



What's Poppin'?

Population-Based Palliative Care Research Network

<http://www.uchsc.edu/sm/hospice>

Spring 2001

Kernel's Corner

Jean S. Kutner, MD, MSPH

Welcome to the Spring 2001 "What's Poppin'?". I'd like to share with you two issues that have been occupying my thoughts – growth and sustainability. Thanks to the participation and interest of hospice/palliative care organizations nationwide, PoPCRN has now grown to include over 90 hospice/palliative care organizations, approximately 30 of which have contributed data to PoPCRN studies. Such growth is essential to the long-term sustainability of PoPCRN.

The advantage of the network model for conducting research is minimization of data collection burden on any one site while accumulating sufficient sample size to generate quality results that are generalizable across care settings and locations. In order to realize this goal, a sufficient number of sites need to participate in the research network so that individual sites can pick and choose which studies they want to participate in, based on interest, staffing, timing, etc. As one of our Advisory Committee members put it, "sometimes fields need to be allowed to lie fallow in order to maximize return". That is, if there are enough sites participating in the research network, then allowing for sites to "take time off" from study participation will minimize the burden on any one site while maintaining the overall desired study sample sizes. Thus, growth is essential for PoPCRN to achieve its goal of conducting quality end-of-life research in settings where palliative care is provided. However, growth of the network raises a number of questions:

- ♦ How can we maintain the personal contact and individual support that have been key components of the PoPCRN research process?

Continued on Page 2

Mission Statement:

The Population-based Palliative Care Research Network (PoPCRN) is committed to improving care for persons at the end of life by conducting rigorous, high-quality end-of-life research in settings where palliative care is provided.

Representation

Our current mailing list includes 217 people representing 94 sites and 24 organizations. These 94 sites are located in 16 states and Canada.

Where Have We Been?

Study 1:	Symptom Prevalence Card Study 7/99-10/99
Presentation	Colorado Hospice Organization Fall Meeting, 9/99
Study 2:	Psychosocial/Spiritual Issues Study 1/00-9/00 (continues at some sites)
Study 3:	Bereavement Pilot Study 2/00
Study 4:	Confusion & Delirium Prevalence Study 2/00-3/00
Presentation	Colorado Hospice Organization Spring Meeting, 5/00
Retreat	Strategic Planning Retreat 7/00
Board	Formation of the PoPCRN Advisory Board, 10/00
Presentation	Colorado Hospice Organization Fall Meeting, 10/00
Presentation	National Hospice Work Group 1/01

Where Are We Now?

Study 5:	Discharge Follow-up Study 7/00-6/01
Study 6:	Symptom Study-Phase I 8/00-6/01
Conference	Symptom Study-Phase I Training Conference, 3/01
Presentation	NHPCO Meeting, 3/01

Kernel's Corner, continued:

- ♦ How can we maintain quality and uniformity and facilitate data collection across sites that are more widely distributed geographically?
- ♦ How many sites are “enough”?

We are certainly pleased by the growth of PoPCRN over the past two years, and are excited by the recent interest in PoPCRN shown by the National Hospice Work Group (NHWG) and National Hospice and Palliative Care Organization (NHPCO). We see this growth as key to the ongoing success of PoPCRN's research activities. We are committed to continuing to do things “right” – maintaining the high quality of the research being conducted, continuing the personal contact with PoPCRN sites and meeting the needs of each participating site.

Long-term sustainability of PoPCRN, and ongoing quality end-of-life research using the PoPCRN model, will require a solid infrastructure that is not entirely dependent on project-specific funding. PoPCRN's growth and the questions I've raised above have prompted me to work on a “vision plan” for the continued growth and success of PoPCRN, including the resources necessary to continue to meet our stated mission. In addition to resources to support the day-to-day functioning of PoPCRN, I specifically plan to address development of resources to support study sites and facilitate study participation, such as on-site training, compensation for study participation, and additional data collection staff.

We will rely on the guidance of the PoPCRN Advisory Committee, composed of individuals from PoPCRN hospice/palliative care organizations as well research experts at the University of Colorado Health Sciences Center, as we approach this next phase of PoPCRN's development. I am also interested in your comments and thoughts. Please contact me (Jean.Kutner@uchsc.edu; 303-372-9086), or write in to the PoPCRN list serve (hospice@thor.uchsc.edu) if you have any thoughts regarding the issues I've raised in this “Kernel's Corner”.

From NHPCO...

By Karen Davie

President, National Hospice and Palliative Care Organization

NOTE: The Following was included in the President's Memo – February 19, 2001

PoPCRN Urges NHPCO Member Participation... The Population-based Palliative Care Research Network (PoPCRN) is welcoming participation from all hospice and palliative care organizations that provide care to terminally ill patients and their families. Since its inception, PoPCRN has grown to include more than 90 sites (34 of 37 Colorado hospices) from 15 states. More than 30 sites have actively participated in PoPCRN studies. PoPCRN is committed to improving care for persons at the end of life by conducting rigorous, high quality end-of-life research in settings where palliative care is provided.

Directed by Jean Kutner, MD, MSPH and David E. Nowels, MD, MPH and managed by Cordt Kassner, MA, PoPCRN was initiated in 1998 with project funding from the Hartford/Jahnigen Center of Excellence in Geriatrics at the University of Colorado Health Sciences Center, where it is based. It is modeled after practice-based research networks that have provided critical innovations in primary care research. The research network model permits high quality, “generalizable” research to be conducted while minimizing the data collection burden on any one site.

Further information regarding PoPCRN, its current studies, and how to become involved is available from the web site (<http://uchsc.edu/sm/hospice>) or by contacting Jean Kutner (303-372-9086), Cordt Kassner (303-372-9364) or David Nowels (303-315-9700).

The National Hospice Work Group

By True Ryndes, ANP, MPH

President and CEO, National Hospice Work Group

Comfort. Safety. Choice. Support. Whenever You Need It.

A professional coalition of executives from some of the nation's largest and most innovative hospices, The National Hospice Work Group (NHWG) is committed to expanding access to the palliative services offered by hospices. For more than 20 years its members have made significant contributions to the care of patients facing life-threatening disease. However, according to their President, True Ryndes, "in the next decade we intend to promote re-engineering the hospice industry, extending the proven model of care for the terminally ill to those who are similarly suffering or in need of guidance, but not medically or emotionally ready for classic hospice care."

NHWG members have a wealth of experience in end of life care:

- The 18 member organizations of the National Hospice Work Group provide care to nearly 10% of all hospice patients in America every day;
- NHWG members are located across the U.S. with programs serving from 100 to over 2500 patients per day in rural communities, suburbs and inner cities across this nation;
- In addition to traditional hospice services, many NHWG organizations offer state-of-the-art palliative treatment services and provide consultation and education through affiliations with hospitals and medical schools;
- In partnership with the Hastings Center, NHWG members are exploring the evolution of stakeholder values and social demographics that will shape hospice care over the next 30 years, fueling policy support for new models of care beyond traditional "Medicare Hospice."

The National Hospice Work Group has developed a valuable track record in demonstrating the effectiveness of hospice care. Partnering with the National Hospice and Palliative Care Organization, they recently completed a series of studies developing measures for the end-result outcomes of care identified in NHPCO's landmark document, *A Pathway for Patients and Families Facing Terminal Illness*. Among the findings: 82% of patients admitted to hospice programs in pain, who were still alive and able to report 3-4 days after admission, had their pain brought to a comfortable level within 72 hours. 99% of those who stated they wanted to avoid CPR did not get CPR. "We are beginning to demonstrate the power of our teams," says Ryndes. "This is very welcome information in light of the SUPPORT study findings about the experiences of the terminally ill in hospitals."

Like hospice programs across the country, NHWG members have created an interdisciplinary approach to care that responds to the wide range of personal, social and cultural needs experienced by those confronting death. "We've learned how to deliver consumer-driven, high quality, compassionate care in a capitated, "managed care" environment," reports Ryndes. "We are not unique in that respect. But we all feel strongly that other populations, in addition to the terminally ill, can benefit from our unique perspective on the meaning of health. Why should you be close to death before your family has its concerns addressed or your symptoms effectively relieved? As all aspects of health care are undergoing profound change, it is more important than ever to pay close attention to the evolving needs in our communities. As people walk away from their doctors office, overwhelmed by their new cancer diagnosis, we should be there."

For more information regarding the National Hospice Work Group, contact True Ryndes, ANP, MPH, at email Tryndes@aol.com or address 4745 Miracle Drive, San Diego, CA, 92115.

Site Comments
Discharge Follow-up Study

NOTE: Hospice of Northwest Ohio is the highest enrolling site for the Discharge Follow-up Study. Thanks!

It has been exciting for Hospice of Northwest Ohio to take part in the Discharge Follow-up Study. Our site felt this was an important opportunity to take part in providing national data on what happens to people after discharge from our program. We have often questioned whether the guidelines we follow under HCFA clearly paint the picture of a dying patient and whether terminal patients are discharged from hospice programs prematurely.

Each month when I make follow up calls not only do I look forward to talking with each person, I believe they do as well. Making monthly follow up calls has allowed patients and families to voice questions, concerns, joys, and sadness. This results in a continued bond between our site and discharged patients. Recently, I explained to a previous patient that the six months following discharge were up and that I appreciated him taking the time to help us. He replied, "Oh, won't you please call again, I really enjoy your calls".

The biggest challenges I have found in the last few months have only been with two families and seem to be related to altered family dynamics. Specific problems were related to alcoholism and mental illness among the caregivers. As a result, I found it difficult to have productive conversations. Unfortunately, this created tension among the family. With the assistance of the PoPCRN team, a decision was made in the best interest of the families to remove them from the study.

Staff members are very interested in how previous patients are doing and saddened when someone has passed away. Because we get to know our patients so well, it is nice to be updated on how they are doing. It amazes me everyday how privileged I am to make a difference in the lives of those we touch at hospice whether it is to provide patient care or to collect data for this research study. Thank you for giving us this opportunity to contribute in providing data to help terminal patients!

Hospice of Northwest Ohio, Perrysburg, Ohio

Site Comments
Natural Course of Symptoms in Hospice Patients Study

NOTE: Lamar Area Hospice Association was the first site to enroll a patient into the Natural Course of Symptoms Study. Thanks!

I'm very fascinated about the end of life studies. Why? you might ask. No one has ever looked into the signs and symptoms that are associated with death before now. Sadly the end of life is not something people want to think about, much less discuss.

I feel the more symptoms we are aware of, the greater overall comfort we can provide. Research results from this study will also provide assistance to and for our physicians. Any education we can provide for them is also helpful for us, usually resulting in earlier referrals for hospice.

I believe every discipline will benefit from this study. Any results we can make available to others can potentially make our jobs easier. With the drop in insurance and 3rd party reimbursements, we must be prepared with justifications for our service – so that we can continue to provide the best patient and family care possible. Insurance companies might argue with human factors, but it is much more difficult to argue with research findings.

Denise Koechner
Executive Director
Lamar Area Hospice Association, Lamar, Colorado

Featured Site: Hospice of St. John, Lakewood, Colorado

By Father Peter Wellish

When the Hospice of Saint John opened its doors in the suburbs of Denver in 1977 it was only the second free-standing inpatient hospice in the United States. The concept that Fr. Paul von Lobkowitz, of the Order of Saint John, had in mind when he envisioned the program was to create hospice care using the model long in use in the United Kingdom. Here patients and their families would be treated as a single unit. Palliation and symptom control would be the primary focus, but spiritual care would always be a preeminent part of the program. Fr. Paul believed that spiritual care of the dying could not take second place to the nursing care patients received.

Since 1977 the Hospice of St. John has been the final home of some twenty thousand patients, but the goal was to provide care in an environment where the individual and his or her family became the focal point of care.

In the early days, inpatient hospice care was virtually unheard of. Hospice programs that were opening here and elsewhere were largely programs that provided for hospice care in the patient's own home. While dying at home is usually always a patient's preference, the reality is that our mobile society has made that difficult if not impossible for many families. No longer is there some one who can be a round-the-clock primary caregiver in the home. Many family members worked and many had children who needed their attention as much as their dying loved one. It was this void that in-patient hospice care tried to fill.

The changing face of hospice over the years required that we create a home care program in 1993. While home care often means providing for care in nursing homes, the Hospice of Saint John has always viewed this as a very secondary option at best since even the best nursing homes are not able to provide true hospice care. In our hospice we have the option of bringing home care patients into our residential hospice program when their care requires more aggressive treatment. It also provides the flexibility of allowing stable patients the opportunity to go back to their own homes under the care of home care nurses.

The Hospice of Saint John's mission has always been to provide end of life care to the most needy, and in that spirit the hospice has been home to many patients who simply had no financial resources and who were not Medicaid and Medicare eligible. In an environment where hospitals often want to discharge patients for whom there is little more they can do, families are left scrambling for what options are available. Here financial considerations would never be the primary focus of admission. Indeed, since we started, the Hospice of Saint John has never employed a bill collector or sent any of its accounts to outside agencies for collection. We figured that if the family can't pay they must need the money more than we do. Few health care businesses operate in that way today.

To provide greater peace of mind to families coming distances to see dying loved ones, in 1999 the Hospice of Saint John was able to purchase a small house one block from our in-patient residential hospice through benefactors. Here families without financial resources would be able to stay while visiting their loved ones.

After all, end of life care is not just about medical care – it is about the care of the whole person and that person's family. How often families need a chance to heal rifts from the past or make amends or just have the opportunity share memories and be with the people who have been most important in their lives. The Hospice of Saint John has indeed been fortunate to be able to be here for so many families.

Yet the very idea of hospice is threatened today by businesses intent on creating mass care for the terminally ill. The reimbursement schedules provided by Medicare and Medicaid are often inadequate to provide for the necessary needs of patients, and all too frequently patients who do not die on schedule are forced to look for other options because of government rules. It is for these reasons that the Hospice of Saint John finds the PoPCRN research program so vital and necessary. Many of PoPCRN's projects have the potential to be powerful instruments in making hospice care better and in changing government rules and the way that intermediaries provide for payment.

Information on Current and Upcoming Studies

Discharge Follow-up Study:

This study is following people discharged alive from hospice sites. We hope that information from this study will help justify continuing hospice/palliative care for patients who may not meet current criteria for continued hospice eligibility. Information will be gathered on patients discharged alive from hospice sites through June 30, 2001. Six-month follow-up data will be gathered between August 1, 2000 and December 31, 2001. *To date, 37 sites nationally have agreed to participate. Of the 37 participating sites, 11 have contributed data on 86 patients.* Please contact us if you would like to participate in this study.

Natural History of Symptoms Study:

This is a study of symptoms and quality of life in hospice/palliative care patients funded for 4-years by the Robert Wood Johnson Foundation and the Beeson Award. The first of three study phases began last Fall by describing the time course of and distress due to common symptoms among hospice/palliative care patients. Study materials were sent out mid-November and data collection will continue through June 2001. *To date, 21 sites nationally have agreed to participate. Of the 21 participating sites, 3 sites have contributed data on 3 patients, and the study is in progress with at least 6 more patients.* Please contact us if you would like to participate in this study.

Safety of Home Care Workers Study:

Initiated by concerns from hospice home care workers, this study examines safety issues and concerns relevant to those visiting patients in their homes. Study planning is currently in progress.

- ◆ Please either contact us or see our website, <http://www.uchsc.edu/sm/hospice>, for additional details regarding current studies and results of previous studies.

Book Review By Robin M. Rawlings, MA

Counseling the Terminally Ill: Sharing the Journey. By: George S. Lair. Publisher: Taylor & Francis, Washington DC, 1996 (ISBN 1-56032-517-8); 207 pages, softcover.

Counseling the Terminally Ill: Sharing the Journey, written by psychologist George Lair, is written for any professional who works with terminal patients and desires to learn more about the psychological underpinnings of the dying process. Lair argues for a holistic counseling approach that encompasses existential and transcendental philosophies while concentrating on intrapsychic and spiritual needs, which he refers to as "psychospiritual." Using this approach, Lair believes the counselor is best able to address two critical issues with the dying individual: death anxiety, and the opportunity for growth and transformation. Lair further contends that working with the dying is best facilitated by an authentic relationship which is genuine, empathetic, and provides unconditional love and understanding. He cautions counselors against getting bogged down in specific content; instead, the focus should be on the process that is unique to each individual while striving to understand the needs of the patient, as the patient perceives them, not as others see them.

Although Lair doesn't advocate specific techniques, he does offer suggestions for how this type of holistic model might be facilitated. He recommends meeting the client where he is in his "spectrum of consciousness," an idea borrowed from transcendental expert Ken Wilbur, and proceeding from there. Lair outlines detailed psychological underpinnings as it relates to anxiety, pain, and depression. A list of 11 guiding principles is offered at the end of Chapter 3 and is an excellent summary of the type of facilitative model that he advocates. In chapters 9-12 he provides ideas for employing this type of approach, the nature of the relationship, the process of communication, and use of imagery. Finally, he ends with a reminder of the individuality of death and the possibility for the patient to transcend beyond the physical world.

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Lair provides the reader with a thoughtful rationale for his proposed counseling model. Some of the content, while interesting for professional counselors, may be cumbersome for other members of the hospice interdisciplinary team (i.e., Chapters 3 and 4). Lair reviews various psychological theories and contentions about end-of-life issues, then challenges the reader to think outside of the current medical model. He contends, for example, that the medical model lacks a true IDT integration of treatment and that it emphasizes surface solutions and psychosocial components rather than the deeper issues related to the psychospiritual realm. Overall, this is an excellent book for all readers interested in psychological end-of-life issues. It provides alternative approaches for identifying goals and helping to facilitate them such that the client can die according to his or her own particular needs and desires.

Clinical Focus – Confusion and Delirium

By David E. Nowels, MD, MPH

Confusion is a common issue experienced by the terminally ill, and one that impacts the patients, their loved ones, and their clinicians. The many causes of confusion commonly include dementia, depression, or/and delirium. It is important to recognize confusion as a symptom and further assess its potential causes because sometimes the confusion can be alleviated. This is especially true for many depressed and some delirious patients. Unless they have a superimposed depression or delirium, demented patients are not expected to improve cognitively with treatment though their behavioral manifestations can be managed. Additionally, the recognition and management of confusion, with its manifestations and complications, can improve quality of life for patients and their loved ones.

Our recent study confirmed that confusion is common.

- ◆ 50% of patients in hospice were identified by their nurses as having been confused within the previous week.

It also confirmed that confusion is problematic.

- ◆ 80% of the time a patient was confused the nurse felt the confusion caused a problem for the patient, their loved ones, or the hospice staff.

Depression

Major depression occurs in 10-25% of the terminally ill. Diagnosing depression in the terminally ill is difficult because somatic symptoms are virtually always present due to the underlying terminal process. Therefore evaluation of psychological and cognitive symptoms is important. Evaluating confused patients for the following signs and symptoms may assist in diagnosing depression: a) tearfulness, depressed appearance; b) social withdrawal, decreased talkativeness; c) brooding, self-pity, pessimism; and, d) lack of reactivity. Some have proposed a single question to screen for depression - "Have you been feeling down, blue, or depressed most of the time over the last few weeks?" A "Yes" answer would initiate additional follow-up and evaluation focusing on the signs and symptoms above. Suicidal ideation is quite likely to be associated with depression in the terminally ill, even in mild and passive forms.

Depression is usually managed with a combination of supportive counseling and medications. Counseling often involves re-establishing self worth, assisting development of new coping strategies, and providing education about modifiable factors. Focusing attention on appropriate, short term, attainable goals can re-establish hope, an important intervention. Each member of the hospice team and loved ones can provide this supportive counseling. Choice of pharmacological agent is, in part, dictated by the time to effect. Other usual considerations in managing antidepressants also apply: start low and go slow; choose an

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antidepressant in part for its desired side effects. Frequently SSRI agents are used. Psychostimulants can have a more rapid impact on depressive symptoms and have value for select terminally ill depressed patients. They can improve appetite, reduce sedation associated with opioids, and promote a sense of well being. These effects can occur over days rather than the weeks more typical of antidepressants. However, side effects including agitation, insomnia, and anxiety are common. Many clinicians initiate treatment with both a psychostimulant and a more typical antidepressant, tapering off the psychostimulant after several weeks.

Delirium

Delirium, also called acute confusional state, is also common among the dying. The incidence in cancer patients is reported between 25% and 80%, depending on the study and setting. Delirium has been found in 20% of inpatients in general acute care hospitals. In the terminally ill, delirium complicates evaluation of pain and other symptoms, is associated with abnormal grief of survivors, and is associated with shortened lifespan. Treatment often is not helpful in clearing the sensorium since the cause is usually multifactorial, but a small percentage of patients are able to clear their confusion enough to interact with their loved ones.

Many of the signs and symptoms identified of the confused patients in our study correspond with the DSM IV criteria for delirium.

DSM IV criteria for Delirium

- ◆ Acute onset (hours to days) and fluctuating course
- ◆ Clouding of consciousness or reduced ability to focus, sustain, or shift attention
- ◆ Perceptual disturbance, disorientation, or memory deficit that is not better accounted for by an established dementia.
- ◆ General evidence from history and physical or laboratory findings of a medical condition related to the disturbance.

Common characteristics of confused patients in our study

- ◆ Change in cognition occurred over hours to days (28%)
- ◆ Disorientation to time and/or place (80%)
- ◆ Impaired short term memory (78%)
- ◆ Drowsiness (68%)
- ◆ Easily distracted (64%)
- ◆ Altered sleep-wake cycle (58%)
- ◆ Misinterpretation of events (55%)

Unfortunately, delirium is very often not recognized. In non-terminal patient populations 30% - 66% of patients suffering from delirium are not identified. For some patients delirium may be superimposed on dementia, depression, psychosis or other causes of cognitive impairment, making identification more difficult. Traditionally two subtypes of delirium have been identified – one associated with agitation and the other with hypoactivity. Patients with agitated delirium tend to be recognized most frequently and, in our study, those with agitated symptoms were more commonly identified as having delirium that caused a problem for someone.

A common cause for delirium in the dying is unrelieved pain. Other common causes include: *Drugs* – especially psychotropics, *Electrolyte or glucose imbalance*, *Liver failure*, *Ischemia or hypoxia*, *Renal failure*, *Impaction of stool*, *Urinary or other infection*, and *Metastases to brain*.

Management of delirium may be non-pharmacological and/or pharmacological. Measures to reduce anxiety and disorientation include keeping lights on low at night, surrounding the patient with quiet familiar objects,

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family presence, and keeping a clock and calendar in the visual field. First-line pharmacological management uses neuroleptics because they help calm the patient and improve mentation. Haloperidol is most commonly used, but chlorpromazine is often useful particularly in the agitated delirious patient. For severely agitated delirious patients (including those with terminal agitation or terminal restlessness), sedation may be a higher priority than clearing mentation. Consider adding lorazepam or midazolam when the goals of therapy shift to sedation.

References/resources:

Educating Physicians for End-of-life Care (EPEC), module 5. www.EPEC.net.

Fast Facts, End-of-life Physicians Education Resource Project. <http://www.eperc.mcw.edu/start.cfm>.

Storey P and Knight CF. UNIPAC FOUR: Management of Selected Nonpain Symptoms in the Terminally Ill. 1996.

Brietbart W and Strout D. *Delirium in the terminally ill*. Clinics in Geriatric Medicine, 16 (2):357-372. 2000.

Calendar of Events

March

14-15 *2nd National Conference on End of Life Care for Inmates*, Atlanta, Georgia. For more information, email mmorgan@voa.org.

28-4/1 *Association for Death Education and Counseling Creating Intimacy: Exploring Boundaries and Frontiers in Death*, Toronto, Ontario. For more information, email info@adec.org or call 860-586-7503.

April

1-5 *7th Congress of the European Association for Palliative Care*, Palermo, Sicily. For more information, call K&K Congress @ +41 22 908 1188 or see their website @ www.kenes.com/eapc.

5-6 *Missoula-Vitas Quality of Life Index Implementation Train-the-Trainer Program*. The Hospice of the Florida Suncoast will host a training for providers interested in utilizing the MVQOLI. This training will provide participants with the knowledge and skills necessary to train staff and integrate the MVQOLI into agency systems. Everyone who completes the two-day training will receive the MVQOLI Toolkit and a license to utilize the MVQOLI as part of the registration fee. Registration and Materials Fee: \$600. To register, please call (727) 586-4432 ext. 2772. *Space is limited to the first 50 paid registrants.*

24-5/1 *Harvard Medical School Center for Palliative Care Program in Palliative Care Education and Practice*, Boston, Massachusetts. For more information, email pallcare@partners.org, call 617-724-4597, or see the website at www.hms.harvard.edu/cdi/pallcare.

May

12-16 *The 19th King's College Conference on Death and Bereavement*, London, Ontario. For more information, call Dr. John D. Morgan @ 519-432-7946.

June

21-24 *American Academy of Hospice and Palliative Medicine (AAHPM) 13th Annual Assembly*, Phoenix, AZ. For more information, call 847-375-4712 or see their website @ www.aahpm.org.

November

14-20 *Harvard Medical School Center for Palliative Care Program in Palliative Care Education and Practice*, Boston, Massachusetts. For more information, email pallcare@partners.org, call 617-724-4597, or see the website at www.hms.harvard.edu/cdi/pallcare.

Announcements

American Board of Hospice and Palliative Medicine: Exam Dates

Exam dates are April 21, 2001 and October 13, 2001. For more information, contact ABHPM at 301-439-8001 or see the website at www.abhpm.org.

Palliative Care Fellowship

The Massachusetts General Hospital Palliative Care Service offers BE/BC physicians a 1-year fellowship in palliative care. For more information, contact J. Andrew Billings, MD, at 617-724-9196 or email jbillings@partners.org.

Roxane Visiting Nurse Scholar Program in Palliative Care

The Palliative Care Program of the Medical College of Wisconsin is pleased to offer a visiting scholar program designed for nurses. For more information, contact Sandy Muchka, RN, MS, OCN at 414-805-4607.

The Harvard Medical School Center for Palliative Care Education Announces the HMS Program in Palliative Care Education

This program will offer an intensive learning experience for physician- and nurse-educators who wish to become experts in the clinical practice and teaching of comprehensive, interdisciplinary palliative care and to gain expertise in leading and managing improvements in palliative care education and practice at their own institutions. For more information, contact J. Andrew Billings, MD at 617-724-9197 or email jbillings@partners.org.

Project to Improve Residency Training in End-of-Life Care

The Robert Wood Johnson Foundation has funded a 3-year project coordinated by David Weissman, MD, Director of Palliative Care at the Medical College of Wisconsin, to improve training in end-of-life care at 180 internal medicine or family practice residency programs. For more information, contact Lisa Pelzek-Braun at 414-805-4605 or email lpelzek@mcw.edu.

Carmel Corn (a sweet ending...)

The following story was shared with us from a hospice worker this holiday season, and we thought it important to pass on to you:

I was walking through the streets of our town, doing some Christmas shopping, when a woman approached me. Given the holiday season, she said, she wanted to thank hospice for our outstanding work. Her comment brightened my day. At the next store I was browsing in, a man saw me and walked over. "Here's \$100, please contribute this to your hospice in memory of my five friends." Now I was stunned. When a similar event occurred later in the day, I was amazed. I was reminded of the importance of our work and its long-lasting impact – in a completely unsolicited way. As this gift was given to me, I give it to you.

Hospice of the Plains, Wray, Colorado

Do not let great ambitions overshadow small success.

PoPCRN Is...

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University of Colorado Hospital

Population-based Palliative Care Research Network (PoPCRN)
Information / Study Sign-up Form

YES, I am interested in participating in the following *Population-based Palliative Care Research Network* studies and/or opportunities:

- Discharge Follow-up Study
- The Natural History of Symptoms in Hospice / Palliative Care Patients
- PoPCRN email listserv – discussion and articles pertinent to palliative care
- PoPCRN newsletter

NO, I am not interested in participating in the Population-based Palliative Care Research Network Studies, but please notify me of your progress on current projects and upcoming events.

Please send materials to:

Contact Person: _____
Position: _____
Site: _____
Address: _____

Phone: _____
Fax: _____
Email: _____

Thank you for taking the time to complete and return this form!
Please Fax or Mail This Form To:

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