

## New Palliative Medicine Fellowship Accredited by ACGME

The Accreditation Council for Graduate Medical Education (ACGME) has approved the accreditation for The University at Buffalo Palliative Medicine Fellowship. Official word of the approval was received in January by Amy McDonald, M.D., Palliative Medicine Fellowship Director with the VA Western New York Healthcare System and assistant professor of Clinical Medicine at UB.

"This is wonderful news that the Palliative Medicine fellowship has been accredited by the ACGME! We previously had accreditation by the PMRC (Palliative Medicine Review Committee)," said Dr. McDonald, "but now this is official. They must have liked the 125-page application. I want to thank everyone for their dedication to teaching as part of this program."

The Palliative Medicine Fellowship began in 2005 in close collaboration with The Center for Hospice & Palliative Care (CHPC). Two fellow positions are available each academic year. CHPC Faculty members include: Christopher Kerr, MD., Ph.D., assistant professor Clinical Medicine UB and CHPC medical director; John Tangeman, M.D., assistant professor Clinical Medicine UB and CHPC associate medical director; Elizabeth Maher, M.D., clinical instructor UB and CHPC Home Hospice physician; Mary Alfano-Torres, M.D., clinical instructor UB and CHPC associate medical director Hospice Inpatient Unit; and Andrew Esch, M.D., assistant professor Clinical Medicine UB and CHPC Inpatient and Home Hospice physician.

"UB's medical school already has a robust partnership with Hospice, and is one of only 17 medical schools to have state-of-the-art medical fellowship training with Hospice and The Veterans Administration Hospital," stated William E. Finn, president & CEO of The Center for Hospice & Palliative Care. "It is our hope and belief that

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## CAPC Announces New State-By-State Report Card

*America's Care of Serious Illness: A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals has been released by the Center to Advance Palliative Care (CAPC). The report lists a number of factors that have led hospitals to establish palliative care programs.*

- More than half of US caregivers of a patient hospitalized with a life-threatening illness say their patient got "suboptimal care."
- More than 30% of families "lose most or all of their savings in caring for a loved one with a serious illness."
- Every year more than 70% of the 1.5 million Americans who die of a chronic illness are admitted to a hospital during their last six months.
- Of patients hospitalized with a serious illness, 25% report "inadequate treatment of pain and shortness of breath," 33% "are not provided with arrangements for follow-up care after hospital discharge," and 33% of families report that they received "no education on how to treat their pain and other symptoms following a hospital stay or were not provided with arrangements for follow-up care after hospital discharge."

**The authors say, "Hospital palliative care programs are one solution to improving the quality of health care in hospitals for our most seriously ill and vulnerable patients. Although the reasons for inadequate care of the seriously ill are many, most stem from a medical culture that is focused on curing individual diseases and a health care system that is designed to reimburse disease-specific care."**

**They further add, "The needs of seriously ill patients cannot be met by medical specialists who focus only on treating or improving their organ of expertise, function as independent consultants rather than as members of a care team, lack the training and knowledge to adequately coordinate care and view symptoms and suffering as important only in guiding them in diagnosis. Nor can these needs be met by a reimbursement system that fails to adequately cover the combination of life-prolonging treatments, treatment of symptoms or rehabilitation and support for family caregivers. Patients with serious and life-threatening illness typically live with multiple disease processes, multiple symptoms, caregiving requirements and complicated transition planning that can be met only by specialized teams of health care providers. The absence of team-supported, coordinated care for the seriously ill results in health care that is often unsafe, ineffective, untimely, inefficient, inequitable and rarely patient-centered."**

**The report says that hospital palliative care teams are "safe and effective,"** resulting in a reduction of high levels of suffering, addressing of caregivers' needs, and improved communication among all parties concerned with patient care. They are **"timely and efficient,"** facilitating transitions between care settings, ensuring that the provided care is "of the very highest quality and consistent with patients' values and goals." They are also **"patient centered,"** reducing "unwanted, unnecessary and painful interventions," enhancing families' abilities to cope with the demands of the patient and the illness, and improving "patient and family satisfaction with care."

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## Calendar of Events

### Friday, March 27 – Hospice & Palliative Care in Advanced Alzheimer's Disease "The Food Issue" –

Presented by Lita Goodman, RN, and Leilani Pelletier, MSW; Time: 8:30 a.m. – 10:00 a.m. at Hospice Buffalo's Education Center, 225 Como Park Blvd., Cheektowaga, NY 14227. No charge. To register, email [cfe@palliativecare.org](mailto:cfe@palliativecare.org) or call Amy Maxwell at (716) 989-2009.

### March 31, 2009 – Registration deadline for ACP Course

#### Become a certified advance care planning facilitator with the award winning Respecting Choices® Advance Care Planning system.

The course is \$139 and consists of two components: an online training course and 1 classroom day. The online training must be completed prior to the classroom day scheduled for April 30 from 7:30 a.m. – 4:30 p.m. at the Hospice Buffalo's Education Center, 225 Como Park Blvd., Cheektowaga, NY 14227. Registration and payment is required by March 31. To learn more, email [rcollins@palliativecare.org](mailto:rcollins@palliativecare.org) or call (716) 686-8259.

### Thursday, April 16 – National Health Care Decisions Day

Join Americans across the country to talk to others about your future healthcare decisions and to complete your advance directive. Visit [www.compassionaandsupport.org](http://www.compassionaandsupport.org) and place National Health Care Decisions Day in the search bar to learn what is available in your community or go to [www.sharingyourwishes.org](http://www.sharingyourwishes.org) to download an advance directive and post it at a secure site online for free.

### May 7 – Early registration deadline for Hospice Buffalo Memorial Walk

Celebrate memories with a full day of fun on Sunday, May 17 at the Erie Canal Harbor Central Wharf. Walk as a team or an individual walker and help raise funds for Hospice care in our community. Go to [www.hospicememorialwalk.com](http://www.hospicememorialwalk.com) by May 7 to register and learn about great prizes. Presented by Wegmans.

## Clinical Notes

- A recent *JAMA* article, "Agitation and Delirium at the End of Life," says, "Delirium is the most common neuropsychiatric complication experienced by patients with advanced illness, occurring in up to 85% of patients in the last weeks of life."

Patients with delirium may be agitated or not, but both kinds of delirium "are harbingers of impending death and are associated with increased morbidity in patients who are terminally ill, causing distress for patients, family members, and staff. Delirium is a sign of significant physiological disturbance, usually involving multiple causes, including infection, organ failure, and medication adverse effects. **Often these causes of delirium are not reversible in the dying patient, and this influences the outcomes of its management. Delirium can also significantly interfere with the recognition and control of other physical and psychological symptoms, such as pain.** Unfortunately, delirium is often misdiagnosed or unrecognized and thus inappropriately treated or untreated in terminally ill patients." (*JAMA*, 2008;300(24):2898-2910)

- In a recent interview, Dr. Robert L. Martensen, author of *A Life Worth Living: A Doctor's Reflections on Illness in a High-Tech Era*, said, "Most Americans die in hospitals or nursing homes, and neither is configured to take care of dying patients. There's little palliative care available, and often the payment structure of health insurance doesn't support it." **Martensen thinks "doctors should get comfortable with being realistic."** "Right now, we say, 'I can't take away a person's hope,' as if doctors were bestowing life. You have to support those hopes that are realistic, not this fantasy land." (*The New York Times*, 1/20/09)

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A Membership Service of the Hospice and Palliative Care Association of New York State*

CAPC Announces New State-By-State Report Card, continued from page 1.

According to the report, the first national study of palliative care was conducted in 2002, when *Last Acts* published *Means to a Better End: A Report on Dying in America Today*. At that time, no state earned an A or a B, only two got a C, ten received a D, and the other 39 got an F. Since then, many hospital palliative care programs have been established. The current report examines patient access to hospital palliative care services and to physicians who are board-certified in palliative medicine, access to clinical training in palliative medicine for medical students, and access to specialty-level training in palliative medicine for physicians. It also focuses mainly on non-specialty hospitals with more than 50 beds.

The current study reports considerable progress since 2002. Nearly half the states were graded either A or B, nearly 40% need improvement, and only 20% received a D or an F. An A grade represents a state with palliative care programs in 81-100% of hospitals, a B, 61-80%; a C, 41-60%; a D, 21-40%; and a F, 0-20%.

### The current study found that:

- 53% of hospitals with 50 or more beds had palliative care programs.
- 75% of hospitals with 300+ beds had programs, while 41% of public hospitals, 20% of for-profit hospitals, and 29% of sole community provider hospitals had them.
- Mid-sized hospitals (50-300 beds) who had palliative care programs were more likely to be ACS-approved cancer program hospitals, affiliated with a hospice, not-for-profit, and located in areas where more than 70% of the population were college graduates.
- Large hospitals (300+ beds) with programs were more likely to be affiliated with a hospice, not-for-profit, and affiliated with a medical school

The authors note that living in an area with only small hospitals greatly reduces one's chances of finding a palliative care program. They also cite "strikingly low rates of palliative care programs in public and sole community provider hospitals." These latter institutions "often serve as the only option for medical care for the forty-seven million Americans lacking health care coverage and geographically isolated communities, respectively. Thus, our finding that the majority of these institutions lack palliative care services speaks to a disparity in access to comprehensive care for some of America's most vulnerable patient populations."

The report calls for increased opportunity for medical education in palliative care for both medical students and physicians. The data shows that 85% of non-military medical schools have alliances with at least one hospital offering a palliative care program, with only three states reporting no medical school with such an affiliation. Eighty-eight percent of private medical schools affiliate with a hospital with a palliative care program, as do 82% of state-funded schools.

The authors include a lengthy list of recommendations for change, with sections for patients and families, the healthcare community, medical schools, teaching hospitals, and elected officials and policymakers. According to the report, the recommendations "are a call to action to both increase the prevalence of palliative care programs in United States hospitals and maximize access to training in this field in teaching hospitals across the nation."

In conclusion, the authors say, "The ultimate goal of palliative care is to improve the overall quality of care for both patients experiencing life-threatening illnesses and their families. To benefit from that goal, however, patients and their caregivers must be able to access these services in their local hospital, and physicians in training must learn from direct exposure to high-quality hospital palliative care programs. Focused efforts by hospital administrations, the health care community, and policymakers are required to promote the development of quality palliative care programs in all hospitals, with special attention needed in small, rural, public and for-profit hospitals. This will result in a more efficient and effective use of hospital resources and will enhance the quality of care delivered to our nation's most seriously ill patients and their families."

An additional related article by the same authors, "Variability in Access to Hospital Palliative Care," appears in the current *Journal of Palliative Medicine*, and is online at [www.liebertpub.com/jpm](http://www.liebertpub.com/jpm). The CAPC report, and additional information and links, are available at [www.capc.org/reportcard](http://www.capc.org/reportcard). (CAPC Website; *Journal of Palliative Medicine*, 2008;11(8):1-9)

## Hospice Buffalo Continuum of Care

- Homes
- Palliative Care/Hospice Beds in Hospitals
- Hospice Assisted Living and Nursing Home Services in area adult homes, nursing facilities, and group homes
- Mary & Ralph Wilson, Jr. Hospice Inpatient Unit at the Mitchell Campus for short-term pain/symptom management, respite and end-stage care
- Hospice Buffalo House at the Mitchell Campus and the St. John Baptist/Hospice Buffalo House for hospice-eligible patients needing 24-hour nursing care during the final months or weeks of life.

## Definitions of Hospice & Palliative Care

**Palliative Care** is comprehensive care, provided by an interdisciplinary team for patients living with a life-limiting illness and their families. Care is focused on alleviating suffering and promoting quality of life. Major issues addressed are pain and symptom management, information regarding the illness, advance care planning, psychosocial and spiritual needs and coordinated care with other community resources.

**Hospice Care** is palliative care for terminally ill patients who have a prognosis of 6 months or less to live. Services are provided to the patient's family during their loved one's illness and through a period of bereavement.

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What the Media Said about End-of-Life Care This Week Volume 12, Number 38, October 7, 2008  
A Membership Service of the Hospice and Palliative Care Association Of New York State

**MISSION STATEMENT**

The Center for Hospice & Palliative Care serves individuals with serious illness, and their families and caregivers, through a continuum of care spanning the course of illness and bereavement.

The Center's specially-trained professionals, support staff and volunteers, assist individuals to make choices about their care, support those who are grieving and educate the professional and lay communities about end-of-life issues.

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*A Palliative Care Program of*



*New Palliative Medicine Fellowship Accredited by ACGME, continued from page 1.*

Hospice Buffalo and our education partners can create a world-class model of training, education and research that improves both the quality of care for Western New Yorkers, and can be replicated across the country."

"Congratulations to Dr. Amy McDonald, fellowship director, and Sandra Gilliam, training administrator, as well as dedicated faculty for earning an initial accreditation for the Palliative Care Fellowship Program," noted Roseanne C. Berger, M.D., Sr. Associate Dean for Graduate Medical Education at UB. An initial accreditation cycle of four years is highly unusual and a testimony to the partnerships and unique opportunities for palliative care training here in Buffalo. The future is bright!"

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