



What's Poppin'?

Population-Based Palliative Care Research Network

WEBPAGE: WWW.UCHSC.EDU/POPCRN *** Toll Free: 866.372.9417

Volume III, Issue I

Spring 2002

KERNEL'S CORNER

Jean S. Kutner, MD, MSPH

Palliative Care at the Olympics

What? Are we talking Senior Olympics here? No, I'm talking about the 2002 Winter Olympics, recently held in Salt Lake City. OK, you may be thinking, this must be a joke, why would there be palliative care at the Olympics? Bear with me...

I had the unique opportunity to serve as a volunteer primary care physician at the "Polyclinic" in the Olympic Village during the recent Winter Olympics. Over a 10 day period in February, I had the privilege of working 7 shifts as a primary care physician in the Olympic Village - providing health care to athletes, coaches, Olympic committee members, Olympic volunteers, security personnel, and anyone else who had Olympic Village security clearance. While, fortunately, I did not provide any end-of-life care during this period, I would argue that much of what I (and the other physicians, nurses and physical therapists) did during that time had much in common with what we do in palliative care - assessing symptoms and how they are affecting quality of life and treating individuals as whole persons, rather than as diseases.

Given the setting, much of our focus was on working with people to attain their individual goals - to be able to compete, to be able to complete a work assignment, or to be more comfortable with whatever ailment they had. My interventions ranged from antibiotics, to symptomatic relief (lots of ibuprofen and decongestants - within the Olympic formulary, of course), to reassurance, to listening to and providing support.

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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 344 people from 134 research sites located in 25 States and Canada.

WHERE HAVE WE BEEN?

- Study 1: Symptom Prevalence Card Study
7/99-10/99
- Study 2: Psychosocial/Spiritual Issues Study
1/00-9/00
- Study 3: Bereavement Pilot Study
2/00
- Study 4: Confusion & Delirium Prevalence Study
2/00-3/00
- Study 5: Discharge Follow-up Study
7/00-12/01
- Study 8: Web-based Hospice Fall Rate Study
10/01
- Study 9: Web-based Hospice Education Study
12/01-2/02

WHERE ARE WE NOW?

- Study 6: Symptom Study-Phase I
8/00-5/02
- Study 10: Palliative Care Guidelines for Symptom Management Study, 3/02-4/02
- Study 11: Hospice Nurses Symptom Management Study, 3/02-4/02

WHERE ARE WE GOING?

- Study 2A: Psychosocial/Spiritual Issues Study in Dept. of Corrections sites
- Study 7: National Hospice Outcomes Project, 4/01-3/03

Under Development:

- ◆ Web-based Pharmacy Cost Study
- ◆ Safety of Hospice Home Care Workers
- ◆ Web-based Pre-hospice program Study

KERNEL'S CORNER, CONTINUED FROM PAGE 1:

For example, a lonely food service worker from out of state who came in with a headache and nausea, who, it turns out, had been up all night crying about an unfaithful boyfriend back home. I also learned a great deal from those I treated – about the countries they represented, their sports, and their Olympic experiences. One of my favorite encounters was with a man who competed in the luge representing a South American country. He finished his competition within the first few days of the Olympics. I asked him if he was going to stay for the entire 17 days of the Olympics. His response embodied the Olympic experience. He told me that he came in knowing that he would not have much of a chance to medal, but that he had enjoyed the experience of competing, and *of course* he was going to stay. He was there to “soak it all in” – going to other events, learning new sports (he had tried skiing for the first time that day), and meeting people from around the world. This athlete embodied the general feeling of my entire experience, that of a large number of people from quite varied backgrounds coming together for a common purpose and goal.

So, why am I telling you this, aside from the fact that it was an amazing experience? First, to share the affirmation that good, holistic medical care, even when caring for some of the healthiest people in the world, embodies much of what we emphasize in palliative care – symptom assessment and management and attention to quality of life and individual goals. Second, to share the sense of energy that came from these many people from many different settings coming together for a common goal. Everyone I met, whether athletes, coaches, Olympic committee personnel, security staff or volunteers, from whatever country or part of the U.S., believed in the Olympic ideals and creating a positive experience. Each individual contributed to the success of this huge event. Even the security personnel who had been working straight through since the end of December at various national events and were, as one man said “dragging”, said there was something special about being involved with the Olympics and were glad to be there. The positive energy surrounding the Olympics was almost palpable.

I hope that I've brought home some of this positive energy and am able to apply it to my “real” work. Think about what we (meaning all of us) are doing and accomplishing by participating with other hospice/palliative care organizations in PoPCRN's varied settings. We (that means everyone) can accomplish much good with our combined efforts. The Olympic slogan for the 2002 Winter Olympics was “light the fire within” (which was the butt of a number of jokes, but I won't go into that). I think that I can confidently assume that people in the hospice/palliative care world don't need any help to “light the fire within” about the need to improve end-of-life care. I'm hoping that we (as everyone participating in PoPCRN) can “light the fire within” to continue efforts to collect data to improve both the clinical care that we provide and end-of-life care overall. We can, collectively, make a difference.

RECENT POPCRN PRESENTATIONS:

- ◆ 14 Annual Assembly of the American Academy of Hospice and Palliative Medicine, 2/02
- ◆ 16th Annual Primary Care Research Methods & Statistics Conference, 11/01
- ◆ Colorado Hospice Organization Meeting, 10/01
- ◆ Coleman Institute Workshop, 10/01
- ◆ American Geriatric Society Meeting, 5/01
- ◆ Society of General Internal Medicine Meeting, 5/01
- ◆ National Hospice and Palliative Care Organization Meeting, 3/01

Upcoming Presentations:

- ◆ New York Hospice and Palliative Care Organization Meeting, 4/02

PoPCRN PUBLICATIONS:

- ◆ Kutner JS, Kassner CT, Nowels DE. “Symptom Burden at the End of Life – Hospice Providers’ Perceptions.” *Journal of Pain and Symptom Management* 2001;21(6):473-480.
- ◆ Nowels DE, Kutner JS, Kassner CT. “Estimation of Prevalence of Confusion in Terminally Ill Hospice Patients.” In press, *Journal of Palliative Medicine*. 2002.
- ◆ Kutner JS, Blake M, Meyer S. “Predictors of Live Hospice Discharge: Data from the National Home and Hospice Care Survey (NHHCS).” In press, *Am J Hospice and Palliative Care*. 2002.

Web-based Research

Thank you to the 79 sites who participated in the Hospice Education Study!

We are currently analyzing this data and will report results as soon as they become available

Look for the Pharmaceutical Cost Study due to run April 1, 2002 – June 30, 2002!

From the PoPCRN webpage (<http://www.uchsc.edu/popcrn>), go to the “Web-based Research” link.

If you have additional ideas for web-based studies, please let us know!

SPECIAL RECOGNITION!

Over the past several months PoPCRN has expressed our appreciation to four people who have contributed to the growth and development of PoPCRN in extraordinary ways. We want to acknowledge who these special people are and how they have supported PoPCRN:

- ◆ **Susan Young**, Hospice of Metro Denver, for coordinating and exceeding expectations with the Natural History of Symptoms Study, Phase I.
- ◆ **Barb Kamlet**, Exempla Lutheran Hospice, for coordinating and exceeding expectations with the Natural History of Symptoms Study, Phase I.
- ◆ **Robin Rawlings**, PoPCRN Research Volunteer and Pikes Peak Hospice & Palliative Care, for exceptional work on the Discharge Follow-up Study and the Natural History of Symptoms Study, Phase I.
- ◆ **Tom Johnson**, Hospice of St. John, for successfully coordinating multiple PoPCRN studies with both staff and patients.

PoPCRN has provided gift certificates to Mentor Books (www.mentorbooks.com) in appreciation of their efforts.

Thank You!

CONGRATULATIONS!

Congratulations to PoPCRN’s **Cordt Kassner** for completing his Ph.D. in Health and Behavioral Sciences from the University of Colorado – Denver. He successfully defended his dissertation, titled “Understanding Suffering at the End of Life”, in December 2001.

Congratulations also to **Sue Meyer** for receipt of a Dennis Jahnigen Memorial Education Award for her work with PoPCRN on the study of outcomes of patients who are discharged from hospice.

CLINICAL FEATURE

DOZING ON THE ROAD TO OZ: MINIMIZING OPIOID-INDUCED SEDATION

By Daniel Johnson MD, University of Colorado Health Sciences Center, Denver, CO.

One might contend (well, not really) that the 1939 film adaptation of L. Frank Baum's *Wizard of Oz* is an early pharmacology lecture on the side effects of opioids. Few people can forget the image of the Wicked Witch of the West gazing into her clouded crystal ball, concocting a field of poppies to interrupt Dorothy (played by Judy Garland) and her new-found friends' trek through the land of Oz. Ultimately, Dorothy, Toto, and the Cowardly Lion (the only other "biological creatures") drift into a deep slumber amidst the meadow of poisonous flowers only moments away from their destination - the Emerald City.

There is no question that opioids can provide our patients dramatic relief from multiple symptoms, most prominently pain and dyspnea. Unfortunately, the side effects of opioids can lead some patients and/or providers to limit the use of these drugs despite uncontrolled symptoms.* To some of our patients, their "trek to Oz", a quest to find relief from their pain, is fraught with a trip through the poppy field - daytime drowsiness and mental cloudiness. Depending on the goals of patients and their families, this sedation may create significant distress, especially if it interferes with communication with loved ones.

Some basic points regarding the management of opioid-induced sedation:

1. **Sedation is most prominent at the initiation (or escalation) of opioid use and typically lessens over several days.** Recent studies confirm that morphine produces little measurable impairment of cognitive and psychomotor function, particularly for patients receiving continuous treatment with stable doses. Minimize sedation by using long-acting or sustained release agents (minimizing peaks), combined with an immediate-acting agent for breakthrough symptoms.
2. **Excessive sleepiness in many patients may represent "catch-up" sleep rather than oversedation.** Patients who have just begun opioid treatment often have experienced days to weeks of severe pain and are often deprived of much-needed sleep. Leave the opioid dose the same for the first few days, and if the patient still complains of excessive drowsiness, lower the dose.
3. **Sedation is often multifactorial. Minimize contributing causes where possible, paying special attention to other medications.** Suspect medications include benzodiazepines, barbiturates, cimetidine, anticholinergic drugs (e.g. tricyclic antidepressants), antihistamines, alcohol, and drugs that decrease glomerular filtration in the context of opioid treatment (ACE inhibitors and NSAIDs). Other causes of sedation include infection, brain metastasis, subdural hematoma, hypercalcemia, hyponatremia, uremia or hepatic failure.
4. **Symptomatic interventions to reduce narcotic induced sedation include changing or reducing the opioid agent or adding a psychostimulant.** If sedation persists when contributing factors are eliminated, try decreasing the dose of the sustained-release opioid by 10 to 25% and monitor the patient's use of rescue medication (to assess symptom control). Psychostimulants include methylphenidate (begin at 2.5 mg QD), dextroamphetamine (begin at 2.5 mg QD) and pemoline (for patients who cannot swallow pills, begin at 18.75 mg AM +Noon). In one study, methylphenidate (Ritalin) was effective in reducing drowsiness in over 90% of cancer patients.
5. **Remember that understanding the patient's (and families) goals of care is critical when assisting patients and families in symptom management decisions at the end of life.** For example, for some patients, the drowsiness associated with opioid use may cause little or no distress.

* Of interest, a new PoPCRN survey (to be distributed this month), "Hospice Nurses Symptom Management Study" will explore the hospice nurses perceived barriers to effective symptom management. Limiting the use of certain medications secondary to unwanted side effects is one example of a potential barrier to effective symptom management.

Abraham JL. *A Physician's Guide to Pain and Symptom Management in Cancer Patients*. Baltimore: The Johns Hopkins University Press, 2000.

Dolye, Derek, Hanks, MacDonald, eds. *Oxford Textbook of Palliative Medicine*, 2nd ed. Oxford: Oxford University Press, 1998.

FEATURED SITE

HOSPICE OF METRO DENVER, DENVER, CO

By Mele Telitz, Public Relations Manager

Is it possible that there is a “good” way to die? Is it possible to bring the foundation of good hospice care to patient families earlier in the end-of-life care continuum? Perhaps most importantly, is there a way to recognize when death is coming?

Hospice of Metro Denver (HMD) was founded on the belief that the answer to all these questions is yes. Since 1978, HMD has helped more than 38,000 terminally ill patients and families cope with death by providing physical and psychological care for both the dying and those they are leaving behind. Hospice of Metro Denver is the largest hospice in the Rocky Mountain region serving one out of every four hospice patients.

An important and growing component of HMD’s work is its education outreach program geared toward healthcare professionals. The program involves palliative care liaisons, trained nurses, who talk to physicians, nurses and others who care for patients with advanced diseases. The goals of the program are to familiarize health-care professionals with the concept of hospice care, to encourage collaboration between HMD and the doctors who refer patients to hospice services, and to help care providers recognize when life’s final transition is near. Since 1996, HMD’s palliative care liaisons have made presentations at hospitals, physician groups, clinics, skilled-nursing facilities and assisted living facilities.

Over the years, many providers have seen hospice care services constrained by Medicare reimbursement and regulatory threats, resulting in a narrow scope for doctors when considering this form of care for their patients. Hospice of Metro Denver’s vision is to redesign what end-of-life care looks like in Denver. HMD encourages doctors to consider palliative care earlier, offering palliative care as an adjuvant therapy when curative treatments become less effective for their patients. What that means for healthcare professionals is they would no longer be forced into a choice: curative therapies vs. hospice.

Due to payor constraints, this new approach is done on a case-by-case basis. In hospitals, HMD staff helps with palliative consults to patients where they discuss advanced directives, pain and symptom control management as well as goals and values clarification for patients and families.

Last year, HMD professionals collaborated with a major payor to introduce a pilot program which experimented with early intervention. The pilot program resulted in:

- better patient care
- decreased hospital visitation
- increased patient/family satisfaction
- an overall decrease in care expenses.

The results of this intervention gave enough proof to justify a pre-hospice benefit that went into effect for one payor earlier this year. Many of the payors involved with HMD’s collaborative efforts are encouraged to make this change in end-of-life care.

For additional information about Hospice of Metro Denver, please contact:

Beth Courville

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www.hospiceofmetrodenver.org

**Report on Part II of the Harvard Medical School Center for Palliative Care
Program in Palliative Care, Education and Practice
By William Reiquam, MD**

The first week long session of this course in April, 2001, set the pace for the continuation session (November, 2001). The same group gathered again in Boston to discuss new topics and to compare notes on how the previous experiences in April had played out on home turf. The second week continued the pervasive themes of overlapping encounters in developing webs of alliance critical to effective palliative care. This collaborative milieu was the essence of the take home stuff, simple and ultimately so successful. The process refreshingly mainstays trust, a step at a time; timeliness and persistence are premiums. Participants cannot escape the “in your face” approach which facilitates moving on with the work of palliation of suffering for patients and their families.

How do these binding interactions work as a teaching mechanism? Small basic groups are presented with agendas – single members of each cluster enter sessions of another group as a listener, evaluator, or presenter. Reports are taken back to the primary group for further discussion. A pertinent lecture for the entire group likely set the stage for the cross-thinking sessions. Lectures are rare and exceptional. None is scheduled for the first session after meals, nor for naptime in the mid-late afternoon.

Each day is opened by a prelude, a poem, a dance, hula, an essay from a participant who could hardly wait to make a presentation to jumpstart the day.

Critique of sessions centered on effectiveness of communication techniques, on cultural or social lenses through which a subject as pain control would be filtered. How might techniques of communication be perfected when caring for the dying, for cross cultural encounters?

Powerful and practical insights develop from these face-to-face small group encounters. Participants bond in their quests and are filled with “take home” material. Embodiment of these attitudes becomes the glue that step by step builds collaborative interdisciplinary contexts for palliative care at home, in clinics, and hospitals.

Troves of valuable material are collected in notebooks for use at home. This material is easily accessible and far beyond the usual “handouts”. These reference notebooks are superb in their documentation and refinement of material presented in real time.

In recounting these experiences from a few months distance, I see even better that passion that has gone into the spoken and written material for this adventure. Patient care, all of it, is presented through the lenses of palliation, of attending to suffering no matter how spectacular or compelling the latest technical breakthrough might be. From Alzheimer’s disease, to AIDS, to pain relief wherever it confronts us, to home care, hospice, end-of-life care, to sensitivities about spirituality and taking time to tend to families, the interactions of staff and participants becomes solidly affirming.

As program participants, we are challenged to think beyond the routine workaday to the hopes of collaborative health care in the relief of suffering for patients and their families. The time together for the group seems like a long time as one reads the brochure and the program contents. In reality, the weeks are so packed with real life experiences and pertinent patient care material that having the opportunity for such a session each year could possibly become a yearning.

INFORMATION ON CURRENT AND UPCOMING PoPCR N STUDIES

Discharge Follow-up Study:

Thank you to the 18 national sites who enrolled 164 patients into this study! Patient enrollment and data collection have ended and we are currently analyzing data. Results will be available soon!

Hospice Education Survey:

Thank you to the 79 national sites who participated in this study! Results will be available soon!

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 phase of this study describes the time course of and distress due to common symptoms among hospice/palliative care patients.. ***Data collection for this study will continue through May 1, 2002.*** To date, 23 sites nationally have agreed to participate. Of the 23 participating sites, 10 have contributed data on 69 patients. Our sample size goal is 100 patients. ***Please contact us if you would like to participate in this study.***

Psychosocial/Spiritual Issues Study in the Department of Corrections:

Last year PoPCR N conducted a patient interview study assessing psychosocial and spiritual issues in community hospice patients. Thanks to the work of Liz Craig, Resource Coordinator for the GRACE Project, 5 hospices located in various Department of Corrections systems have agreed to conduct this same survey in their hospices. We have received IRB approval and data collection is beginning.

National Hospice Outcomes Project:

We are proud to announce that Colorado PoPCR N hospices have been invited to participate in the National Hospice Outcomes Project. This two year research project, supported by the Robert Wood Johnson Foundation Chronic Care Initiative, is being conducted by the Institute for Clinical Outcomes Research in conjunction with the National Hospice and Palliative Care Organization. The overall objective of this project is to conduct a Clinical Practice Improvement study of pain control, dyspnea control, and self-determined life closure to determine which treatment modalities are associated with better outcomes of hospice care. The ultimate goal of this project is to develop research-based dynamic protocols for better pain control, dyspnea control, and self-determined life closure. This goal fits well with the current focus of PoPCR N studies on symptom management and quality of life at the end of life. Five PoPCR N sites are participating in this study. Project tools will be integrated into the hospice systems in **March 2002**, and the study data collection begins **April 2002**.

Palliative Care Guidelines for Symptom Management Study:

This is a study to describe the current use of protocols or guidelines for the management of patients' physical symptoms. ***Data collection for this study will continue through May 1, 2002. Please contact us if you would like to participate in this study.***

Hospice Nurses Symptom Management Study:

This is a study to identify barriers to physical symptom management from the perspective of hospice nurses. ***Data collection for this study will continue through May 1, 2002. Please contact us if you would like to participate in this study.***

Safety of Home Care Workers Study (under development):

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

Learning to Fall: The Blessings of An Imperfect Life, by Philip Simmons

By William Reiquam, MD

Learning to die is a clumsy project, most of us would not wait in line to sign up for it. The course would not fit all moods anyway. Those who feel wild and free wouldn't like their enthusiasm ruffled by taking time to think about death. Others, dismissing the inevitable, think of life as problems to be fixed; others see life as a mystery and just live with it.

So, Philip Simmons, sensitively and beautifully shares his thoughts about living in the face of a foreshortened life, laid out by ALS (Lou Gehrig's disease). No hidden agendas here. Instead of bemoaning life's imperfections, Simmons acknowledges the imperfect life. With a sense of humor, he seriously puts us on trial in a search for clues about falling with grace.

ALS is mean. Unconditionally we are brought to our knees by helplessness. What is one to do? Simmons takes us on a journey of seeing the radiance of ordinary things. We explore the city dump; here are relics that in someone's life lifted them over a hump. We see a plaque with faded, chipped paint tucked in with other rubbish. We are comforted by an artifact of life, screaming at us "It Might Come in Handy." Surely it was a fix for something. But the possessor had leaned to fall, free now of another piece of clutter.

Simmons' book is a tale of a metered death with buoyances that make falling bearable. We all know death is coming but the timing has become predictable here. We stop to flush out the details of "spring's awakenings", the "unfolding of leaves", "the loamy scent of earth", the "blue true dream of sky". We know that pain of uncertainties, yet we are distracted by the beauty around us.

Simmons' story is not pretty; it is beautiful. It is an accounting of life's imperfections, made so poignant by disease of almost unthinkable tragedy. He quotes Wallace Stevens *The Poems of Our Climate* – "clean water in a brilliant bowl / pink and white carnation" – beautiful but dull! "The imperfect is our paradise," Simmons explains.

With skillful and meticulous writing, the author captivates us, building art from calamity. He has us feeling harsh winds at our backs. We grasp the certainty of being blown into a dark canyon from the cliff's edge. Yet in the distance we glimpse the dark blue turbulence of the storm, "the awesome" sky, the "astonishment of the sublime".

This book will attract philosophical and academic criticisms. It will be found to be too religious, not religious enough, or just "not my thing". But as an account of coping in the face of the ultimate in disquietings, this little gem will mean a lot to a lot of readers. The poetry of the writing alone is captivating and uplifting.

CALENDAR OF EVENTS

March

20-23 *3rd Joint Conference and Exposition on Hospice and Palliative Care: Palliative Care, Collaborative Practice*

& *All That Jazz*, Hyatt Regency New Orleans, New Orleans, LA. For additional information:
www.nhpc.org.

April

4-7 *National Council on Aging / American Society on Aging: Crossing the Great Divide: A Call for Compassion and Creativity*, Denver, CO. for additional information: phone 800-537-9728 or see their webpage at www.agingconference.org.

5-7 *Education for Physicians on End-of-Life Care: Become an EPEC Trainer*, Santa Fe, NM. For additional information: phone 312-503-8533.

30-5/1 *The Duke Institute on Care at the End of Life and NHPCO End of Life Care: A Timeless Model*, Washington DC. For additional information: see their website at www.nhpc.org.

May

15 *Colorado Hospice Organization Annual Spring Conference*, Doubletree Hotel, Denver, CO. For additional information: contact the Colorado Hospice Organization at CoHospOrg@aol.com.

June

18-19 *End-of-Life Nursing Education Consortium (ELNEC) Training for Nurse Educators*, San Francisco, CA or Seattle, WA. For additional information: contact Susan Taylor at email susantaylor@thehospice.org or phone 727-588-2864.

August

17 *10th World Congress – International Association for the Study of Pain*, San Diego, CA. For additional information: contact Ellen Wilson at email iasp@locke.hs.washington.edu or phone 206-547-1703. See their webpage at <http://www.halcyon.com/iasp/02cong.html>.

September

7-9 *National Hospice and Palliative Care Organization (NHPCO) Hospice Administrator's Certificate Program (HACP)*, Washington, DC. For additional information: see their webpage at www.nhpc.org.

10-12 *National Hospice and Palliative Care Organization (NHPCO) 17th Management and Leadership Conference*, Washington, DC. For additional information: see their webpage at www.nhpc.org.

17-18 *End-of-Life Nursing Education Consortium (ELNEC) Training for Nurse Educators*, St. Louis, MO or Chicago, IL. For additional information: contact Susan Taylor at email susantaylor@thehospice.org or phone 727-588-2864.

October

5-10 *14th International Congress on Care of the Terminally Ill*, McGill University, Montreal, Canada. For additional information: phone 514-286-0855 or email info@eventsintl.com.

10-12 *Colorado Hospice Organization Annual Fall Conference & Exposition*, Marriott Mountain Resort, Vail, CO.

For additional information: contact the Colorado Hospice Organization at CoHospOrg@aol.com.

10-12 *The Center to Advance Palliative Care (CAPC) Palliative Care Fall Forum*, New Orleans, LA. For additional information: see their webpage at <http://www.capcmssm.org>.

April 2003

2-5 *8th Congress of The European Association For Palliative Care*, The Hague, The Netherlands. For additional information: email eapc03@kenes.com or see their website at <http://kenes.com/eapc>.

September 2003

2-6 *European Federation of IASP Chapters, Pain in Europe IV*, Prague, Czech Republic. For additional information: email Pain2003@cbttravel.cz or call 42-2-2494-8708.

ANNOUNCEMENTS

The American Board of Hospice and Palliative Medicine: Physician Certification Exam

Next Exam Date: November 2002. The American Board of Hospice and Palliative Medicine (ABHPM) seeks to increase competencies in skilled end-of-life medical care by promoting voluntary, periodic examination and certification in hospice and palliative medicine. For additional information: contact the American Board of Hospice and Palliative Medicine, phone: 301-439-8001, email: mail@abhpm.org, webpage: www.abhpm.org. (Information from the Journal of Palliative Medicine, 2001, Volume 4, Number 4.)

Clinical Fellowships Available

San Diego Hospice will be offering four clinical fellowships beginning July 1, 2002. The fellowships will lead to eligibility for certification by the American Board of Hospice and Palliative Medicine. Preferred candidates will be BE or BC by an ABMS-recognized board. For additional information: contact Charles von Gunten, MD, PhD, at cvongunten@sdhospice.org. (Information from the Journal of Palliative Medicine, 2001, Volume 4, Number 4.)

The Program in Palliative Care Education and Practice

The Harvard Medical School Center for Palliative Care offers these intensive learning experiences for physician- and nurse-educators who wish to become expert in the clinical practice and teaching of comprehensive, interdisciplinary palliative care, as well as to gain expertise in leading and managing improvements in palliative care education and practice at their own institutions. Sessions for 2002 are April 23-30 and November 12-19. For additional information: contact Wendy Katz at 617-724-9505 or see their website at www.hms.harvard.edu/cdi/pallcare.

Palliative Care Fellowship

The Massachusetts General Hospital Palliative Care Service offers BE/BC physicians a 1-year fellowship in palliative care. For additional 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 additional information, contact Sandy Muchka, RN, MS, OCN at 414-805-4607.

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 additional information, contact Lisa Pelzek-Braun at 414-805-4605 or email lpelzek@mcw.edu.

JOINING PoPCRN

If you are interested in additional information about PoPCRN or being added to the PoPCRN mailing list and/or email listservs, please contact Cordt Kassner, PhD, at (P) 303.372.9364 or (E) Cordt.Kassner@uchsc.edu

Carmel Corn (A Sweet Ending...)

*We avoid suffering only at the great cost of distancing ourselves from life.
In the depths of every wound we have survived is the strength we need to live.
The wisdom our wounds can offer us is a place of refuge.
Finding this is not for the faint of heart.
But then, neither is life.*

Rachel Remen, My Grandfather's Blessings

POPCRN Is...

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