subject to applicable statutory restrictions, including geographic and site of service limitations. In this major shift in statutory interpretation, CMS points out that these restrictions should be applied only "to a discrete set of physicians' services that ordinarily involve, and are defined, coded, and paid for as if they were furnished during an in-person encounter between a patient and a health care professional," and not to communication technology-based services that were never intended to be face-to-face patient interactions. This stance signals that CMS can begin paying for some common time-consuming services. Separate payment will now be available for the following newly defined services:

- Brief communication technology-based service, e.g. virtual check-in by patient with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed (HCPCS code G2012)
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)
- Chronic care remote physiologic monitoring (CPT codes 99453, 99454, and 99457)
- Interprofessional internet consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449).

As part of its effort to expand virtual care, CMS added prolonged preventive services (HCPCS codes G0513 and G0514) to the telehealth list and removed geographic limitations for using telemedicine to treat substance abuse disorders, acute stroke and end-stage renal disease.

## Continued Engagement

AAHPM remains actively engaged with the AMA and specialty society partners to inform ongoing efforts to update CMS payment policies, recognizing their potential to significantly affect our members, the care they deliver, and the vulnerable patients they serve. In a December 2018 letter to CMS Administrator Seema Verma, the Academy reiterated the following principles we believe should guide any reforms to E/M payment and coding. Payments should:

- Align with practice and resource costs and be sufficient to cover costs of delivering care.
- Be tied to patient complexity, to reflect the higher costs of delivering care to patients with complex care needs.
- Incentivize the delivery of comprehensive, patient-centered, and coordinated care.
- Be uniform across all specialties, without separate add-ons or codes for any given subset of specialties.
- Support simplification of documentation requirements and reduce audit burden, while ensuring sufficiently robust documentation is included in medical records.

Should CMS ultimately implement the payment consolidation and specialty-focused add-on codes that were finalized for 2021, AAHPM has urged adding HPM to the add-on code descriptor to account for the intensive resources required for HPM specialists to provide care to seriously ill beneficiaries. ●

*Jacqueline M. Kocinski is AAHPM's director of health policy and government relations. Phil Rodgers is the Academy's representative on the RUC Advisory Committee. For more information or questions about the Academy's advocacy efforts, email advocacy@aahpm.org.*

# TRACKING THE EVOLUTION OF HPM SCIENCE

BY LARRY BERESFORD

One of the most important developments in the growth and maturation of the field of hospice and palliative medicine (HPM) as a recognized medical subspecialty has been the emergence of a research base documenting the outcomes that result from palliative care and the effectiveness of various treatments for the symptoms of serious illness. And for the past 15 years, one of the key forums for sharing that emerging scientific body of knowledge with rank-and-file providers has been the State of the Science plenary session presented at the Annual Assembly of Hospice and Palliative Care.

Each year, this presentation by academic leaders in the field highlights eight significant recent research studies in HPM. The presenters explain how the research was done, what the researchers found, and what practice-changing insights the findings offer frontline providers.

"The field is growing in part because of the increasing quality and quantity of supporting research and scholars whose careers are centered on advancing the science as well as the practice," said Julie Bruno, MSW LCSW, AAHPM's chief learning officer. "What the State of the Science has done is translate the complexities of scientific research into usable pearls for frontline clinicians. It's been very popular for our members, who have realized that this information could actually help them in their practice."

## HOW DID STATE OF THE SCIENCE START?

Daniel Fischberg, MD PhD FAAHPM, chief of palliative medicine for the John A. Burns School of Medicine and the Queen's Medical Center, Honolulu, HI, presented the State of the Science session at the Annual Assembly for its first 5 years starting in 2004, the first 2 years by himself and then for the next 3 years, in partnership with Nathan Goldstein, MD FAAHPM, professor of geriatrics and palliative medicine at Icahn School of Medicine at Mount Sinai (ISMMS) in New York. But according to Fischberg, the real mastermind for the presentation was R. Sean Morrison, MD FAAHPM, system chair for geriatrics and palliative medicine at ISMMS.

"The State of the Science session would not have come to be without (Morrison), who proposed the idea and recruited me to give the first presentation. It was his idea to highlight research in the field in a plenary session at the Assembly," Fischberg said. "I chose the articles to present but when I met with (Morrison), he set the tone, asking key questions, which helped tremendously."

Morrison has been a champion of evidence-based medicine in palliative care and author of some of the field's most landmark research, including some studies highlighted at State of the Science sessions. He is director of the Lilian and Benjamin Hertzberg Palliative Care Institute and of the National Palliative Care Research Center, and received AAHPM's Excellence in Scientific Research Award in 2013.

For Fischberg, the State of the Science offered an opportunity to celebrate the diversity of the HPM field, the spectrum of hospice and palliative care, and the diversity of the Academy's membership—along with its colleagues from the Hospice and Palliative Nurses Association. "I aspired to make it celebrate the field in general, not just the research. I didn't want it to just be of academic interest but to highlight things that clinicians could do something about when they got home from the conference," he explained.

"Only a small percentage of our community produces published research. We wanted to share the research and bring it to the patient's bedside by making it understandable to frontline clinicians, demonstrating immediate applicability of the chosen studies to their practice," Fischberg said. "I think it is considered by attendees one of the high points of the Assembly. It's a core value of hospice and palliative care professionals that we want to get better, and the research (shared) can help clinicians make their practice better tomorrow than it is today."

"In the beginning, our field was not as evidence based as we are now," said Goldstein, who has presented the State of the Science a whopping six times. "The State of the Science was designed to highlight the latest science of palliative medicine, but over the years, it has changed as the quality of the science has improved. Now it's all about the evidence: How do we build it? How do we critique it?

"We identify new things that people could apply to their patients, and we try to make it funny," he added. "That's where the use of cartoons came about. What we've found is that if we have fun presenting it, the audience will have fun, too. My goal is that if I can boil it down to a few simple questions—such as, 'What is the research question being asked?' and, 'Are the results valid?'—and I can make them laugh, then I've done my job.

"I'm still proud of the presentation I made highlighting Dr. Jennifer Temel's important 2010 study showing the benefits of early palliative care for patients with metastatic non-small-cell cancer.[1] That was the year singer Lady Gaga wore a dress made of meat. I said the only thing that got more attention last year than Dr. Temel's research was Lady Gaga's dress," Goldstein said.

"We try to break down the science, not to dumb it down but to make it more accessible. We have explained multivariate analysis, propensity scores, and other complex statistical concepts in a way that nonresearchers could understand and then talk to their colleagues about. And we always had fun doing it," Goldstein added. "For me it was also a great way to make sure I had my finger on the pulse of the current science."

## HOW IS IT DONE?

With the body of HPM research and the number of new studies growing year by year, State of the Science presenters use a careful, thorough process to identify, evaluate, and cull published studies down to a manageable number. Articles are then chosen based on the quality of the science, their value to frontline clinicians, and their potential impact on practice.

The process starts with a review of all the articles in the past year reporting original research relevant to the clinical practice of HPM. Some of these are found in the journals specific to the field of HPM, including the *Journal of Pain and Symptom Management*, AAHPM's official journal; the *Journal of Palliative Medicine*, the official journal of the Center to Advance Palliative Care; *The Journal of Palliative Care*; the internationally focused journal

*Palliative Medicine*; and *Pain*, the journal of the International Association for the Study of Pain.

In addition, HPM-oriented research increasingly is found in high-impact general medical journals such as *JAMA*, the *New England Journal of Medicine*, *BMJ*, and *The Lancet*. The review of research article titles and abstracts also has incorporated specialized journals in internal medicine, oncology, pediatrics, geriatrics, nursing, and social work. Examples of topics that have made the short list of studies highlighted at State of the Science include dignity therapy, feeding tubes, acupuncture in chronic obstructive pulmonary disease, palliative care in heart failure, communication skills for medical residents, care interventions for patients with advanced dementia, continuous care in hospice, advance care planning, and goals-of-care conversations.

Other studies have explored the herb and laxative senna in preventing problematic constipation and the role of physical touch in cancer care. Research calling into question the efficacy of standard statin therapy in advanced illness, haloperidol for managing delirium at the end of life, and the use of feeding tubes has garnered a lot of interest.

The plenary presentation includes a summary list of recommendations, noted Nick Dionne-Odom, PhD RN, assistant professor in the School of Nursing at the University of Alabama at Birmingham, and State of the Science presenter from 2015 through 2017. "I tried to avoid 'do-and-don't' language, which may be a little too forceful in (that) context," he explained. Instead, recommendations typically used the word "consider." "We're very careful about what's on this list and our real take-home messages," he added. "We need the best science undergirding our recommendations. We always need evidence."

## A LOT OF WORK

Organizing the State of the Science requires a lot of work, Goldstein said. "We review literally thousands of abstracts and article titles." The current year's presenters are helped in this review process by the prior year's presenters and other mentors in the field. They rate articles based on quality of the science, potential for impact, and appeal to the broadest audience in HPM.

This review and rating process leads to a list of 30 highest-rated abstracts. The articles are then read in their entirety. From these 30 research articles, the eight highest rated and most inclusive of disciplines, practice locations, focus areas, and methodology are chosen for presentation at the Assembly. Then they must be boiled down to a PowerPoint presentation that highlights essential take-home messages—all within 60 minutes.

"It is a lot of work," confirmed Cardinale Smith, MD PhD, associate professor of geriatrics and palliative medicine at ISMMS, who was recruited to co-present the plenary in 2015. "They told me it would be a lot of work, but it pretty much took my entire month of January. But it's fun, exciting, and energizing. For people like me, it rejuvenates and revitalizes our commitment to the work and shows us how others do their work and what we can incorporate into our own practice. Was all that effort worth it? Absolutely.

"We need to bring out the quality of the science, the potential for impact, the appeal to a breadth of interests," Smith said. "We have tried to be specific, to make sure nursing science is recognized, and pediatrics is represented, and there's something from integrative medicine. Then we practice the presentation to where we can do it without looking at the slides—making it as polished as we can."

A lot of slides are shown, and they need to be as precise and pristine as possible, Dionne-Odom added. "We hold multiple meetings to go through them. You may only have one sentence for each slide. Then there's a lot of practice, timing the presentation, editing the slides up to the very last minute." Asked why they put so much work into practicing it, he replied, "We want this presentation to be the highest quality it can be because it reflects the quality of our profession and the respect we think our specialty deserves."

"I was lucky enough to be invited to be one of the presenters in 2017," said Laura Gelfman, MD, assistant professor at ISMMS. "It is a tremendous honor to be asked and a tremendous opportunity. The process of going through and identifying articles is a big education in itself. There is a lot of work in a very iterative process of boiling the long list down to eight."

Gelfman and her co-presenter Heather Coats, PhD MS APRN-BC, palliative care nurse practitioner and assistant professor at the University of Colorado College of Nursing, spoke to each other about planning their presentation every other week for 6 months. "There are multiple layers to the conversation and to the process," Gelfman said. "We are mindful of honoring the diversity of groups represented at the Assembly. I feel like I was asked to join a special club—a supportive network of people who have gone before and who want to see the younger generation excel. I am grateful for that."

Coats completed her PhD in nursing from the University of Arizona and did a postdoctoral fellowship at the University of Washington. "I was being groomed for research, with an opportunity to talk across the interprofessional field of palliative care." She was invited to do the State of the Science plenary starting in 2017. "This opportunity is typically given to relatively junior faculty who are launching their career trajectory. From a practical standpoint, they are more likely to have the time required for developing the presentation than more established faculty," she said.

"(Gelfman) and I reach out to our mentors and other leaders to make sure that the research we are highlighting represents the state of the science. I try at every step to keep the inter-professional focus front and center," Coats said. "Last year, as I walked offstage, a nurse came up to me and said, 'I'm going to take all of your presentation back to my own clinical practice. Thank you for presenting it in a way I could understand.'"

## THE NEXT STEP IN PALLIATIVE SCIENCE

But 1 hour is no longer enough to represent the state of the burgeoning science of HPM, Goldstein said: "How exciting that is. It would have been inconceivable a decade ago." A 1-hour State of the Science plenary by Coats and Gelfman was held at the 2019 Annual Assembly in Orlando, but AAHPM's commitment to highlighting the growing body of HPM research and the success of the annual State of the Science plenary have driven the planning of a new meeting solely devoted to research, scheduled for March 20–22, 2020, coinciding with the Annual Assembly in San Diego.

This 2-day research symposium's Steering Committee is co-chaired by Morrison and Jean Kutner, MD MSPH FAAHPM, chief medical officer at the University of Colorado Hospital and co-director of the Palliative Care Research Cooperative. Dionne-Odom and Abby Rosenberg, MD, a pediatric oncologist at Seattle Children's Hospital, are co-chairing the symposium's Program Committee. "Much of what we have tried to do in the State of the Science will infuse the full conference," Dionne-Odom said.

Dionne-Odom recalls his first Assembly in 2011. "I thought the State of the Science was one of the coolest sessions I'd ever seen. A few years later, in 2015, Jay Horton asked me if I'd ever consider doing it. I had just finished my PhD, so the timing was perfect. Only after I got involved did I come to appreciate how critical this function is to identify articles representing the breadth and scope of where we are scientifically," he explained.

"We will want hardcore researchers on stage at the research symposium," Bruno said. "More importantly, we want to create an environment where researchers can network and make connections, get excited, and further their projects. The majority of HPM science has been presented at our conferences in posters and 15-minute sessions. We are now trying to put rocket boosters on to advance the field's science." ●

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PATHWAYS TO PALLIATIVE CARE

# FROM GERIATRICS TO PALLIATIVE CARE (TIMES TWO)

*Marcin Chwistek, MD FAAHPM*

Anna Marissa Araw, MD HMDC, and Anna Clarissa Araw, MD HMDC, twins who are palliative care physicians, are inseparable in life and work. And as the three of us spoke on the phone in November, the day after an unusually early pre-Thanksgiving storm dumped half a foot of snow onto the Northeast, I realized my first problem: How do I tell their voices apart? As we chatted, Marissa and Clarissa took turns telling their story, and our conversation zigged and zagged from their native Philippines to New York, where they both trained, to the West Coast of the United States, where they now live and work.

Marissa and Clarissa grew up in a very close-knit, traditional Filipino family, where multiple generations live together and the elderly are revered. When they were 8 years old, they went to visit their paternal grandmother in the hospital. She was in her late 70s and, to the sisters, seemed fine and healthy and was able to converse as always. To their complete surprise, the grandmother they grew up knowing and loved dearly died the next day. They were confused. How did it happen so quickly? Why did it happen? In retrospect, it was obviously a formative experience that prompted them to become physicians. "We decided we would take care of the elderly," they concluded in unison.

After graduating from a medical school in the Philippines, Marissa and Clarissa moved to the United States and started in the same family medicine program in the Bronx. Three years later, in keeping with the promise they made to themselves more than a decade earlier, the sisters entered a program in geriatrics. It was during their training that they were first exposed to palliative care.

Marissa (or was it Clarissa?) recalled a history of a patient with dementia she cared for while as a fellow. The patient and his family struggled with a decision about a PEG tube placement: the geriatric team recommended against the procedure, but the family strongly resisted. Following the tube placement, the patient was transferred to a nursing home only to be readmitted a few days later with aspiration pneumonia, which quickly led to his death. Marissa remembers that, as a fellow, she struggled to console the patient's daughter. "What is the best way




*Clarissa (left) and Marissa (right) Araw strike a pose in the photobooth at the 2018 Annual Assembly of Hospice and Palliative Care*

to support and comfort her? If I only knew the words!" she kept repeating to herself at the time.

The opportunity to learn those words came when they both applied and were accepted to the palliative care program of the Long Island Jewish Medical Center of North Shore University Hospital in Manhasset, NY. Following their training, and forced by life circumstances, Clarissa moved to Bellingham, WA, to take her first job, while Marissa stayed in New York. Five years later, the sisters were reunited, and now live and work in Washington. In fact, they live together and work at the same hospital network—although in different hospitals. They also live closer to their older sister who lives with her family in Vancouver—and can enjoy all the opportunities for outdoor fun that living in the West affords.

Marissa and Clarissa both are steeped in their work—they "breathe palliative care," they said. But, they quickly clarified, "We have a rule of 'time limit.' We allow ourselves to talk about work and patients for only a limited period. Otherwise, we would spend all day talking!" they added laughing.

"And we are foodies," one said when I asked what else they do to relax. "When we were little, our dad used to take us out to lunch every Sunday. Each time we would try a different cuisine: Japanese, Swiss, European foods. It stayed with us to this day. We love food!"

As our conversation drew to an end, I realized how the concepts of family, taking care of each other, and enjoying the simple pleasures in life are perfectly embodied in the lives and work of these twin sisters.

To learn more about Clarissa and Marissa, email acaraw.md@gmail.com marisarawmd@yahoo.com, respectively. ●


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DIVERSITY & INCLUSION

# DIVERSITY & INCLUSION FORUM ON CULTURE: YOU SPOKE, AND WE HEARD YOU

*Ronit Elk, PhD*

With the increasing cultural diversity of seriously ill patients and their families, clinicians frequently care for patients whose cultural beliefs, values, and preferences may differ from their own. Studies suggest that clinicians as well as patients and families find these interactions especially challenging. As part of the Diversity and Inclusion Forum (D&I) at the 2018 Annual Assembly, "Why Do You Want to Know and Why Should I Trust You? Implicit Messaging in Cross-Cultural (Mis) Understandings," attendees were invited to submit questions on the aspects of culture they wanted the Academy's D&I Committee to focus on when developing programming for future meetings. More than 135 attendees responded. Two key themes emerged from their written input: the importance of self-awareness and a need for training in understanding how to care for patients from different cultures.

## Self-Awareness and Intercultural Sensitivity

Most of us are familiar with the term "cultural competence," the ability to function effectively across cultures, to think and act appropriately, and to communicate and work with people from different cultural backgrounds. However, fewer may be familiar with the term "intercultural sensitivity," a genuine interest in other cultures—a desire to recognize, appreciate, and understand cultural differences, and equally importantly a willingness to modify one's own behavior as a way of respecting people of other cultures.[1,2] Developing intercultural sensitivity requires a level of self-awareness about our own culture and how it may guide our interactions with others. This self-awareness may improve our ability to care for the culturally diverse patients we serve. "There are many of us who have only recently had our eyes opened to our own privilege. I think the more we continue to be made aware of our biases and are reminded of others' perspectives, the better care we can provide to our patients," wrote one attendee.

Milton Bennett, a sociologist, developed the widely used Developmental Model of Intercultural Sensitivity (DMIS), which explains how people understand or view cultural difference.[3-5] The model identifies a continuum of six stages of personal growth (Figure 1).[2,6] The first three stages are conceptualized as ethnocentric, where one's own culture is experienced as central and superior. These include:

1. Denial of culture: People at this stage have lack of interest in cultural differences, to the extent that they don't recognize cultural differences even exist.
2. Defense against cultural difference: At this stage people recognize cultural differences but react negatively to them and tend to avoid "the other."
3. Minimization of cultural differences: Those at this stage tend to see their culture as superior.

The second three DMIS stages are defined as ethnorelative, ie, one's own culture is experienced as one of a number of equally valued cultures, and include:

1. Acceptance of cultural difference: A person's own culture is experienced as just one of a number of worldviews.
2. Adaptation to cultural difference: At this stage people are able to adapt to other cultures' behaviors, values and perceptions, while maintaining their own cultural roots.
3. Integration of cultural differences: Those at this stage can function effectively on the various planes of different cultures and are able to interact effectively and collaborate with other cultures.

The beauty of this model is that respecting and responding to cultural differences can become an active part of one's worldview. Progression along the continuum described in Bennett's model can be facilitated by self-awareness, study, and training, eventually resulting in an

## Figure 1, Developmental Model of Intracultural Sensitivity

| Denial | Defense | Minimization | Acceptance | Adaptation | Integration |
|---|---|---|---|---|---|
| ETHNOCENTRISM | | | ETHNORELATIVISM | | |

**Hammer et al. 2003*

expanded understanding of one's own, as well as other, cultures. Understanding where you fall on the continuum may help determine where you should begin on your journey to developing intercultural sensitivity. Hammer and colleagues[6] developed a test to measure one's intercultural competence, the Intercultural Development Inventory (IDI), a 50-item measure. Without the benefit of this state-of-the-art testing, where do you think you fall on this continuum?

## A Request for Training in Communicating with Patients and Families from Other Cultures

Using the model above, the majority of comments reflected an ethnorelative perspective and a desire for the "integration of cultural differences" in caring for seriously ill patients. These included requests for training in how to become culturally sensitive. "I practice in the Mid-South. I would like workshops on how to be culturally sensitive with minority or other groups," wrote one attendee. "[Teach us about the] interplay of religion and end of life discussions and prognosis," requested another. There also was an understanding that a lack of intercultural competence can potentially cause harm to patients and families: "When you have a patient from a culture with which you are not familiar, or even if you are familiar, there are differences—how do you ask the question and not inadvertently use a microagression?"

A minority of comments reflected an ethnocentric perspective, highlighting the difficulty of communicating with patients whose cultural beliefs and preferences may differ from our own or may be contrary to our training. These included requests for training in communication focused on convincing patients to pursue hospice when they want life-prolonging treatments in the face of poor prognosis, or on convincing those who expect miracles near the end of life to relinquish these beliefs and accept their poor prognosis. We are aware that such situations reflect circumstances that can be challenging for clinicians who genuinely wish to provide quality care, but we also need to recognize that unless we understand and respect patients' and families' values, which may be very different to our own, we may inadvertently cause harm.

You spoke and we heard you. At the 2019 Annual Assembly, the D&I Committee held a half-day training that provided clinicians with practical strategies and tools to improve the care of culturally diverse patients: "Improving the Care of Culturally Diverse Patients: Strategies to Address and Navigate the Elephant in the Room." There also were several other sessions during the Assembly designed to enhance your intercultural sensitivity, including one on the significance of miracles to African Americans and another focusing on cultural aspects important to Latinos. This is just the beginning. Stay tuned. ●

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QUARTERLY PROGRESS REPORT

# AAHPM POINTS OF PROGRESS

More than 30 committees and task forces representing the efforts and expertise of hundreds of Academy members have made significant progress toward implementing AAHPM's goals. This progress report highlights accomplishments within each goal area of the strategic plan during the last quarter of 2018.

## Strengthen Engagement

*Hunter Groninger, MD FAAHPM, chair, Membership and Communities Strategic Coordinating Committee*

Membership remained steady with 5,200 members at the end 2018. Seventy-nine percent are physicians; 12% are affiliates (nurses, nurse practitioners, physician assistants, chaplains, social workers); and 9% are fellows, residents, and students.

The Communities Committee hosted more than 50 community leaders for its first-ever half-day preconference workshop focused on leadership and innovation within their unique communities. Rodney O. Tucker, MD MMM FAAHPM, presented "Leadership Wellness: An Annual Check Up." This innovative session encouraged leaders to use tools to assess and examine your leadership style, strengths, and behaviors.

The Diversity & Inclusion (D&I) Committee is working on the revised Strategic Plan for review by the Board of Directors. It developed two educational sessions for the 2019 Annual Assembly: an interactive preconference workshop and a 1-hour discussion on gender equity with physician leaders from the American College of Physicians. The committee also sponsored an engagement activity at the Annual Assembly, which involved attendees interacting with giant block letters spelling out unity.

*AAHPM Connect* is an active online platform for members to share articles, post presentations, and participate in discussions. To join a community, add it to your demographic profile by going to your Member Profile page. Learn more at connect.aahpm.org.

## Support Workforce and Career Development

*Stacie K. Levine, MD FAAHPM, chair, Workforce and Career Development Strategic Coordinating Committee*

Hospice and Palliative Medicine (HPM) Match Day was November 28, and on that day, 285 of 355 positions were filled with 106 of 148 programs filling. HPM participates in the Medical Specialties Matching Program that includes internal medicine specialties, allergy and immunology, and geriatrics. As of February 22, an additional 50 have been filled, as well.

The *Fellowship Program Directors' Guide*, a resource guide for starting and running an HPM fellowship program, was completed and is available at aahpm.org/education/fellowships.

The Leadership and Career Development Committee finalized a resource guide including links to quick start materials for the first 90 days in a new leadership role, reading lists, leadership assessment profiles, and a list of professional coaches. This guide is available at aahpm.org/career/leadership.

Forty-five physician leaders gathered at AAHPM Ascend to learn about leading and managing through change. They listened to HPM Visionary Martha L. Twaddle, MD HMDC FACP FAAHPM, discuss her leadership journey; worked on how to create environments of safety, value, and communication with Katie Neuendorf, MD; and participated in small group discussions with HPM leaders. The program received outstanding evaluations with 100% of respondents indicating they would recommend the program to their peers. 2019 Ascend is scheduled for October 6-8 in Oak Brook, IL.

The Hearst AAHPM Leadership Scholars Fund call for applications will be open April 1–30. The Scholars Fund provides financial support to physician members seeking to participate in leadership development engagement activities to support growth as a leader.

## Advance Knowledge and Competency

*Vincent (Jay) Vanston, MD, chair, Education and Training Strategic Coordinating Committee*

The Board of Directors approved a proposal at the fall meeting to retain a consultant to develop a Digital Learning Strategy. Part of the planning will include a member assessment of learning preferences and delivery options available through various vendors. Watch for education innovations in the next year!

AAHPM is pleased to announce a new meeting coming in 2020. The State of the Science in Hospice and Palliative Care will be "co-located" with the 2020 Annual Assembly in San Diego, giving attendees the option to attend both. This new research meeting, which will begin the evening of March 20 and go through the morning of March 22, is using the popular State of the Science brand and will offer researchers the opportunity to grow as investigators, present cutting-edge research, and advance the science of hospice and palliative care. Learn more at aahpm.org/stateofthescience.

The *Primer of Palliative Care*, 7th edition, is now available. Under the capable leadership of editors VJ Periyakoil, MD, and Timothy E. Quill, MD MACP FAAHPM, the content has been thoroughly reviewed and updated. Questions at the end of each chapter are included to help promote discussion and integration of content. The *Primer* is the perfect resource for all members of the hospice and palliative care team.

AAHPM is collaborating again this year with the National Hospice and Palliative Care Organization and the Hospice and Palliative Nurses Association to host a 2-day virtual conference on July 17–18. This conference brings high-quality content to the entire team without the costs of travel and lodging. Mark your calendars.

## Promote Quality of Care, Research, and Evidence-Based Practice

*Laura Hanson, MD MPH, chair, Quality and Research Strategic Coordinating Committee*

With the support of a 3-year grant from the Gordon and Betty Moore Foundation, AAHPM convened several organizations, including the Center to Advance Palliative Care (CAPC), the National Palliative Care Research Center (NPCRC), the Global Palliative Care Quality Alliance (GPCQA), and the Palliative Care Quality Network (PCQN), for phase II of the Palliative Care Quality Collaborative project. At the conclusion of phase II (August 2021), a unified palliative care registry that captures both program and patient-level quality data will be established and housed under a new quality organization. In December 2018, representatives from AAHPM, CAPC, NPCRC, GPCQA, and PCQN met in Chicago to officially kick off phase II. Each partner's commitment was reaffirmed, as was the project direction and scope. In 2019, the Palliative Care Quality Collaborative (PCQC) looks forward to establishing a new 501(c)(3) organization with a founding Board of Directors, engaging stakeholders in market research, and selecting a vendor to build the new unified registry system.

With the support of a 3-year grant from the Centers for Medicare & Medicaid Services (CMS), AAHPM has partnered with the National Coalition of Hospice and Palliative Care and the RAND Corporation to develop two patient-reported quality measures. The project team held a kickoff meeting in Chicago in December 2018. The National Patient Advocate Foundation presented at this meeting, which helped confirm the intent to center the measure development on patients and caregivers. Additionally, the group discussed logistics for the 2019 focus groups, cognitive interviews, and the Technical Expert Clinical User Patient Panel (TECUPP).

## Advance Public Awareness and Policy

*Gregg VandeKieft, MD MA FAAHPM, chair, Advocacy and Awareness Strategic Coordinating Committee*

Gregg VandeKieft, MD MA FAAHPM, represented AAHPM at the second Integrative Pain Care Policy Congress. He was one of 80 attendees from more than 65 organizations representing healthcare providers, public and private payers, policy experts, and pain

research and patient advocacy organizations invited to consider joint strategies for advancing individualized care for people with pain.

Delegate Chad Kollas, MD FACP FCLM FAAHPM; Alternate Delegate Ron Crossno, MD HMDC FAAHPM; and Young Physician Section Delegate Kyle Edmonds, MD FAAHPM, represented the Academy at the American Medical Association (AMA) House of Delegates Interim Meeting. They advocated for patients with serious illness in testimony to reference committees and worked with the Pain and Palliative Medicine Section Council to craft new AMA policy addressing misapplication of the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain.

Alternative Payment Model (APM) Task Force Chair Phil Rodgers, MD FAAHPM; Past President Janet Bull, MD MBA HMDC FAAHPM; and CMO Joe Rotella, MD MBA HMDC FAAHPM, met with the director and staff of the Center for Medicare and Medicaid Innovation to discuss community-based palliative care and advocate for a serious illness APM that reflects key priorities of the field with regard to patient eligibility, participating providers, payment, and quality. AAHPM worked with the Coalition to Transform Advanced Care on a follow-up letter reiterating these points in joint recommendations for model design. The letter was signed by 33 stakeholder supporters.

Rodgers also attended the fall meeting of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) as AAHPM's RUC advisor. ●


# What's your knowledge of hospice and palliative medicine?

## Find out with HPM PASS and HPM FAST.

HPM PASS **is a 147-item practice test designed to test your knowledge, identify gaps, and help you prepare for the board exam.**

HPM FAST **modules contain 25 case-based topical questions and explanations in four different areas—Hospice Regulatory, Prognostication, Pediatrics, and Psychiatry and Cognition—providing guidance for further study.**

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HMDCB UPDATE

# HMDCB CERTIFICATION: MORE THAN JUST LETTERS AFTER YOUR NAME

With the first recertification exam on the horizon for Hospice Medical Director Certification Board (HMDCB) certificants who certified in 2014 (the opportunity to apply to take the exam one year early, in 2019, opens in June), this issue of the *AAHPM Quarterly* seemed like a perfect place to share the full picture of HMDCB certification. While some people choose to participate in the certification program for the recognition of their work, HMDCB certification offers certificants more than just the letters after your name.

Passing HMDCB's initial certification exam is just the start of a program that encourages continued education and lifelong learning. In fact, when HMDCB's Board of Directors announced and launched the organization's continuing certification program (CCP), they wanted it to

- assess the certificant's competency, skill, and judgment
- maintain the knowledge of the certificant during the certification period
- be flexible by offering various options to satisfy continuing certification requirements
- accurately reflect what occurs in practice.

So although earning the credential is a valuable aspect of certification, participating in the certification program is about ensuring certificants are competent and knowledgeable not only at the time they passed the initial exam, but also that they are continuing to develop in the areas covered by the organization's content blueprint (HMDCB.org/blueprint.)

Beyond the initial exam, HMDCB's certification program includes other requirements meant to help accomplish these goals, including a professional development tool, offered in a certificant's third year, that helps assess competence and drive Continuing Medical Education priorities in the final 3 years of the certification cycle. The program includes the need to complete continuing medical education and professional activities requirements aimed at ensuring certificants maintain their knowledge.

So, as you consider applying for the HMDCB initial certification program in 2019, please know that in addition to receiving the HMDC credential to use after your name, you will join a group of nearly 950 others who have committed not only to continued education and lifelong learning, but also to the success and enrichment of the field of hospice medicine.

In doing so, you achieve the HMDCB mission to help relieve suffering and improve quality of life by promoting the excellence and professional competency of hospice physicians. ●

**The application cycle is open until April 22. Apply for the HMDCB certification exam at HMDCB.org/apply before March 26 to save $250 on your application fee.**

## INITIAL CERTIFICATION CYCLE TIMELINE

January 8—Online application cycle opens

March 26—Last day to submit an application without the late fee

April 22—Final deadline to apply for 2019 examination (late fee assessed)

April 23—Last day to request special accommodations

April 23—Last day to withdraw from 2019 examination without penalty of full cancellation fee

May 1—Last day to schedule examination

May 23–June 14—Examination testing window



AAHPM NEWS

# CONGRATULATIONS, 2018 FELLOWS OF THE ACADEMY

The following physicians recently earned the designation Fellow of the American Academy of Hospice and Palliative Medicine. Advancement to fellowship status within the Academy honors dedication to and scholarship in the field of hospice and palliative medicine. This distinction represents a minimum of 5 years of membership, participation in AAHPM activities, letters of recommendation, and board certification in hospice and palliative medicine.

The new Fellows received their designation during the Annual Assembly in Orlando, FL.

Scott Jackson Akin, MD FAAFP FAAHPM
Mary Alfano-Torres, MD DABFM FAAHPM
Aziz A. Ansari, DO SFHM FACP FAAHPM
Michael Aref, MD PhD FACP FHM FAAHPM
Wesam S. Aziz, MD HMDC FACP FAAHPM
Todd Alan Barrett, MD MBA FAAHPM
Stephen H. Berns, MD FAAHPM
Karen Ann Blackstone, MD FAAHPM
Rafael Bloise, MD MA HMDC FACP FAAHPM
W. Richard Boyte, MD MA FAAP FAAHPM
Katherine L. Brazzale, MD HMDC FAAHPM
Matthew Brimberry, MD HMDC FAAHPM
Mark A Casanova, MD FAAHPM
Elizabeth L. Cobbs, MD FACP FAAHPM
Kelly J. Cooke, DO FAAHPM
Kimberly Angelia Curseen, MD FAAHPM
Toni M. Cutson, MD MHS FAAFP FAAHPM
Marvin Omar Delgado Guay, MD FAAHPM
Jennifer D. Dulin, MD FAAHPM
Bridget I. Earle, MD HMDC FAAHPM
Kristin Elaine Edwards, MD CPE FACP FAAHPM
Lama El Zein, MD FAAFP FAAHPM
Christina E. Fitch, DO, MPH FAAHPM
Hilary A. Flint, DO MEd FAAP FAAHPM
Brendan M. Flynn, DO FAAHPM
Michael Fratkin, MD FAAHPM
Laura P. Gelfman, MD MPH FAAHPM
Angela S. Gerguis, MD FAAHPM
Rebecca R. Goett, MD FACEP FAAHPM
Naomi Goloff, MD FAAP FAAHPM
Matthew J. Gonzales, MD FAAHM
Marianne M. Holler, MSW DO FACOI FAAHPM
Joshua A. Jones, MD MA FAAHPM
Tammy I. Kang, MD MSCE FAAHPM
Laurel Kilpatrick, MD FAAHPM
Christine S. Koniaris, MD FAAHPM
Wendy L. Knowlton, DO HMDC FAAHPM
Keith R. Lagnese, MD HMDC FACP FAAHPM
Michael J. Lalor, MD MBA CPE HMDC FAAHPM
Deena R. Levine, MD FAAHPM
Kathy Ligon, MD FAAHPM
Elizabeth Lindenberger, MD FAAHPM
Jennifer S. Linebarger, MD MPH FAAP FAAHPM
Debra Lotstein, MD MPH FAAP FAAHPM
Kevin B Mathews, MD FAAFP FAAHPM
Adam D. Marks, MD MPH FAAHPM
Michael Mencias, MD FAAHPM
Elissa G. Miller, MD FAAP FAAHPM
Charles Newton, MD FACS FACC FAAHPM
Kevin D. Nguyen, MD FAAHPM
Ashley C. Nichols, MD FAAP FAAHPM
Michael J. Nisco, MD MBA HMDC FAAFP FAAHPM
Danielle M. Noreika, MD FACP FAAHPM
Samuel J. Perna, DO FAAHPM
Gregory L. Phelps, MD MPH MAHCM FACPM FAAFP FAAHPM
Kerrie A. Pinkney, MD MPH FAAP FAAHPM

Shawnta R. Pittman-Hobbs, MD FAAHPM
Lillian F. Pliner, MD FACP HMDC FAAHPM
Michael Raphelson, MD HMDC FAAHPM
Coleen Marie Reid, MD FAAHPM
Elizabeth McCann Rickerson, MD FAAHPM
Steven C. Robinson, MD FAAHPM
Steven Rosenzweig, MD FAAHPM
Justin Sanders, MD MSc FAAHPM
Linda B. Siegel, MD FAAP FAAHPM
Lara Michal Skarf, MD FAAHPM
Bethany Cox Snider, MD HMDC FAAHPM
Angela Reneé Stiltner, MD HMDC FAAHPM
Susan C. Stone, MD MPH FAAHPM
Thomas B. Strouse, MD DFAPA FACLP FAAHPM
Beth E. Susi, MD FACP FAAHPM
Richard Teitzman, DO HMDC FAAHPM
Jennifer Tjia, MD MSCE FAAHPM
Michael F. Trexler, MD FACP FAAHPM
Debra Vermette, MD FAAFP FAAHPM
Kenneth N. Vermette, MD FAAFP HMDC RMA FAAHPM
Anne M. Walling, MD PhD FAAHPM
Jason A. Webb, MD FAPA FAAHPM
David R. Wenner, DO FAAFP FAAHPM
Alison C. Wiesenthal, MD FACP FAAHPM
Sara E. Wordingham, MD FAAHPM
David Shih Wu, MD FAAHPM
Kelly Lee Wu, MD FAAP FAAHPM
Mei-Ean Yeow, BMBCh FACP FAAHPM
Finly J. Zachariah, MD FAAFP FAAHPM
Jessica Nutik Zitter, MD MPH FCCP FAAHPM







# 2019 CALL FOR BOARD AND AWARDS NOMINATIONS

## AAHPM Board and Nominating Committee

Members are invited to nominate colleagues for the AAHPM Board of Directors. We urge your participation in this process—it is an important way to promote diversity and balance and encourage the sharing of fresh ideas in the Academy. Self-nominations are welcome. An AAHPM officer or director at large must be an AAHPM physician member in good standing. There are openings for president-elect, treasurer, secretary, and three directors at large.

Nominations will be accepted May 1–June 3 at aahpm.org. All eligible nominations will be considered by the Nominating Committee. Each candidate will be required to complete a board competency self-assessment survey after applications have been submitted.

## AAHPM Awards

Members are invited to recognize a fellow colleague's accomplishments by nominating them for an AAHPM award. All Academy members may submit nominations for the following awards:

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

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

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

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

The Award for Excellence in Scientific Research in Palliative Care recognizes meaningful, exemplary research contributions to the hospice and palliative care field.

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

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

Nominations will be accepted May 1–June 3 at aahpm.org. Eligible nominations will be reviewed by the AAHPM Awards Committee. ●

# NEW LEADERSHIP FOR *PC-FACS* EDITORIAL BOARD

Last fall, the Academy issued a call for new editorial board members of *PC-FACS*, and more than 20 AAHPM members applied to serve. The applications were reviewed by the senior section editors who, with the approval of Editor-in-Chief Mel Davis, MD FAAHPM, and Associate Editor-in-Chief Robert Arnold, MD, made appointments of the following individuals to associate editor positions:

- Kate Aberger, MD—Psychosocial
- Ahsan Azhar, MBBS MD FACP—Geriatrics and Care Transitions
- Dashima Carthen, MD—Geriatrics and Care Transitions
- Elizabeth Chuang, MD MPH FAAHPM—Diversity and Inclusion
- Kenneth Cornetta, MD—Basic Science
- Jane Loitman, MD MBA MS FAAHPM—Diversity and Inclusion
- Regina Mackey, MD—Basic Science
- Sara Martin, MD—Symptoms Assessment and Management
- Kyle Neale, DO—Hospice and Hospice and Palliative Care Interface, Regulatory Issues
- Ritika Oberoi-Jassal, MD HMDC—Psychosocial
- Regina Okhuysen-Cawley, MD—Pediatrics
- Laura Patel, MD—Geriatrics and Care Transitions
- Mona Patel, DO—Diversity and Inclusion
- Gregory Phelps, MD MPH MAHCM—Bioethics, Spirituality and Humanities
- Alan Roth, DO FAAFP FAAHPM—Hospice and Hospice and Palliative Care Interface, Regulatory Issues
- Renato Samala, MD HMDC FACP FAAHPM—Hospice and Hospice and Palliative Care Interface, Regulatory Issues
- Megan Thorvilson, MD MDiv—Pediatrics
- Mei-Ean Yeow, MD—Diversity and Inclusion

Their terms begin in mid-March.

Thank you to all AAHPM members who have served or continue to serve on the *PC-FACS* editorial board. Your service is greatly appreciated. ●





**Join Our Team!**

*RVUCOM Announces Open Rank Faculty Positions*

*Rocky Vista University is a health sciences university with two beautiful locations, including the newest campus in Ivins, a suburb of St. George, Utah. The College of Osteopathic Medicine boasts among the top board scores and pass rates in the nation and has received the Military Friendly Schools Gold Award for its many programs for servicepeople.*

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# AAHPM PAST PRESIDENT NAMED PRINCIPAL DEPUTY COMMISSIONER OF THE FDA



In late 2018, former AAHPM President Amy Abernethy, MD PhD FACP FAAHPM, was named principal deputy commissioner for food and drugs of the Food and Drug Administration (FDA), the highest nonappointed office in the administration. Before she began this important role, we asked Abernethy about her priorities, how her past as a palliative care practitioner will influence her work, and how fellow AAHPM members can follow her progress.

**Tell us about your new role at the FDA.**

Soon, I will be joining FDA as the incoming principal deputy commissioner (pending ethics approval). This is the second-highest office at FDA and the highest that isn't a political appointment. In this job I will have a trans-FDA remit, overseeing medical programs and initiatives that are cross cutting and clinical, scientific, regulatory, or operational.

**What will be your top priority as principal deputy commissioner?**

My first responsibility is to make sure that I lead and execute on my primary remit (ie, ensuring that the many cross-cutting responsibilities of the principal deputy commissioner are accomplished). That being said, I will also have specific areas where I intend to direct additional personal energy, namely clinical evidence generation, personalized medicine, and patient-informed drug design. You also might see me get more involved in issues related to software, IT infrastructure, and digital health because this is one of my core areas of expertise.

How do my priority areas relate to our concerns in AAHPM? Confident care of people with advanced life-limiting illness and their families demands evidence about treatment effectiveness matched to the very unique and personal needs of the patient sitting (or lying) right in front of us. This is personalized health care in the truest sense. And I have spent much of my career on evidence generation that includes the full spectrum of human experience, including symptom concerns, psychosocial well-being and personal meaning-making. This includes development and incorporation of patient-reported outcomes data, patient-(and family-) informed drug development, and developing new study endpoints that are applicable for end-of-life care.

**How has your background, including your time as president of AAHPM, prepared you for this role?**

What I learned from the hospice and palliative medicine community greatly informs my point of view.

My clinical perspective as an oncologist and palliative care clinician is a constant reminder of the imperative to get medical interventions to the bedside as soon as possible—if something is effective, we need it in our clinical toolbox right away. Patients and families cannot wait.

When I was a faculty member at Duke, one of my key areas of focus was advancing our processes for evidence generation in palliative medicine so that we can most quickly establish which interventions are helpful and which need to be replaced. This included clinical trials (eg, evaluating palliative oxygen), research networks (eg, the Palliative Care Research Cooperative Group), evidence implementation (eg, *PC-FACS*) and quality monitoring and improvement (eg, Q-DACT). We focused on building the IT systems to support this including technology-based solutions to collect reliable symptom data directly from patients and families wherever they are.

And AAHPM has taught me so much. As a member of the Academy, I have learned about the importance of being a part of a professional community that incorporates all voices, and the power of persistence; I also learned how ideas and concerns need to translate into meaningful output and products. For example,

as we contemplated the workforce shortage, we needed to find inclusive solutions that support professionals of all backgrounds (eg, hospice, palliative medicine, nurses, physicians assistants, doctors, etc.) and to get something done by employing all of the mechanisms in front of us (eg, education, legislation, certification). We simultaneously worked on certification for hospice professionals, the Palliative Care and Hospice Education and Training Act, new clinical resources and palliative care practitioner education, and physician assistant pathways. Being AAHPM president took it to the next level. I experienced the importance of organizational strategic planning, generative discussions to reinforce a future-focused perspective, and effective cross-organizational communication. I always cared a lot about my palliative care colleagues, but I am not sure I said it enough; being president reminded me of the importance of leading by authentic appreciation. The experiences that I had as a leader in AAHPM will be foundational for my role as a leader at FDA.

**What do you hope to accomplish?**

The FDA regulates a huge span of the US economy, with real influence on the world economy, too. It is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices and by ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation, as well as tobacco. In line with my personal focus, the FDA is responsible for advancing the public health by helping to speed innovations that make medical products more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medical products and foods to maintain and improve their health.

I am honored to be able to join the FDA and help advance this mission. As I look across the FDA's remit and what has motivated me throughout my career, they line up remarkably. I look forward to supporting the amazing people who currently work at the FDA and those who will join us at the FDA in the future in advancing this goal.

**How can members follow your activities at the FDA?**

I am still learning the answer to this, but, for now, the quickest way to follow my activities is to follow me on Twitter: @dramyabernethy. ●

*The views expressed in this article do not necessarily reflect those of the US Food and Drug Administration or federal government.*


# Need to spice up your sock wardrobe?

**Buy a pair of these AAHPM socks.**

Your feet will thank you.




Purchase at **aahpm.org**.





# WELCOME, NEW MEMBERS

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Griffen Allen, MBE
Grace Amadi, MD
Andrew Ambort, DO
Jennifer Aron, DO
Zeena Audi, MD
Karim Bakhtiar, MD
Amy Balog
Juan Becerra, MD
Carey Belcher, NP
Amy Berman, BS RN
Kerry Ann Bertke, DO
Hemangini C. Bhakta, MD
Shyam Bhansali, DO
Joshua Biddle, MD
Daniel Burczak, MD
Edward Burke, MD
Blaire Burton
Jonathan Burton, DO
Alla Byakova, MD
Michael Cafarchio, MD
Mary Callahan, MD
Yu Cao, MD
Christina Capps, MD
Ann Cavazos Chen, JD
Nuha Cebeci
Imelda Chan-Villanueva, MD
Abby Chilsen
Alex Choi, MD
Amber Comer, JD PhD
Albert J. Cook III, MD MPH
Ryan Costantino, PharmD
Michelle Crouse
Eleanor Curtis, MD
Kim Ann Dang, MD
Nancy Davis, MD
Elaine De Leon, MD
Elyse Demers, MD
Anil Desai, MD
Jennifer Dibiase
James N. Dionne-Odom, PhD RN ACHPN
Michael Drapala, MD
Komal D'Souza
Nancy Dudley, PhD MS MSN
David Dumont, MD
Sarah Durante, MD
Jessica Eichler, MD MA
Deborah Ejem, PhD MA
Mikhail Elfond,
Cameron Ellis, MD
Alyson Emmons, DO
Lizzie Eubank
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Rachel Feldman, MD
Hector Flores
Emilee Flynn, MD MPH
Jennifer Forsyth, DO
Anna Francisco, MD
Timothy Fuller, MD
Burak Gezen, MD
Amrita Ghosh, MD PhD
Yamuna Gnanadev, MD
Allyson Goldberg, MD
Tiffany Gonzales, MD
Laura Hallstrom
Carrie Hammond, APRN
David Harris, MD
Katherine Hicks, MD
Andrew Hinojosa, MD
Raj Hiranandani
Britney Holden, BSN
Sharene Hollenbach, MSN GNP ANP
Andrew Hunter, MD
Taylor Huntington, MD
Yuko Iwanaga, DO
Paula James, BSN
Nicole Jernick, MD
William Johansen, MD
Sarah Johnson, MD
Sarah Johnson, DO
Candice Johnstone, MD
Lucretia Jones, PharmD
Melida Juarez, MD
Deborah Kahn
Jordan Karow
Rupinder P. Kaur, DO
Thanmayi Kaza, MD
Katherine Kelsey
Benjamin S. Kematick, PharmD
Raya Kheirbek
Christina Klein, MD
Zachary Klock, MD
Nicole Knight, RN
Alicia Kolling, PA
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Susan Kunihiro, MD
Michael Landzberg, MD
Samantha Lau

Virginia LeBaron, PhD ACHPN AOCN
Seon Lee
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Gina Lutz, MD
Kasie Mahan, NP
Angela Marks, MSED
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Toyosi Okurounmu, MD MBA MPH
Doha Omar
Michelle Park, MD
Bhavini Patel, MD
Jyoti M. Patel, MD
Hayda Perdue
James Perle, MD
Allison Perrin, MD
Nicholas Polis, MD
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Jyothsna Ponnuri, MD HMDC
Amy Porter, MD PHD
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Luis Ramos, MD
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William Richardson, MD
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Nathan Riley, MD
Jessiela Roberts, MD
Courtney Rodich, CNS
Maggie Rogers, MPH
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Marta Salek, MD
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Sam Webb, MD
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Kerry Will, MD
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Kayla Wolofsky
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Shabnam Yekta, MD
Colleen Zogby, FNP
Jennifer Zuar, MD
Jonathan Zygowiec, DO MPH





# CONGRATULATIONS, AAHPM COMMITTEE, WORKING GROUP, AND ADVISORY GROUP CHAIRS

AAHPM gratefully acknowledges the efforts of the following chairs who will advance the strategic objectives of the Academy in the coming year. More than 200 members are engaged in the work of our 39 committees, working groups, and advisory groups and assist in the governance of the Academy. Thank you for your leadership and commitment to AAHPM.

**Committees of the Board**

Awards Committee:
Tammie Quest, MD FAAHPM

Development Committee:
Charles Wellman, MD HMDC FAAHPM

Finance Committee:
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# CARING CARTOONS




*"OK, which one of you scratched the word 'HELP' into the Zen garden?"*

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Created by Nathan Gray, MD, a palliative care physician and assistant professor at Duke University School of Medicine. His work has appeared in *Narrative Magazine* and was selected for the *Annals of Internal Medicine*'s Graphic Medicine feature.


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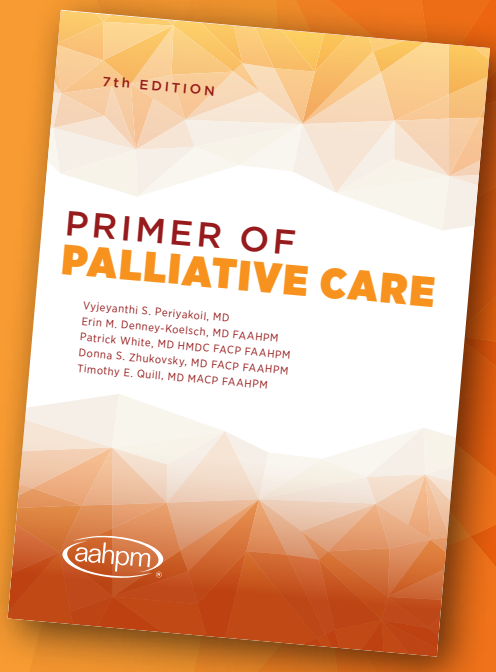
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