

**MINUTES OF THE MEETING OF THE STATE ADVISORY COUNCIL ON  
PALLIATIVE CARE AND QUALITY OF LIFE  
MAY 10, 2019**

Alabama Department of Public Health (ADPH)  
The RSA Tower, Suite 1586  
Montgomery, Alabama

**Members Present**

Rodney O. Tucker, M.D., M.M.M., Chair  
Karen Marlowe, Pharm.D., Co-Chair  
Kristi A. Acker, D.N.P.  
Gregory W. Ayers, M.D. (via phone)  
John G. Beard, M.B.A.  
Stormy Dismuke, M.S.N.  
Amy L. McAfee, M.S.W.  
John P. Miller, M.D.  
Mary Ann Somers, M.A.Ed.

**Members Absent**

Richard J. Brockman, J.D.  
Jimel LeShun Gibbs, M.S.N.  
Leigh Ann Matthews, M.S.N.  
Timothy Mayhall, M.Div.

**Staff Present**

Scott Harris, M.D., M.P.H., State Health Officer  
Dennis Blair, Bureau of Health Provider Standards (BHPS)  
Diane A. Mann, BHPS  
LaKesha E. Hopkins, BHPS

**Guests Present**

Andy Alvarez (Proxy for Leigh Ann Matthews)  
Mary Ann Crow, M.S.N. (via phone)

**CONSIDERATION OF THE MINUTES OF FEBRUARY 15, 2019:**

The Council recommended approval of the Minutes of February 15, 2019, as distributed; the motion carried unanimously.

**INTRODUCTION OF NEW MEMBER:**

Dr. Rodney Tucker welcomed Dr. John P. Miller as a new Council member, representing the Alabama Hospital Association.

**OPIOID PRESCRIBING AND REGULATION UPDATES (EXHIBIT “A”):**

Dr. Gregory Ayers provided the Council with an update of the opioid epidemic and discussions with Medicaid. He also provided the Council with a copy of the revision of §540-x-4-.09 of the Risk and Abuse rule. He stated that the public comment period for the rule ends on June 4, 2019.

**TRANSPORTABLE ORDERS FOR PATIENT PREFERENCES UPDATE:**

Ms. Mary Ann Crow informed the Council of the purpose and procedure of the Alabama Order for Pediatric Palliative and End of Life Care form. She also informed the Council that Alabama was currently the only state using the form. She stated the form would be released to the public in about 4 to 6 weeks and she would be taking it to the National Physician Orders for Life Sustaining Treatment Paradigm so that it would have an impact nationally and a national form could be created for all states.

**PRESCRIPTION DRUG MONITORING PROGRAM (PDMP) PATIENT FACT SHEET (EXHIBIT “B”):**

Dr. Karen Marlowe requested feedback from the Council on the PDMP Patient Fact Sheet. After the Council reviewed the document and made suggestions and edits, a motion was made and approved to upload the document on the ADPH website by Monday, May 13, 2019.

**STATE HEALTH POLICYMAKERS SUMMIT APPLICATION:**

Dr. Scott Harris informed the Council that the National Academy for State Health Policy’s 32<sup>nd</sup> Annual State Health Policy Conference would be held August 21-23, 2019, in Chicago, IL. Following discussion regarding the Council being represented at the conference, Dr. Harris informed Dr. Tucker that ADPH would assist with submitting the application, which would be due May 23, 2019.

**DISCUSSION OF FUTURE PUBLIC AWARENESS MEETING CAMPAIGN:**

Dr. Tucker informed the Council of ongoing efforts with Blue Cross and Blue Shield to provide public awareness regarding palliative care. Dr. Tucker requested that members provide their input on what to include in the campaign and send their comments via email to him.

**FUTURE MEETING DATES:**

Dr. Tucker discussed the possibility of two of the quarterly Council meetings being held virtually. Dennis Blair provided the options that were currently available and informed Dr. Tucker of the capabilities that may be an option in the future.

**OTHER MEMBER DISCUSSION (EXHIBIT “C”):**

Dr. Tucker informed the Council that the next Palliative Care Summit would be held in May 2020. Dr. Tucker distributed a handout on Training Clinicians, created by Amy Beasley with the Palliative Care and Hospice Education and Training Act, and stated Ms. Beasley would be invited to present her work at future meetings.

**NEXT MEETING DATE:**

The next meeting of the Council is scheduled for Friday, August 9, 2019.

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Rodney O. Tucker, M.D., M.M.M., Chair  
State Advisory Council on Palliative Care and Quality of Life

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Dennis Blair, Director  
Bureau of Health Provider Standards  
Alabama Department of Public Health

Approved August 9, 2019

540-X-4-.09 Risk and Abuse Mitigation Strategies

(1) The Board recognizes that all controlled substances, including but not limited to, opiates, benzodiazepines, stimulants, anticonvulsants, and sedative hypnotics, have a risk of addiction, misuse, and diversion. It is the opinion of the Board that the best practice when prescribing controlled substances shall include medically appropriate risk and abuse mitigation strategies, which will vary from patient to patient. Additional care should be used by practitioners when prescribing medication to a patient from multiple controlled substance drug classes.

(2) Every practitioner shall provide his or her patient with risk education prior to initiating controlled substances therapy and prior to continuing the controlled substances therapy initiated by another practitioner.

(3) Every practitioner shall utilize medically appropriate risk and abuse mitigation strategies when prescribing controlled substances. Examples of risk and abuse mitigation strategies include, but are not limited to:

- (a) Pill counts;
- (b) Urine drug screening;
- (c) PDMP checks;
- (d) Consideration of abuse-deterrent medications;
- (e) Monitoring the patient for aberrant behavior;
- (f) Using validated risk-assessment tools, examples of which shall be maintained by the Board; and

(g) Co-prescribing naloxone to patients receiving opioid prescriptions when determined to be appropriate in the clinical judgment of the treating practitioner.

(4) The Board recognizes that the best available research demonstrates that the risk of adverse events occurring in patients who use controlled substances to treat pain increases as dosage increases. The Board adopts the "Morphine Milligram Equivalency" ("MME") daily standard as set out by the Centers for Disease Control and Prevention ("CDC") for calculating the morphine equivalence of opioid dosages. The Board further adopts the "Lorazepam Milligram Equivalency" ("LME") daily standard for calculating sedative dosing when using the Alabama Prescription Drug Monitoring Program.

(5) For the purpose of preventing controlled substance diversion, abuse, misuse, addiction, and doctor-shopping, the Board sets forth the following requirements for the use of Alabama's Prescription Drug Monitoring Program (PDMP):

(a) For controlled substance prescriptions totaling less than 30 MME or 3 LME per day, physicians are expected to use the PDMP in a manner consistent with good clinical practice.

(b) When prescribing to a patient controlled substances of more than 30 MME or 3 LME per day, physicians shall review that patient's prescribing history through the PDMP at least two (2) times per year, and each physician is responsible for documenting the use of risk and abuse mitigation strategies in the patient's medical record.

(c) Physicians shall query the PDMP to review a patient's prescribing history every time a prescription for more than 90 MME or 5 LME per day is written, on the same day the prescription is written.

(6) Exemptions: The Board's PDMP requirements do not apply to physicians writing controlled substance prescriptions for:

- (a) Nursing home patients;
- (b) Hospice patients, where the prescription indicates hospice on the physical prescription;
- (c) When treating a patient for active, malignant pain; or
- (d) Intra-operative patient care.

(7) Due to the heightened risk of adverse events associated with the concurrent use of opioids and benzodiazepines, physicians should reconsider a patient's existing benzodiazepine prescriptions or decline to add one when prescribing an opioid and consider alternative forms of treatment.

(8) Effective January 1, 2018, each holder of an Alabama Controlled Substances Certificate (ACSC) shall acquire two (2) credits of *AMA PRA Category 1™* continuing medical education (CME) in controlled substance prescribing every two (2) years as part of the licensee's yearly CME requirement. The controlled substance prescribing education shall include instruction on controlled substance prescribing practices, recognizing signs of the abuse or misuse of controlled substances, or controlled substance prescribing for chronic pain management.

(9) A violation of this rule is grounds for the assessment of a fine and for the suspension, restriction, or revocation of a physician's Alabama Controlled Substances Certificate or license to practice medicine.

**Author:** Alabama Board of Medical Examiners

**Statutory Authority:** Ala. Code §§ 34-24-53, 34-24-336, 20-2-54.1, and 20-2-214(2)

**History:** Approved for Publication: September 21, 2016. Adopted: January 18,

2017. Effective Date: March 9, 2017. Amended/Approved: May 16, 2018.  
Certified approved: July 18, 2018. Certified filed: July 19, 2018. Effective Date:  
September 4, 2018. Amended/Approved: April 11, 2019. Effective Date:  
August 5, 2019.

## Palliative Care Medication – Questions and Answers, Information Resources

Question: What do I need to know about getting my prescriptions filled?

- To make sure your pharmacist is aware of all of your medications, try to fill all of your medications at one pharmacy.
- When possible try to fill your medication before your current supply runs out. This allows your pharmacy to ensure that they will have your medication in stock.
- When a medication is discontinued, please talk to your pharmacist about proper disposal of your medication.
  - A link to information about medication disposal is available:
    - <https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186188.htm>
  - For information about disposal locations in your area:
    - <https://apps.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1>

Question: Why does the pharmacy need my driver's license or social security information to fill some of my prescriptions?

Answer: A Pharmacist is required to submit this information for to the Alabama Prescription Drug Monitoring Program (PDMP). This is an electronic database of all controlled substance dispensed in Alabama. Alabama's PDMP collects information from a pharmacy about what controlled substances prescriptions were dispensed, how much, to whom, and by whom. This information is securely stored and can be accessed by a limited number of people, in a limited number of situations. For more information about this program: <http://www.alabamapublichealth.gov/pdmp/>

Question: Can my caregiver or family member show their license to get my prescription filled?

Answer: It is very important that the information on the prescription match the license information given to a pharmacy. This system is used by pharmacies and prescribers to verify who has received prescriptions for controlled substances. Utilizing a caregiver or family member's driver's license with your prescription, will result in incorrect information in Alabama's Prescription Drug Monitoring Program. This may also result in delays in your care.

Question: Who has access to the information about my prescriptions?

Answer::Your physicians and pharmacists will have access to the information. If you are seen by a new physician or admitted to a hospital, they will also be able to access this information.

For more information about your medication therapy, here are some helpful resources:

# Training Clinicians to Care for Individuals with Serious Illness

## Urgency to Support the Palliative Care and Hospice Education and Training Act

U.S. Congress members can make a big impact for Alabama Healthcare by supporting increased palliative care and hospice education and training.

## What is Palliative Care?

Palliative care is “medical care for people living with a serious illness that focuses on providing relief from the symptoms and stress of the illness with the goal being to improve quality of life for both the patient and the family” (Centers to Advance Palliative Care, 2017). Palliative care has been recognized as a human right; therefore we need to find a means to increase access for the American Public (World Health Organization, 2018a).

### **Chronic, Serious Illness**

Chronic, serious illness has become a public health crisis in the United States. More than two-thirds of Medicare recipients age 65 and older have at least two chronic conditions (Lochner & Shoff, 2015). In addition to the existence of patients with chronic, serious illness, the population is aging and will continue to grow with the rise of the baby boomer population.

### Palliative Care Fast Facts

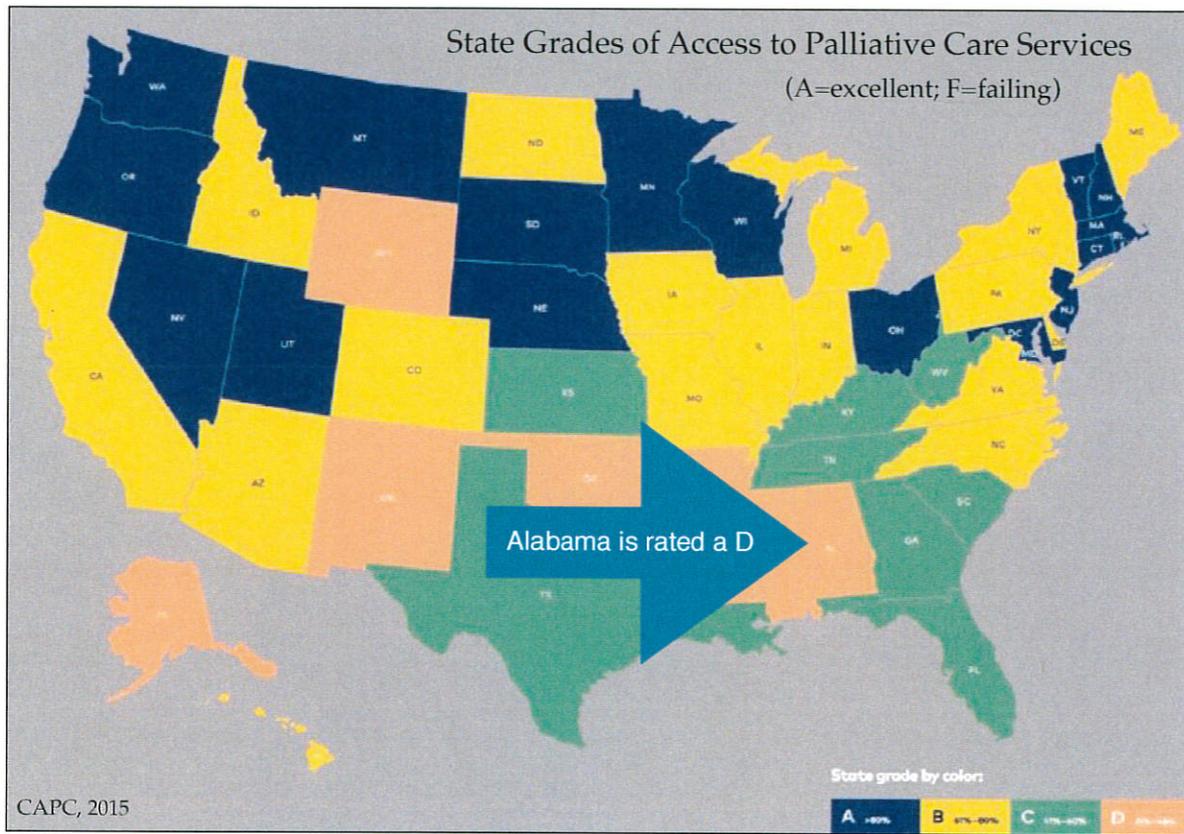
- ◆ Approximately 6 million U.S. citizens could benefit from palliative care
- ◆ Early introduction of palliative care has shown to decrease symptom burden, improve quality of life, and increase survival for patients living with chronic, serious illness
- ◆ Palliative care has shown to decrease caregiver burden.
- ◆ Palliative care has shown to reduce hospital admissions and total spending for patients with chronic, serious conditions

(Bakitas et al., 2009; Temel et al., 2010; Dionne-Odom et al., 2015; Smith et al., 2014)

## Access Issues to Palliative Care

Access to palliative care has improved over the last 10 years for the Mid Western and Northeastern United States (Centers to Advance Palliative Care [CAPC], 2015).

Unfortunately, access to palliative care services is often limited to hospitals and hospices for patients that are close to the end of life (CAPC, 2015). The Southeastern United States, including Alabama, has continued to lag behind in access to palliative care services (CAPC, 2015). One recommended suggestion to combat this shortage is the use of



primary palliative care that is provided by primary care and family medicine physicians (FMP) and nurse practitioners (NP)(World Health Organization, 2018b). Unfortunately, the number of FMP and NPs trained to provide palliative care falls short of the number of patients needing these services. To add to the problem, currently there is limited education on palliative care in medical and nursing schools (World Health Organization, 2018b). This gap in education and training is creating a potential barrier in access to quality palliative care for the American public (Fulmer, Escobedo, Berman, Koren, Hernandez, & Hult, 2018).

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# National Policy Support of Palliative Care and Hospice Education and Workforce Expansion

Currently, there are three initiatives that are attempting to push the topic of palliative care forward: Medicare Part B fee-for-service reimbursement for advanced care planning discussions, *Dying in America* recommendations for educational institutions and professional societies to increase education and the palliative care workforce, and the Palliative Care and Hospice Education and Training Act to increase education, fund research, and establish a public health campaign (Institute of Medicine, 2014; Medicare Learning Network, 2018; Patient Quality of Life Coalition, 2019). However, a recent assessment of the use of the Medicare Part B codes showed that only 1.6% of all providers that entered claims were from Alabama, whereas the remaining 98.4% encompassed the other 49 states (Coalition to Transform Advanced Care, 2016). The *Dying in America* report did not address organizations at the state level, however the recommendations were directed towards all educational institutions and professional societies in the United States. The Palliative Care and Hospice Education and Training Act has the potential to impact palliative care education and increase access for all Americans, however it currently is awaiting a vote in the United States Congress for the 2019 session.

	Medicare Part B fee-for-service reimbursement	Dying in America recommendations	Palliative Care and Hospice Education and Training Act
When?	Established in 2016	Recommendations made in 2015	First introduced and passed by U.S. House of Representative in 2018
Who?	Physician and non-physician practitioners	Educational institutions, professional societies, accrediting organizations, healthcare delivery organizations, and other organizations	Physicians, nurses, social workers, chaplains, pharmacists, physician assistants, and psychologists
What?	30 minutes sessions on advanced care planning are billable	Increase the number of palliative care clinicians and expand the knowledge based for all clinicians that care for patients with serious illness	Establishment of education centers, expanding palliative care research, academic and career achievement awards, and establishing a public awareness campaign
Why?	Increase goals of care discussions	Increase the number of palliative care specialist clinicians and increase palliative care and hospice education for clinicians	Increase education and awareness in palliative care and hospice for both clinicians and the lay public

## Proposed Policy

The Palliative Care and Hospice Education and Training Act has many components including workforce development training, national public awareness campaign on palliative care, and enhanced research support. While several valuable competes are include in the Palliative Care and Hospice Education Act, workforce development and training requires special attention.

### What does the Palliative Care and Hospice Education and Training Act?

1

Establish palliative care workforce training



2

Launches national palliative care education and awareness

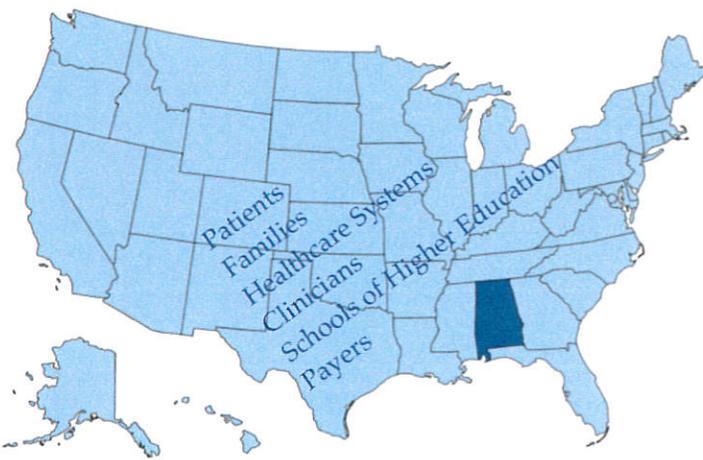
3

Enhances research in palliative care

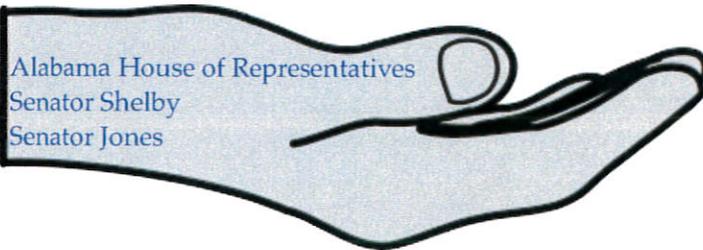


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# The Stakeholders That Will Be Impacted By The Palliative Care And Hospice Education and Training Act



There are many stakeholders that would be impacted by the Palliative Care and Hospice Education and Training Act, however the stakeholders that will make the greatest impact is the seven Alabama House of Representatives, U.S. Senator Shelby, and U.S. Senator Jones. Additional stakeholders include patients, families, healthcare systems, clinicians, schools of higher education and payers.



Ultimately, the impact in care will be made for patients and family caregivers. This will allow the patient to have their wishes honored as their illness progresses and will allow the family caregiver to have peace knowing that these wishes are being carried

out. It is imperative that administrators of healthcare systems have trained palliative care and hospice clinicians so that quality patient care is accessible to all. Schools of higher education must incorporate education and training on palliative and hospice care throughout the curriculum. Lastly, the payers will be impacted by reduced healthcare expenditures.

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# Policy Analysis and Methods

The policy was analyzed using Collins (2005) Health Policy Analysis. This plan involves eight steps to assist practitioners with limited policy training to succinctly analyze a policy and move it forward to fruition. During the evaluation phase of the policy, the John Hopkins Health Policy Analysis Checklist was utilized. This evaluation checklist was chosen because of the detailed list and the relevant assessment to health policy (Weiner, 2005). The policy context and problem have been identified.

## Policy Analysis Steps:

(1) define the context; (2) state the problem; (3) search for the evidence; (4) consider different policy options; (5) project the outcomes; (6) apply evaluative criteria; (7) weigh the outcomes; and (8) make the decision

## Search for the Evidence: Methods

Evidence for this policy analysis was obtained through review of PubMed and CINAHL databases and lay literature, using 'palliative care' AND 'workforce' AND 'education and training' as the keywords. Most literature was identified from [gov.com](http://gov.com) and other supporting agencies of the act. A total of 22 relevant publications were found in CINAHL and 10 relevant publications were found in PubMed. Information related to education and workforce development was examined in the literature. Stakeholder analysis was conducted through in-person and phone conversations with key stakeholder.

# Evidence Behind the Policy

## Scholarly and Lay Evidence

Barriers to Workforce Training and Education	Evidence to Address Barriers
There is a misperception by clinicians that palliative care is appropriate only at the end of life	Numerous descriptions of palliative care exists, various models of care and timing of initiation of services cause increased ambiguity of the topic
A workforce shortage exists in palliative care and will continue to grow with the aging population	The current specialist palliative care workforce is older (over 50 years) and efforts must be made to increase the specialist palliative care providers
Currently, palliative care education for clinicians is not a requirement during coursework	Creating more sustainable and accessible models will allow for increased education for all clinicians
There is a limited number of trained faculty and educators to teach palliative care	Training of faculty can increase the implementation of palliative care education in formal education programs

(Berendt, Stiel, Nauck, & Ostgathe, 2017; Kamal et al., 2016; Quill & Abernathy, 2013; Ferrell et al., 2005).

## Current Recommendations and Guidelines for Support of Palliative Care

A number of American healthcare organizations support the early introduction of palliative care. However, these guidelines do not address access to care and education of palliative care.

Healthcare Organizations	Recommendations for Palliative Care
American Society of Clinical Oncology	Inpatient and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease courses, concurrent with active treatment.
American Heart Association/American Stroke Association	Provides patients with access to continuous, coordinated, comprehensive, high-quality palliative care given simultaneously with specialist level cardiovascular and stroke care
American Lung Association	Palliative care, also know as supportive care, is key in managing chronic obstructive pulmonary disease (COPD).

(Ferrel et al., 2017; American Heart Association/American Stroke Association, 2013; American Lung Association, 2018).

## Current Organizations that Support the Palliative Care and Hospice Education and Training Act

There are over 50 organizations that support the Palliative Care and Hospice Education and Training Act (American Academy of Hospice and Palliative Medicine, 2019).

## Stakeholder Input

Patient with Serious Illness	Nurse Practitioner	Family Member	Undergraduate BSN Student
"I wish I would have had this support earlier. I think I could have been able to do more before I got so down."	"I have trained myself on palliative care prior to getting my certification. We didn't have any other training during my NP education"	"I don't know how I could do this by myself. The nurse makes me feel so confident with what I am doing"	"Honestly, I don't feel ready to care for someone with a life threatening illness. I have had one class on palliative care, but don't know if I am ready to use what I learned."

# Policy Alternatives

## Decision Making Process

Two policy options are evaluated in this analysis. Option 1 is to maintain the status quo, with optional and sporadic training of clinicians, and no formal education or training on palliative care. Option 2 is an alternative, where the acceptance and passing of the Palliative Care and Hospice Education and Training Act offers equal opportunity for education and training for all clinicians. The policy options were evaluated based on evidence according to the following factors: benefits to the population of patients living with serious illness, costs of implementing the policy, equity of policy for clinicians and patients living with serious illness, feasibility of the policy, and stakeholder perspective of the policy.

## Decision criteria comparing status quo with the Palliative Care and Hospice Education and Training Act

	Option 1: Status Quo	Option 2: Palliative Care and Hospice Education and Training Act
	Palliative Care and Hospice Education is Optional in Higher Education Systems	Palliative Care and Hospice Education is Required by Higher Education Systems
Population Benefits 0: No benefit 1: Low benefit 2: High benefit	1	2

	Option 1: Status Quo	Option 2: Palliative Care and Hospice Education and Training Act
	Palliative Care and Hospice Education is Optional in Higher Education Systems	Palliative Care and Hospice Education is Required by Higher Education Systems
<b>Cost</b> 0: High additional cost 1: Minimal additional cost 2: No additional cost	1	0
<b>Equity of Education</b> 0: Inequitable 1: Questionable equity 2: Equitable to full population	0	2
<b>Feasibility</b> 0: Requires major practice change 1: Requires minor practice change 2: Requires no practice change	2	0
<b>Stakeholder Perspectives</b> 0: Unsupportive of policy 1: Indifferent to policy 2: Supportive of policy	0	2
	<b>Total Score: 4</b>	<b>Total Score: 6</b>

# Recommendations

If the status quo is maintained, clinicians will continue to have limited training on providing quality palliative care and benefits of this care will not come to fruition for millions of American patients.

Recommendation:

1. Congress must approve the Palliative Care and Hospice Education and Training Act to increase clinician education to provide quality palliative care, ultimately impacting patient care and quality of life.

# Discussion

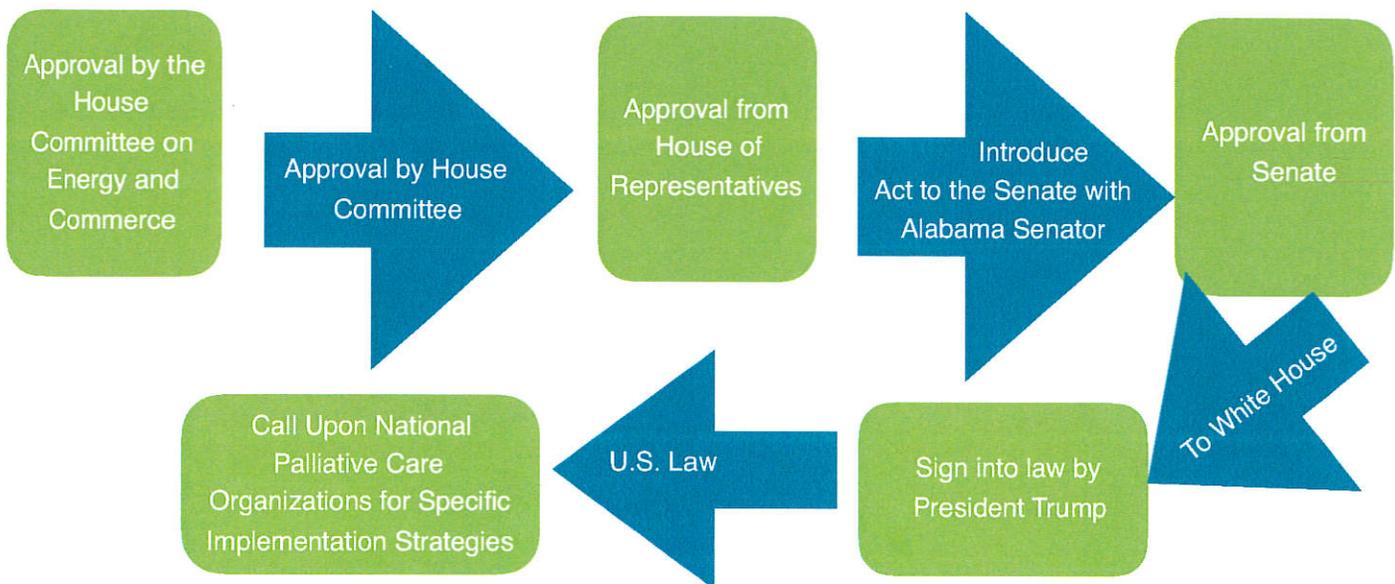
## Rationale for Support and Approval of the Palliative Care and Hospice Education and Training Act by Alabama Members of the U.S. Congress:

Based on this analysis of policies, it's easy to see that approving the Palliative Care and Hospice Education and Training Act is the superior choice to the status quo. The Palliative Care and Hospice Education and Training Act offers quality education for clinicians and supports stakeholders of all types, including patients, families, healthcare systems, and payers. Although, this policy will incur additional costs and more work, the improvement in patient outcomes and the U.S. healthcare system will be worth the money and time.

### Policy Action

**Approval of the Palliative Care and Hospice Education and Training Act will assist in preparing clinicians to care for the aging population in America. It is essential that our Alabama representatives vote YES for the PCHETA to move forward in the passing of the act into law to improve patient outcomes and offer needed family support in our U.S healthcare system.**

### Implementation Strategies



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## **Barriers to Implementation of the Palliative Care and Hospice Education and Training Act:**

As with any new change, barriers will exist with the implementation of the proposed policy. The first barrier being that there is not a Representative from Alabama on the House Committee on Energy and Commerce and not one of the seven Representatives from Alabama has sponsored this bill. In addition, there currently is not a Senator that has stepped forward to sponsor the bill in the Senate. Senators Shelby and Senator Jones need to step forward to sponsor this bill when it comes to a vote in the Senate to assist with bettering care in Alabama and the United States.

## **Methods to Evaluate Policy Implementation:**

Implementation of the Palliative Care and Hospice Education and Training Act can be evaluated by using the following Alabama metrics. These metrics will be measured prior to implementation, following implementation, and then annually thereafter by the Alabama Public Health Department.

<b>Metrics</b>	<b>Goals</b>
The number of new physician fellows in palliative and hospice care training in Alabama	By 2025, there will be a 10% increase of new physician fellows in palliative and hospice care
The number of clinicians educated at a Palliative Care and Hospice Education Center	By 2025, 10% of clinicians in Alabama will attend educational training at a Palliative Care and Hospice Education Center
The number of nursing faculty at BSN nursing programs trained in palliative and hospice care	By 2025, 50% of BSN nursing programs will report at least one faculty member trained in palliative and hospice care that is providing mandatory education to the students prior to graduation
The number of patients enrolled in palliative or hospice services	By 2021, there will be a 10% increase in the number of patients enrolled in palliative or hospice care

## **Limitations of the Analysis:**

Although this analysis considered evidence and the current landscape of palliative care, there are limitations. One limitation is that a single doctoral student with minimal policy experience completed the analysis. Secondly, during this policy analysis there was limited primary stakeholder input and may not represent the opinion of U.S. Congress policymakers.

# Conclusion

The Palliative Care and Hospice Education and Training Act supports equitable educations for clinicians in the area of palliative care and in turn offers improved quality access to care for patients living with serious, chronic illness. The United States Congress must continue to push for support and approval of this bill to assist in the improvement of access to palliative care services for all Americans. Ultimately, the global goal is for patients to have a death that honors their wishes and provides the best quality of life until the last breath is taken.

Future research should be done to determine if the policy was effective and what the impact is on patient outcomes and the use of palliative care

## Implications for Approval and Support of the Palliative Care and Hospice Education Act:

Practice:	Education:	Research:	Policy
Patients and families will receive quality care to assist in managing their serious, chronic illness	Access to education for all clinicians will be easily accessible	Research to assess improved access with increased access for clinics to palliative care education	This policy will serve as a stepping stone to assist employers to implement palliative care education policies in their organizations

### Personal Statement: Amy Beasley, DNP, RN, CCM, CHPN

I am a Alabama resident, palliative care nurse, and a nursing educator. I have worked with patients in hospice for 8 years and have witnessed the impact of access to palliative care services. In that time, I have seen patients and families struggling with balancing symptoms of serious illness with quality of life. As a nurse, we are to advocate for our patients to have quality patient-centered care that honors their wishes. However, as a nurse educator I have witnessed a gap in education on palliative and hospice care and how to care for patients with serious illness. My responsibility as a palliative care nurse and educator is to promote patient-centered care for all persons suffering from serious illness. As a nurse educator, I believe that it is important to advocate for the best education for all clinicians that will impact the life of their patients and families.



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## References

- American Academy of Hospice and Palliative Medicine. (2019). Legislative action center. Retrieved from <http://cqrcengage.com/aahpm/app/write-a-letter?0&engagementId=495587>
- American Heart Association and American Stroke Association. (2013, September). American Heart Association/American Stroke Association principles of palliative care. Retrieved from [https://www.heart.org/idc/groups/ahaec-public/@wcm/@adv/documents/downloadable/ucm\\_467599.pdf](https://www.heart.org/idc/groups/ahaec-public/@wcm/@adv/documents/downloadable/ucm_467599.pdf)
- American Lung Association. (2018, March). Palliative care and COPD. Retrieved from <https://www.lung.org/lung-health-and-diseases/lung-disease-lookup/copd/diagnosing-and-treating/palliative-care-and-copd.html>
- Bakitas, M., Lyons, K. D., Hegel, M. T., Balan, S., Brokaw, F. C., Seville, J.,...Ahles, T. A. (2009). The Project ENABLE II randomized controlled trial to improve palliative care for patients with advanced cancer. *Journal of the American Medical Association*, *302*(17), 741-749. doi: 10.1001/jama.2009.1198
- Berendt, J., Stiel, S., Nauck, F., & Ostgathe, C. (2017). Early palliative care: Current status of integration within German comprehensive cancer centers. *Supportive Care in Cancer*, *25*(8), 2577-2580. doi:10.1007/s00520-017-3667-y
- Center to Advance Palliative Care. (2017). About palliative care. Retrieved from <https://www.capc.org/about/palliative-care/>
- Center to Advance Palliative Care (CAPC). (2015). 2015 state by state report card on access to palliative care in our nations hospitals. Retrieved from <https://reportcard.capc.org>
- Coalition to Transform Advanced Care. (2016). Advanced care planning spending and utilization

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by state. Retrieved from <https://www.thectac.org/advance-care-planning-spending-utilization-state-cy2016-doc-host/>

Collins, T. (2005). Health policy analysis: A simple tool for policy. *Public Health, 119*(3), 192-196.  
doi: 10.1016/j.puhe.2004.03.006

Dionne-Odom, J. N., Azuero, A., Lyons, K. D., Hull, J. G., Tosteson, T., Li, Z., . . . Bakitas, M. A. (2015). Benefits of early versus delayed palliative care to informal family caregivers of patients with advanced cancer: Outcomes from the ENABLE III randomized controlled trial. *Journal of Clinical Oncology, 33*(13), 1446-1452. doi:10.1200/jco.2014.58.7824

Ferrell, B. R., Virani, R., Grant, M., Rhome, A., Malloy, P., Bednash, G., & Grimm, M. (2005). Evaluation of the end-of-life nursing education consortium undergraduate faculty training program. *Journal of Palliative Medicine, 8*(1), 107-114.

Ferrell, B. R., Temel, J. S., Temin, S., Alesi, E. R., Balboni, T. A., Basch, E. M., . . . Smith, T. J. (2017). Integration of palliative care into standard oncology care. *Journal of Clinical Oncology, 35*(1), 96-112/ doi: 10.1200/JCO.2016.70.1474

Fulmer, T., Escobedo, M., Berman, A., Koren, M. J., Hernandez, S., & Hult, A. (2018). Physicians' views on advance care planning and end-of-life care conversations. *Journal of the American Geriatrics Society, 66*(6), 1201-1205.  
doi: 10.1111/jgs.15374

Institute of Medicine. (2015). *Dying in America: Improving quality and honoring individual preferences near end of life*. Washington, DC: National Academies Press.

Kamal, A. F., Bull, J., Wolf, S., Samsa, G.P., Swetz, K. M., Myers, E. R., Shanaflet, T. D., & Abernathy, A. P. (2016). Characterizing the hospice and palliative care workforce in the US:

- 
- Clinician demographics and professional responsibilities. *Journal of Pain and Symptom Management*, 51(3), 597-603. doi: 10.1016/j.jpainsynman,2015.10.016
- Lochner, K. A. & Shoff, C. M. (2015). County level variation in prevalence of multiple chronic conditions among medicare beneficiaries, 2012. *Prevalence of Chronic Illness*, 12. doi: 10.5888/pcd12.140442
- Medicare Learning Network. (2018). Advance care planning. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf>
- Patient Quality of Life Coalition. (2019). Palliative care at-a-glance. Retrieved from [http://patientqualityoflife.org/wp-content/uploads/2019/02/Palliative-Care-At-A-Glance\\_April2018.pdf](http://patientqualityoflife.org/wp-content/uploads/2019/02/Palliative-Care-At-A-Glance_April2018.pdf)
- Quill, T. E. & Abernathy, A. P. (2013). Generalist plus specialist palliative care-creating a more sustainable model. *New England Journal of Medicine*, 368, 1173-1175  
doi: 10.1056/HEJMp1215620
- Smith, S., Brick, A., O'Hara, S., & Normand, C. (2014). Evidence on the cost and cost-effectiveness of palliative care: A literature review. *Palliative Medicine*, 28(2), 130-150.  
doi: 10.1177/0269216313493466
- Temel, J. S., Greer, J. A., Muzikansky, A., Gallagher, E. R., Admane, S., Jackson, V. A., . . . Lynch, T. J. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*, 363(8), 733-742. doi:10.1056/NEJMoa1000678
- Weiner, J. (2005). Health policy analysis checklist. Retrieved from [http://ocw.jhsph.edu/courses/IntroHealthPolicy/PDFs/Bardach\\_Outline\\_IHP\\_7b.pdf](http://ocw.jhsph.edu/courses/IntroHealthPolicy/PDFs/Bardach_Outline_IHP_7b.pdf)

---

World Health Organization. (2018a). Palliative care. Retrieved from

<https://www.who.int/news-room/fact-sheets/detail/palliative-care>

World Health Organization. (2018b). Why palliative care is an essential function of primary

healthcare. Retrieved from [https://www.who.int/docs/default-source/primary-health-care-conference/palliative.pdf?sfvrsn=ecab9b11\\_2](https://www.who.int/docs/default-source/primary-health-care-conference/palliative.pdf?sfvrsn=ecab9b11_2)

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