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in this issue

The Journal

Pain Management

Celebrating Social Work Month Sharing Responsibility for Pain & Symptom Management



Terry Altilio MSW, LCSW, ACSW
Social Work Coordinator
Department of Pain Medicine &
Palliative Care
Beth Israel Medical Center
New York, New York 10003
212-844-1467
taltilio@chpnet.org

Terry Altilio LCSW is Coordinator of Social Work for the Department of Pain Medicine and Palliative Care at Beth Israel Medical Center. She is a recipient of a Mayday Pain and Society Fellowship Award 2006 and a Social Work Leadership Award from the Open Society Institute's Project on Death in America which supported a social work post graduate fellowship and a social work listserv, both of which are continuing programs. In 2003, she received the Social Worker of the Year award from the Association of Oncology Social Work and a Professional Volunteer Recognition Award from the American Cancer Society. In 2009 she was elected to the National Academies of Practice.

Terry Altilio, MSW, LCSW, ACSW and Mary Raymer, LMSW, ACSW, DPNAP are the presenters for the SW End-of-Life Education Project. This 2 day SW intensive is designed to create an effective end-of-life care continuing education curriculum for social workers, improve the knowledge and skill level of SW working with end-of-life care, palliative care and bereavement/grief issues in their practice settings and promote sound critical thinking in SW practice at the end of life. The SW End-of-Life Education Project conference was held in Tupelo, MS in September, 2010 and in Baton Rouge in January, 2011. Due to the success and demand of this program, LMHPCO will be offering this program in Jackson, MS on October 20-21, 2011.

Social Work has long professed a unique commitment to the vulnerable, oppressed & underserved. Social justice as an ethical principle permeates the history of the profession. While some may weave the concept of social justice into a political frame and lead us to discussions about such controversial topics as universal health care, most would agree that persons living with life-threatening illness and those coming to the end of life need to be served by clinicians with a universal commitment to the relief of suffering. Just as suffering is not limited to situations of pain and symptoms, the concept of justice and caring for those who suffer is not the unique province of social work. It is a shared value among those who chose to work with the sick and those who are dying. Yet in many settings team members have not been invited to consider how social work's commitment to justice and to serving those who suffer extends into the realm of pain and symptoms. This article is intended to suggest that the role of social workers in this aspect of care is multi-dimensional and mandated consequent to their shared ethical commitment to social justice and competence.

Setting a Context

Pain and symptoms in life-limiting illness often lead clinicians from the physical domain to the psychological, cognitive, social and spiritual aspects of human experience. In the 1960's, Dame Cicely Saunders, who is deemed to be the founder of the hospice movement and held degrees in nursing, social work and medicine, coined the term "total pain" to capture these elements (Saunders, 1964) which continue to be at the core of services provided to patients and their families.

As one practices in the world of palliative and hospice care, this construct takes shape in the experiences we have with patients, families and caregivers. We hear pain and symptoms such as shortness of breath tied to spiritual concepts such as redemption, punishment or abandonment by God. Psychological, cognitive and social impacts are reflected in expressions of distress that come from the belief that unrelieved pain not only causes suffering to family members but infuses the grief and bereavement of family members who are flooded with the memories of unrelieved symptoms. The management of pain and symptoms is often infused with myths and misunderstanding and some worry that the use of opioids to treat pain or shortness of breath is actually intended to hasten death. These worries may be more or less



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next month: Palliative Care



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Magnolia Regional Health Center & Hospice
2034 East Shiloh Road • Corinth, MS 38834
Phone: 662-293-1405 • 800-843-7553
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LOUISIANA AT LARGE MEMBERS

Larry Durante, St. Joseph Hospice and Palliative Care, LLC
824 Elmwood Park Boulevard, Suite 155
New Orleans, LA 70123
Phone: 504-734-0140 • Toll-Free: 866-734-0140
Fax: 504-734-0320 • ldurante@tulane.edu



Kathleen Guidry

Louisiana Hospice & Palliative Care Jennings
422 Kade Dr. Ste. 4 • Jennings, LA 70546
Phone: 337-616-3482 • Fax: 337-616-9399
E-mail: kathleen.guidry@lhcggroup.com



Sherrill Phelps, Christus Cabrini Hospice

4801 Jackson Street Extension, Suite B
Alexandria, LA 71302
(318) 448-6764 • (318) 449-2568
sherrill.phelps@christushealth.org



MISSISSIPPI AT LARGE MEMBERS

Mike Davis

Odyssey Healthcare of Jackson
5 Old River Place, Suite 200 • Jackson, MS 39202-3449
Phone: 601-973-3550 • Toll Free: 866-973-3550
Fax: 601-973-3551 • mdavis@odyshealth.com



Melita Miller, RN, Forrest General Hospital

1414 South 28th Avenue • Hattiesburg, MS 39402
Tel (601) 288-2421 • Fax (601) 288-2401
(800) 844-4663 • mamiller@forrestgeneral.com



Cindy Clark Van Woert

Delta Regional Medical Center Hospice
300 South Washington Avenue / PO Box 5247
Greenville, MS 38704-5247
Phone: 662-725-1200 • Toll-Free: 888-516-9229
Fax: 662-725-2309 • cvanwoert@deltaregional.com



Executive Director, Jamey Boudreaux

717 Kerlerec • New Orleans, LA 70116
Phone: 504-945-2414 • Toll-Free: 888-546-1500
Fax: 504-948-3908
E-mail: jboudreaux@LMHPCO.org

Education Director, Nancy Dunn

P.O. Box 1999 • Batesville, MS 38606
Phone: 662-934-0860 • Fax: 504-948-3908
E-mail: Nancy@LMHPCO.org



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Glenn Noya with questions, comments and submissions at
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prevalent often infused by cultural, socioeconomic or ethnic influences. These are but a small sampling of variables that inform pain and symptom management. The complexity and the richness of this interface invite not only vigilance and action but also a shared competence to parse out aspects of the patient and family experience and thereby intervene appropriately.

Social Work

Social work has long acted as if pain and symptom management is only the province of medicine and nursing. Yet when one looks at the thoughts, emotions and beliefs that patients and families express and the impact of unrelieved pain on the lived experience of illness, on family distress and on grief and bereavement it is clear that social work intervention in this aspect of care is not a choice but a mandate. Our colleagues in nursing and medicine need to be able to count on social workers to share vigilance and identify undertreated or untreated pain, dyspnea, delirium and such. Clinical assessment of such conditions as anxiety disorder, depression, post traumatic stress add to the multidimensional assessment of pain and symptoms and insure that we create a treatment plan which is uniquely responsive to each patient and family. Social work skills in family systems can be essential to understanding why treatment plans are ignored or aborted. Rather than labeling patients and families non adherent, treatment plans can be adapted and include interventions that are responsive to the patient family dynamics that are discovered via a comprehensive and skilled assessment. For example, family members who fear that opioids will create an addiction differ from those who fear our medications may hasten death and the interventions selected will differ.

In Conclusion

Just as the work of hospice care is a shared responsibility so is the work of pain and symptom management. Social work practice principles of starting where the person is and understanding the person in an environmental context are imminently transferable to the assessment and understanding of pain. Interventions ranging from psycho-education, family counseling, anticipatory guidance, cognitive behavior approaches, relaxation and imagery are skills which social workers can integrate into their practice to complement and enhance the treatment plan created by the interdisciplinary team.

Saunders, C. (1964). Care of patients suffering from terminal illness at St. Joseph's Hospice, Hackney, London. Nursing Mirror, 14 February, vii-x.



Baton Rouge attendees enjoying the SW presentation



Mary Raymer presenting to SW

CONFERENCE KEYNOTE SPEAKER

“A View from Washington”

This presentation will highlight the many issues impacting the hospice and palliative care industry.

PRESENTATION OBJECTIVES:

- List the components of health care reform that impact the hospice industry
- List three regulatory changes that will impact how hospice care is delivered in the future
- Describe the U-shaped payment model and how MedPAC is progressing with implementation of the model
- Identify 3 critical issues that hospices will need to address to be successful in 2011 and beyond.

Dr. Schumacher has more than 30 years' experience in hospice and palliative care administration. Since 2002, he has served as the President and Chief Executive Officer of



J. Donald Schumacher, PsyD

President and CEO

National Hospice and Palliative Care Organization

The National Hospice and Palliative Care Organization (NHPCO), which is the largest nonprofit membership organization representing hospice and palliative care programs and professionals in the world. In 2003, he was appointed as the President and CEO of NHPCO's subsidiary organization, the National Hospice Foundation. He became the President of the Foundation for Hospices in Sub-Saharan Africa in 2004. He also became the President of The Hospice Advocacy Network in 2007.

face



to
face
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Check-in time for all attendees is 4:00PM. Attendees

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Heart of Hospice Nominations Being Sought

Do you know of someone who has attained repeated outstanding achievements in hospice and end-of-life care? Why not take the time to nominate them for the LMHPCO Annual Heart of Hospice Award? The Heart of Hospice Award will be presented to one LA recipient and one MS recipient on Thursday, July 28, 2011 at the lunch meeting of the LMHPCO Annual Leadership Conference in New Orleans.

Deadline for nomination is Wednesday, June 1, 2011.



Heart of Hospice Award 2011 Nomination Form

Deadline for Nomination is Wednesday, June 1, 2011

The Heart of Hospice Award recognizes an individual from each of the two states who has attained repeated outstanding achievements in hospice and end-of-life care. This award will be presented on Thursday, July 28, 2011 at the Lunch Meeting of the LMHPCO Annual Leadership Conference in New Orleans.

Information requested includes all of the following:

- Name of **Nominee**
- Hospice/Palliative Care Program Affiliation:
- Mailing Address:
City:
State:
Zip:
- Phone number:
- Fax:
- E-mail address:

Nominee's Curriculum Vitae/Resume

Narrative

Describe nominee's history and relationship to hospice/palliative care, including accomplishments and contributions to hospice/palliative care.

Reference Letters (at least 1)

- Name of **Nominator** (Your Name):
- Hospice/Palliative Care Program Affiliation:
- Mailing Address:
City:
State:
Zip:
- Phone number
- Fax:
- E-mail address:

All requested materials must be e-mailed, faxed or postmarked by June 1, 2011 to:

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Mail : LMHPCO PO Box 1999 Batesville, MS 38606

PAIN MANAGEMENT: Cost Savings Through the Administrators Eyes



Kathleen Guidry, RN, BSN
Administrator of Hospice Services
LHC Group, Louisiana Hospice
and Palliative Care of Jennings
422 Kade Drive, Suite 4
Jennings, LA 70546
Phone: 337-616-3482
Fax: 337-616-9399
kathleen.guidry@lhcgroupp.com

Looking at ways to save cost while trying to manage a patient's pain can be an administrative nightmare. Determining the best route and drug for a patient may not be the best fiscally sound for an agency with financial woes in this ever changing Hospice world. Administration can overtake sound medical judgment if a patient's cost outweighs his per diem, yet sound medical judgment can be the decisive factor in a patient's pain management if cost effectiveness is achieved through thorough assessment and sound standards of practice. High performance leads to quality care, and a patient's treatment, safety, and comfort are examples of quality measures that are geared toward the promotion of these standards.

Cost effective measures in the treatment of pain will be determined by the patient's need. The World Health Organization and most major pain societies have established an eleven step hierarchy of pain treatment. The steps range from the most conservative over-the-counter medications, such as, non-steroidal anti-inflammatory, muscle relaxants, to the least conservative analgesics, injections, implanted pumps and surgery. Categories of medications range from first line drugs such as Acetaminophen and Ibuprofen, to second line drugs such as Hydrocodone, Oxycodone, Acetaminophen with Codiene, to third line drugs such as, Morphine, MS Contin, Oxycontin,

Fentanyl, Dilaudid, Kadian, and Avinza.

Hospice patient's needs are determined first by a thorough pain assessment. A complete pain assessment is done on admission based

on procedures and protocols for pain assessment and management. The type, intensity, and frequency of pain as well as factors that exacerbate or precipitate pain is valuable information to have when assessing a patient's pain. Along with other information such as onset of pain, duration of pain, and the number of breakthrough doses of pain medication needed to control the pain, pattern of pain, ways used to reduce pain, can also help determine the right drug for the right patient. Whether or not a patient needs a long acting pain medication can also be determined through a thorough pain assessment. Gathering this admission criteria will aide in determining what will be the correct method of treatment for a patient. Decisions such as using long term pain medications, breakthrough pain medications, and bringing in other medications to control side effects and other symptoms that can add to treatment cost, needs to be determined upon initial assessment of the patient. Other information as to how the pain affects the patient's quality of life, additional symptoms associated with the pain, as well as the patient's and family's goals for pain management can assist with pain control. Anticipating a patient's needs and having medications on hand in an emergency can alleviate a patient's anxiety, pain, and symptoms, while saving time and unnecessary worry for the patient, caregiver, and nurse in route to the home.

History is of such importance when gathering information about a patient's pain. Approaching the subject of addiction and abuse also needs to be done. Narcotic drug dependency, addiction and potential for abuse are risk that can be controlled and monitored but are always a consideration when these medications are prescribed. Confronting these problems head on will lead to problem solving behavior and limit setting as well as cost saving measures by letting the caregiver know who is responsible for the medications and what behavior will and will not be tolerated. By delegating accountability to a caregiver patient care will be maintained and secured.

From an administrative point of view certain cost saving items that improve quality and promote safety should be a goal of the Hospice agency. Quality measures have been established to determine how a patient's pain goal has been met. Hospice policy and procedures reflect how pain will be treated and help determine goals of the IDG in delivery of patient care. Goals need to be measurable and should determine the outcome of patient treatment of symptoms whether it be pain, dyspnea, nausea, emotional needs, or spiritual distress. Establishing realistic goals when dealing with a patient's pain aides the Hospice's IDG in patient's outcomes. For example, by reevaluating a patient's pain forty-eight hours after admission, a hospice can determine if medication needs to be adjusted or left alone. Monitoring the effectiveness of treatment allows the hospice to better treat patient's symptoms. Establishing treatment modalities within the Hospice can lead to cost effective regimes. Avoiding waste with medications is a cost saving goal that can help treat a patient and lead to better patient outcomes, thus

providing safe efficient care that is of the highest quality. Goal setting, follow up and measuring outcomes all play a part in proving cost effectiveness and increase efficiency in patient care.

Soon reimbursement will be determined by how patient's symptoms are being addressed. Quality Reporting Programs have been established by the Centers of Medicare Services according to section 3004 of the Affordable Care Act. Hospices will be required to submit data on specific quality measures which will then determine their annual payments. By October 2012, CMS will publish the required measures that will affect payments. CMS envisions these quality measures for Hospice that is valued, meaningful, address symptom management, patient preference, and avoid adverse events. For fiscal year 2014, and each subsequent year, failure

to submit required quality data will result in a 2% reduction to the annual payment update.

So just giving a patient a pain pill or putting a patch on the patient's chest may be one way to control pain, but through the eyes of an administrator there's more to it than that. Having to take cost control measures into consideration and looking into quality outcomes may sound like big ticket items, but it when it comes to your bottom line it could be the difference between red and black. Patient care does not have to suffer because of fiscal issues. Incorporating sound practices of strong policy and procedure, thorough initial assessments, goal setting to establish realistic outcomes, and follow through to assure goals are being met and initiating changes if they are not are key components to the dynamics of

cost effective pain control and symptom management. Getting together with your IDG and communicating patient needs with administrative issues can bring positive changes within your Hospice agency, while safety and efficiency will be the overall outcome for high quality patient care.

Administrators Goals for Cost Savings:

- Policy and Procedure Development
Thorough initial assessments addressing symptoms
- Pain History
- Emergency Medications for Symptom Control
- Caregiver Accountability to avoid abuse
- Goal setting/Follow up
- Quality Outcomes/ Measurable Resolutions

Spiritual Pain and Suffering



Rebecca Pardue, RN
Forrest General Hospice Manager
RPardue@forrestgeneral.com

Modern medicine is filled and consumed by the brilliance of rescue. There is a point of when to discontinue the rescue credo of high-tech medicine and let nature take its course and to be touched by the hospice philosophy.

When the mystery of illness has been unwound and rescue is exhausted we (hospice) will be there for them as a gracious way to die. In order to accomplish this it takes the team working as a whole exploring the causes of pain referred to by C. Saundes

of Modern Hospice as "TOTAL PAIN". Total pain includes physical, spiritual and emotional kinds of suffering commonly experienced by persons with a terminal illness.

We know that physical pain can be exacerbated by non-physical causes such as fear, anxiety, grief and unresolved guilt as well as unmet spiritual needs. Spiritual suffering may manifest itself as physical pain, terminal restlessness and anxiety. Attempts to manage pain pharmacologically often fails with the larger spiritual framework is not adequately addressed and integrated into the plan of care. It is important for the hospice staff to recognize the palliative nature of religious and

spiritual practices. Often times feelings of despair and abandonment by GOD leads to physical pain and may manifest as Anger, shame, grief, fear and loss of hope.

A holistic pain assessment is essential for terminal ill patients. Spiritual growth at the end of life is possible for all regardless of beliefs. When the body is tired and functional limitation occur often this is a time when Spiritual reflection occurs resulting in spiritual growth. Facing death evokes spiritual questions opening the door for greater spiritual growth. Openness and open ended questions allows respectful solutions to spiritual dilemmas. How do we measure success in hospice care: By the effects on humanity twins --- human dignity and human spirit -- both in the family and patient.

Ketamine Use in Palliative Care



Glen Mire, MD
Medical Director,
Hospice of Acadiana
Clinical Associate Professor
LSU Family Medicine
lmire@lsuhsc.edu

Fast Facts #132
Ketamine Use in Palliative Care
Eric Pommer, MD
www.eperc.mcw.edu/fastfact/ff_212.htm

Kotlinska-Lemieszek A, Luczak J. Subanesthetic ketamine: an essential adjuvant for intractable cancer pain. *J Pain Symptom Manage* 2004; 28: 100-102.

Fine PG. Low-dose ketamine in the management of opioid nonresponsive terminal cancer pain. *J Pain Symptom Manage* 1999; 17:296-300.

In response to a request for information on ketamine, I volunteered to research this topic because I knew nothing about it. I had no idea I would put this information to use immediately!

CASE REPORT

A 27-year-old female has been on the inpatient hospice service for several weeks because of intractable abdominal-

pelvic pain caused by widespread carcinomatosis of ovarian origin. Because of a profusely-draining intestinal-cutaneous fistula, oral tablets are not absorbed. Despite receiving hydromorphone intravenously at 60 mg/hr plus lorazepam intravenously at 2 mg/hr, she continued to need several doses daily of hydromorphone 25 mg intravenously for breakthrough pain. She has also been receiving decadron 8 mg intravenously twice daily.

After reading the articles listed, I met with hospital pharmacist, anesthesiologist, and nursing staff to propose starting ketamine. The patient was started on ketamine 5 mg intravenous (0.1mg/kg) every one hour for 3 doses as a trial. This seemed to give her some relief. Because the pharmacy was not able to verify that ketamine would be compatible with hydromorphone and lorazepam in the tubing, ketamine was given orally. Pharmacy mixed parenteral ketamine in syrup to a concentration of 5 mg/mL. Dosing was adjusted, because of sedation, to 5 - 10 mg orally every 4 - 6 hours, plus 5 mg orally every 1 hour for breakthrough pain. Hydromorphone was tapered down after ketamine was started. (Some authors recommend tapering opioid at the start of ketamine use. One article reported opioids could be decreased in only 17 % of patients.) Lorazepam was also tapered down, and is being continued in order to prevent psychotomimetic side effects.

At the time of this writing, the patient is comfortable and rarely requires any medication for breakthrough pain.

My experience with one patient reflects that of cases previously reported in references.

132 Ketamine Use in Palliative Care

FAST FACTS AND CONCEPTS #132

Author(s): Eric Prommer MD

Background Ketamine is FDA approved as a parenterally administered, rapid-acting dissociative general anesthetic. However, in the past 10 years there have been numerous reports of the use of ketamine for pain control, administered via various routes. This Fast Fact reviews the use of ketamine in palliative care as an analgesic.

Mechanism of Action The N-methyl-D-aspartate/glutamate receptor (NMDA) is a calcium channel closely involved in the development of central

(dorsal horn) sensitization. This channel has a role in opioid-resistant pain, neuropathic pain, allodynia, and hyperalgesia. Ketamine enters and blocks the open channel at a phencyclidine site, thereby inhibiting the excitatory effects of glutamate and aspartate. Ketamine also interacts with nicotinic, muscarinic, and opioid receptors.

Pharmacology As an anesthetic agent ketamine is given IV or IM. However, for pain, the parenteral solution of ketamine can be delivered at much lower doses by the oral, intranasal, transdermal, rectal, and subcu-

taneous routes. Onset of analgesia is 15-30 minutes by subcutaneous or oral routes. Duration of action is 15 minutes to 2 hours when administered by the IM or subcutaneous route, possibly longer orally. Ketamine is physically stable when mixed with morphine, low-dose dexamethasone, haloperidol, and metoclopramide. Drugs that interact with CYP3A4 have the potential to affect ketamine metabolism (e.g.azole antifungals, macrolide antibiotics, HIV protease inhibitors, and cyclosporin).

Side Effects Undesirable effects of high dose ketamine used for general

anesthesia (1-2 mg/kg IV or 6.5-13 mg/kg IM) include psychotomimetic phenomena (dysphoria, blunted affect, psychomotor retardation, nightmares, hallucinations), excessive salivation, and tachycardia. Side effects at the lower doses used for pain are dose dependent, with dissociative feelings (“spaced out”), nausea, sedation, and hallucinations reported more frequently at higher doses.

Analgesic Effectiveness There is an absence of large controlled trials supporting ketamine as an analgesic for cancer or neuropathic pain, but there is a large body of case reports and uncontrolled trials. Two small randomized controlled trials reported decreased morphine use and reduced neuropathic pain intensity. However, a recent systematic review found insufficient evidence that ketamine improves the effectiveness of opioid treatment in cancer pain (1).

Titration Schedule There are no studies comparing various titration or dosing schedules, nor routes of administration. Suggested algorithms for have been proposed (see references). Depending on the clinical setting, airway monitoring and availability of resuscitation equipment may be appropriate. Note: clinicians with limited experience in using ketamine should

seek expert consultation to develop an appropriate treatment and patient monitoring plan.

Summary Low-dose ketamine (at sub-anesthetic doses) can be considered for use in the palliative care setting for pain refractory to opioids and adjuvant analgesics.

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Kotlinska-Lemieszek A, Luczak J. Subanesthetic ketamine: an essential adjuvant for intractable cancer pain. *J Pain Symptom Manage.* 2004; 28(2):100-2.

Fine PG. Low-dose ketamine in the management of opioid nonresponsive terminal cancer pain. *J Pain Symptom Manage.* 1999; 17(4):296-300.

Fisher K, Hagen NA. Analgesic effect of oral ketamine in chronic neuropathic pain of spinal origin: a case report. *J Pain Symptom Manage.* 1999; 18(1):61-6.

Fast Facts and Concepts are edited by Drew A Rosielle MD, Palliative Care Center, Medical College of Wisconsin. For more information write to: <mailto:www.drosiell@mcw.edu>.

[edu?subject=EPERC%20Fast%20Facts%20and%20Concepts%20](http://www.eperc.mcw.edu/edu?subject=EPERC%20Fast%20Facts%20and%20Concepts%20). More information, as well as the complete set of Fast Facts, are available at EPERC: <http://www.eperc.mcw.edu/>.

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ACGME Competencies: Medical Knowledge, Patient Care

Keyword(s): Pain – Non-Opioids

JOURNAL ARTICLE SUBMISSIONS

LMHPCO accepts newsworthy items of interest from its membership for publication in the Journal. Submissions should be sent to Nancy@LMHPCO.org and should be received by the 20th of the month to be included in the next month's publication.



The Leslie Lancon Memorial Education Nursing Scholarship was established in 2005 by LMHPCO. The annual scholarship will be awarded to support hospice nursing excellence and education throughout Louisiana and Mississippi. The awards will focus not only on excellence for those seeking academic degrees in hospice nursing, but also those seeking advanced certification in hospice and palliative care nursing.

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HPNA Position Statement Pain Management

BACKGROUND

Pain is a common symptom in most progressive, life-limiting illnesses. Pain is defined as “an unpleasant subjective sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.”¹ This definition underscores the multidimensional nature of pain, which has an impact on all facets of life, including the emotional and spiritual dimensions. Pain has also been defined as whatever the experiencing person says it is and existing whenever he/she says it does.²

As a major symptom for adults and children with cancer, pain has been well-documented.^{1,3-6} Approximately three fourths of people with advanced cancer experience pain.⁷ Pain is also present in many advanced illnesses including heart disease, dementia, and stroke. Prolonged bedrest, pressure ulcers, bowel obstruction, and chronic illnesses (e.g., arthritis) all contribute to pain in advanced illness. Additional factors such as anxiety, depression, and spiritual distress influence and are influenced by the experience of pain. Pain can cause profound suffering and impaired quality of life.

Unrelieved pain remains a serious health problem in the United States. Lack of knowledge by healthcare professionals, irrational fears of addiction, inadequate assessment, and a lack of access to opioids are among the more common reasons for under-treatment of pain.^{1,6}

As one of the most feared symptoms by those at the end of life, unrelieved pain can consume the attention and energy of those who are dying, and create an atmosphere of impotency and despair in their families and caregivers.^{8,9} Pain and the emotional suffering

it can create are often overwhelming for patients, families and caregivers. Unrelieved pain can contribute to unnecessary suffering, as evidenced by sleep disturbances, hopelessness, loss of control, and impaired social interactions. Pain may actually hasten death by increasing physiological stress, decreasing mobility, contributing to pneumonia and thromboemboli.¹⁰

Under-treatment of pain is more common in individuals who are unable to speak for themselves.¹ Populations that are particularly vulnerable include: infants and children, the elderly, people who speak a different language or whose cultural background differs significantly from the clinician’s, and those who are developmentally delayed, cognitively impaired, or severely, emotionally disturbed.^{1,11,12} Special efforts must be taken to ensure adequate assessment and interventions for these populations.

Pharmacologic interventions remain the first line treatment for unrelieved pain. Opioids are needed when pain does not respond to non-opioids alone. Analgesic guidelines are available through several organizations such as the American Pain Society,¹ American Geriatrics Society,¹³ and the National Comprehensive Cancer Network.¹⁴ Some clinicians, patients, and caregivers avoid opioids due to a fear of addiction. Clinicians, in particular, need to understand the difference between addiction, tolerance, and physical dependence. Fears of addiction should not prevent appropriate treatment of pain.

In addition to pharmacologic interventions, treatment should include non-pharmacological therapies as appropriate. Massage, biofeedback, distraction, music therapy, and relaxation therapy are among the nonpharmacological

approaches that have been shown to be effective in pain relief.¹⁵

“Our ability to relieve pain should be the litmus test of our value as healthcare professionals. It is the core of our contract with society and the mandate of our privilege to be nurses.”¹⁸, p. 54

POSITION STATEMENT

This is the position of HPNA Board of Directors:

- All people, including vulnerable populations such as cognitively impaired, infants, children, and the elderly, facing progressive, life-limiting illness have the right to optimal pain relief.
- All healthcare providers have the obligation to believe the patient’s report of pain.
- Pain assessment and management should incorporate principles of cultural sensitivity as well as patients’ values and beliefs.
- All healthcare professionals caring for the patients with progressive, life-threatening illness need to acquire and utilize current knowledge and skills to implement appropriate pain management.
- Healthcare organizations need to adopt policies and procedures that address the assessment, and pharmacologic and non-pharmacologic management of pain.
- Pain management should include, as appropriate, advanced technology.
- Pain assessments and management should be aligned with evidence-based practice.
- The need for regulatory control of opioids must be balanced with access to opioids for all patients who need them.
- Pain management should be part of education for all healthcare providers who are caring for patients with

- advanced, life-limiting illness.
- Healthcare professionals must advocate for their patients to ensure adequate pain relief.
- Uncontrolled pain should be considered an emergency with all healthcare professionals taking responsibility to provide relief.
- Patients have the right to participate actively in decisions about their pain management.
- Families should be supported in their efforts to observe and relieve pain when appropriate.
- Hospice and palliative care programs should share their knowledge of pain management concepts with others in their communities.
- Use of placebos for pain management is inappropriate and unethical. Definition of Terms

Addiction: a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.¹⁶

Pain: an unpleasant subjective sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.¹

Physical dependence: a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.¹⁶

Suffering: an individual and private experience characterized by a state of severe distress induced by loss of intactness of person or threat that the person believes will result in loss of his/her intactness related to physical pain, unrelieved symptoms, spiritual distress, depression, or multiple losses.¹⁷

Tolerance: a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.¹⁶

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Originally developed in 2003 by:
Linda Gorman, RN, MN, APRN, BC, OCN, CHPN®
Patricia Beach, MSN, RN, AOCN
Mary Ersek, PhD, RN
Bridget Montana, MS, APRN, MBA
Judy Bartel, MSN, APRN, BC-PCM

Revised by:
Bridget J. Montana, MS, APRN, MBA
Elizabeth Pitorak, MSN, APRN
Peg Nelson, MSN, APRN, BC-PCM
Approved by the HPNA Board of Directors April 2008

This position statement reflects the bioethics standards or best available clinical evidence at the time of writing or revisions.

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TIPS for Recognizing Behaviors Indicating the Patient Has Pain

Always ask about pain. BELIEVE THE PATIENT! Remember pain is whatever the person says it is, occurring whenever and wherever the person says it does.

People have different coping patterns and may not always appear as though they are in pain. They may deny “pain,” but use vague general terms such as ‘soreness,’ ‘hurting all over,’ or ‘aching.’ Patients may display any of the following either at rest or while being moved:

- Facial expressions such as grimacing, frowning, looking sad, and wrinkling the brow, especially those who are less alert
- Restlessness, fidgeting, moving slowly, pacing, rocking back and forth
- Moaning, groaning, or crying out
- Rubbing or protecting the place that hurts

Patients may also exhibit:

- Difficulty concentrating
- Changes in eating patterns
- Changes in usual behaviors (for example a very vocal patient becomes quiet or a very quiet patient becomes very vocal)
- Changes in activity level or resisting activity or movement
- Withdrawal from family and friends
- Sleeping most of the time; or having difficulty sleeping
- Using behaviors such as humor, conversation, watching TV, listening to music, and guided imagery to deal with the pain

Report any of the above behaviors to your supervising nurse. Also, report to the nurse if the patient is not able to do the things, or enjoy the activities they normally do, because they are experiencing pain, discomfort, or soreness.

Other HPNA TIPS Sheets are available at www.hpna.org.

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Approved by the HPNA Education Committee June 2005. Reviewed September 2009.



TIPS for Recognizing Pain

In Patients with an Inability to Communicate Verbally

Patients may not be able to speak or describe their pain in the late stages of dementia, if they have had a stroke or in the late stages of other diseases such as amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease). However, just because they cannot speak does not mean they are not experiencing pain.

Family members may be the first to notice little changes in patient's mood or behavior that may mean the patient has pain.

- Always ask the patient if there is pain or if the patient is hurting anywhere. Patients who are non-verbal or have dementia may still have the ability to answer questions by nodding or with eye movements
- Ask family members and other caregivers if they have noticed any changes in behavior that might indicate the patient is having pain

Patients may display any of the following behaviors

- Facial expressions such as grimacing, frowning, looking sad, wrinkling of the brow
- Movements such as restlessness, fidgeting, moving slowly, protecting a body part pacing, rocking back and forth
- Noisy, labored breathing
- Looking scared, worried or troubled
- Acting tense
- Wringing of hands or clenching fists
- Pulling at or touching a body part or area
- Increased confusion, restlessness or agitation
- Any change in the patient's usual behavior, for example a very talkative patient may become quiet or a very quiet patient may become very talkative.
- Moaning or groaning

Report any of the above behaviors to your supervisor

Other HPNA TIPS Sheets are available at www.hpna.org.

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Approved by the HPNA Education Committee June 2005.



PATIENT / FAMILY TEACHING SHEETS

MANAGING PAIN

What is Pain?

- It is what the individual says it is
- Hurting or discomfort
- A condition that can cause physical, emotional, spiritual distress and can contribute to financial stress
- An experience that can only be felt and described by the person with the pain
- Pain affects everyone involved
- Older adults may describe pain as aching, burning, gnawing, grabbing, being uncomfortable, soreness
- Children may express pain in different ways, such as they may sleep more, become irritable, or have other behavior changes. They may use words like oowie or boo-boo to describe pain
- Confused patients, those with a cognitive impairment, or those that cannot speak for themselves may have behavior changes such as pacing, moaning, agitation, grimacing, and furrowed brow that can indicate pain

What to Report to the Hospice/Palliative Care Team?

- How severe or intense is the pain. It can be reported as a number – using 0 as no pain and 10 as the worst possible pain imaginable. Other ways of reporting pain are also available such as, mild to severe, using different types of pictures. Ask your nurse to tell you more about these options. There are options for rating children's pain as well
- Where the pain is located
- If the pain keeps you from doing your usual activities
- What makes the pain worse
- What makes the pain better
- How well the pain medication is working
- How often you are taking pain medication

- Any side effects of the medication (common side effects include: constipation, nausea, vomiting, sleepiness, dizziness, itching)
- Concerns about the medications, how to take them or how to administer them
- If you are becoming irritable from lack of sleep because of the pain

What can be done?

The good news is that there is much you, your caregiver, and the hospice and palliative care team can do for managing pain. They will try to find the reason for the pain and discuss treatment options with you. Medications are usually necessary to relieve pain – the nurse will give you information about the medicines, when to take them and what you need to know.

- It is important to take or administer the medicines as ordered
- Many side effects can be treated and/or may even stop after taking the medication for a few days
- Other things that can make the pain better are:
 - Relaxing activities such as listening to music, light massage, soaking in a tub of warm water, or guided imagery (picturing enjoyable relaxing scenes to take one's mind off the pain)
 - Distracting activities such as watching TV, playing a game or just thinking of other things
 - Heat or cold (such as a heating pad, warm compress, or ice pack)
 - Pleasant smells of certain plants or fragrances (aromatherapy), such as, lavender, etc.
 - Story telling, drawing
 - Deep breathing
- Ask your hospice and palliative care team to teach you how to use these ways of relieving the pain.

Once medications are no longer needed your hospice and palliative care team will advise you on the proper disposal of medications.

Other HPNA Patient/Family Teaching Sheets are available at www.hpna.org.

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LMHPCO Introduction and Explanation of Congressional Maps

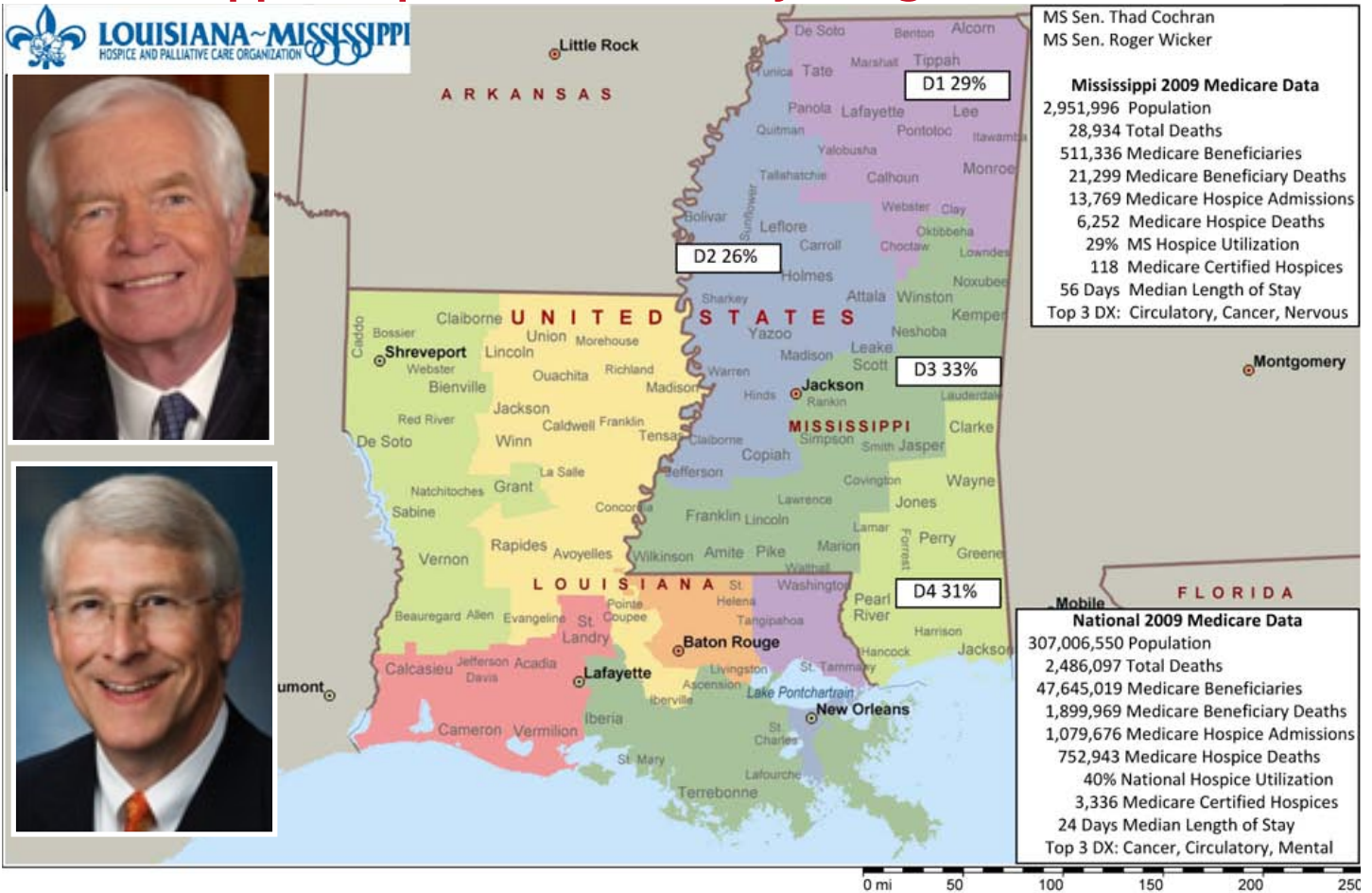


Cordt T. Kassner, PhD
Hospice Analytics, Inc.

LMHPCO is excited to announce a new research partnership with Cordt T. Kassner, PhD, principal of Hospice Analytics, Inc., in Colorado Springs, CO. Dr. Kassner presented a workshop at our Leadership Conference in July 2010, and also met with our Board of Directors during the January 2011 meeting. He will provide formal and informal consulting to LMHPCO and The Alliance for the Advancement of End-of-Life Care, and will present again at the LMHPCO Leadership Conference July 27-28, 2011.

An example of this partnership is customized Congressional District maps for Louisiana and Mississippi, included in the following pages. These maps contain Congressional District specific information (e.g., total Medicare beneficiaries and deaths; total Medicare hospice admissions and deaths; hospice utilization; number of hospices; etc.) and are ideal for educating national legislators and their staff about hospice. These maps highlight similarities and differences at the level legislators are most concerned about – their district constituents. LMHPCO plans to use these materials in conjunction with NHPCO advocacy tools on April 6, 2011, for NHPCO’s Hill Day activities during their Management & Leadership Conference.

Mississippi Hospice Utilization by Congressional Districts



Mississippi Hospice Utilization by Congressional Districts



Rep. Gregg Harper

MS District 3: 2009 Medicare Data
 791,975 Population
 8,262 Total Deaths
 137,041 Medicare Beneficiaries
 5,865 Medicare Beneficiary Deaths
 4,111 Medicare Hospice Admissions
 1,924 Medicare Hospice Deaths
 33% MS Hospice Utilization
 24 Medicare Certified Hospices
 46 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Nervous

Mississippi 2009 Medicare Data
 2,951,996 Population
 28,934 Total Deaths
 511,336 Medicare Beneficiaries
 21,299 Medicare Beneficiary Deaths
 13,769 Medicare Hospice Admissions
 6,252 Medicare Hospice Deaths
 29% MS Hospice Utilization
 118 Medicare Certified Hospices
 56 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Nervous

National 2009 Medicare Data
 307,006,550 Population
 2,486,097 Total Deaths
 47,645,019 Medicare Beneficiaries
 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental

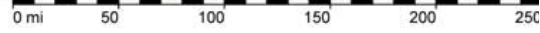


Rep. Patrick Nunnlee

MS District 1: 2009 Medicare Data
 779,891 Population
 7,509 Total Deaths
 141,418 Medicare Beneficiaries
 5,841 Medicare Beneficiary Deaths
 3,429 Medicare Hospice Admissions
 1,673 Medicare Hospice Deaths
 29% MS Hospice Utilization
 34 Medicare Certified Hospices
 50 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Nervous

Mississippi 2009 Medicare Data
 2,951,996 Population
 28,934 Total Deaths
 511,336 Medicare Beneficiaries
 21,299 Medicare Beneficiary Deaths
 13,769 Medicare Hospice Admissions
 6,252 Medicare Hospice Deaths
 29% MS Hospice Utilization
 118 Medicare Certified Hospices
 56 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Nervous

National 2009 Medicare Data
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 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental



Mississippi Hospice Utilization by Congressional Districts



TEXAS



Rep. Steven Palazzo

MS District 4: 2009 Medicare Data
 758,989 Population
 7,153 Total Deaths
 129,473 Medicare Beneficiaries
 5,182 Medicare Beneficiary Deaths
 3,163 Medicare Hospice Admissions
 1,598 Medicare Hospice Deaths
 31% MS Hospice Utilization
 25 Medicare Certified Hospices
 45 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Nervous

Mississippi 2009 Medicare Data
 2,951,996 Population
 28,934 Total Deaths
 511,336 Medicare Beneficiaries
 21,299 Medicare Beneficiary Deaths
 13,769 Medicare Hospice Admissions
 6,252 Medicare Hospice Deaths
 29% MS Hospice Utilization
 118 Medicare Certified Hospices
 56 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Nervous

National 2009 Medicare Data
 307,006,550 Population
 2,486,097 Total Deaths
 47,645,019 Medicare Beneficiaries
 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental

0 mi 50 100 150 200 250



TEXAS



Rep. Bennie Thompson

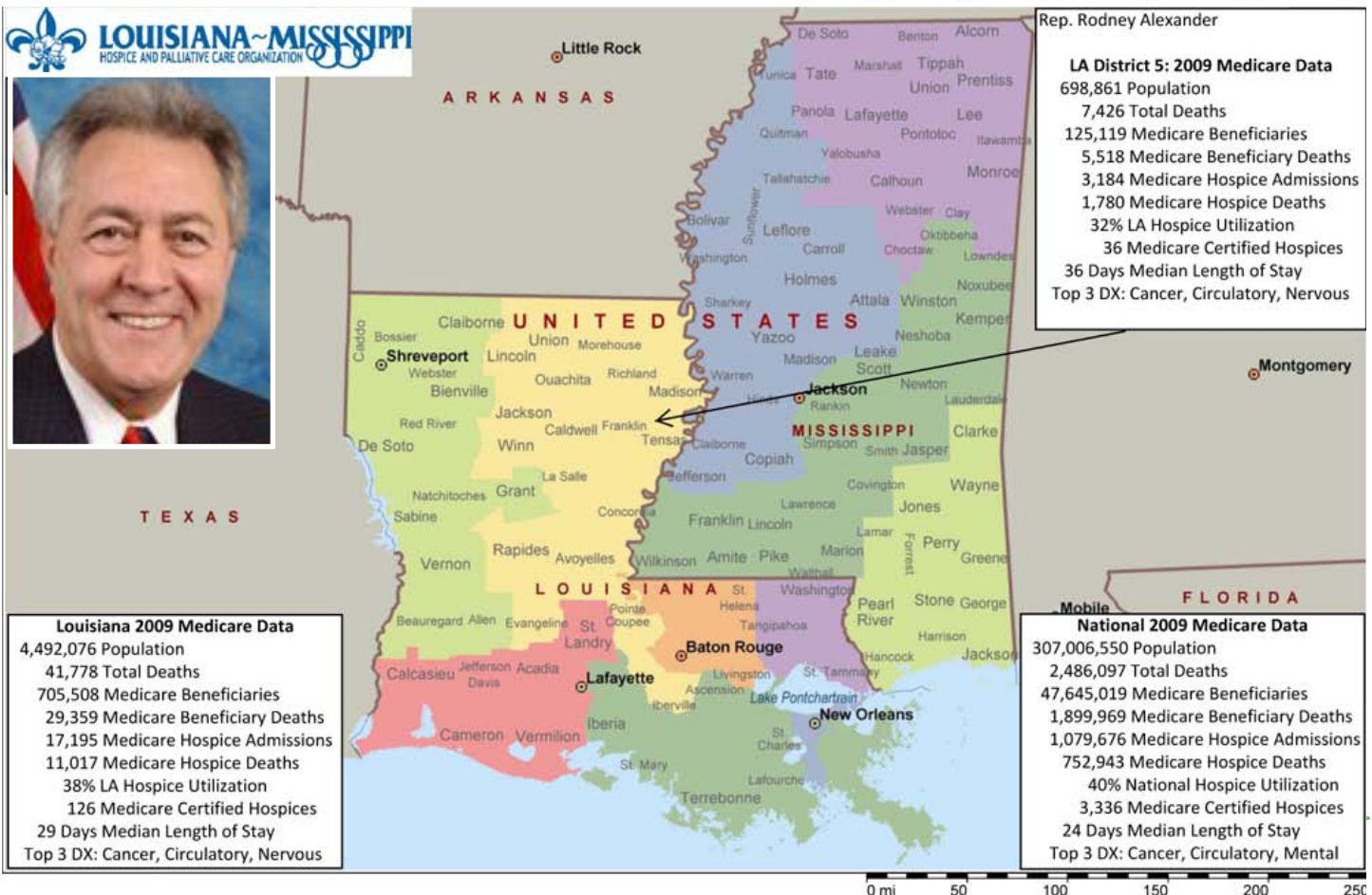
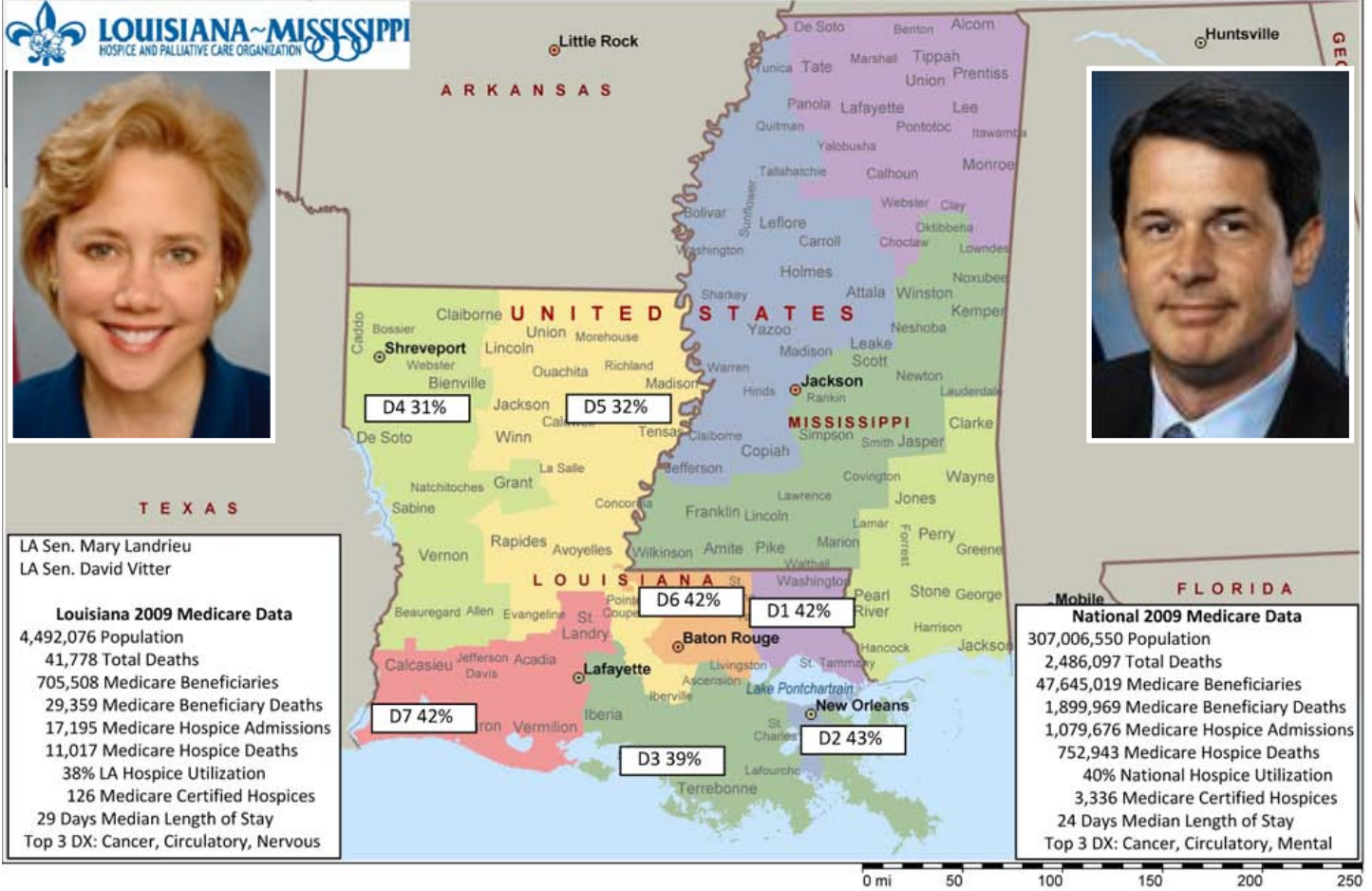
MS District 2: 2009 Medicare Data
 781,042 Population
 7,876 Total Deaths
 128,844 Medicare Beneficiaries
 5,535 Medicare Beneficiary Deaths
 3,840 Medicare Hospice Admissions
 1,462 Medicare Hospice Deaths
 26% MS Hospice Utilization
 42 Medicare Certified Hospices
 49 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Nervous

Mississippi 2009 Medicare Data
 2,951,996 Population
 28,934 Total Deaths
 511,336 Medicare Beneficiaries
 21,299 Medicare Beneficiary Deaths
 13,769 Medicare Hospice Admissions
 6,252 Medicare Hospice Deaths
 29% MS Hospice Utilization
 118 Medicare Certified Hospices
 56 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Nervous

National 2009 Medicare Data
 307,006,550 Population
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 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental

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Louisiana Hospice Utilization by Congressional Districts



Louisiana Hospice Utilization by Congressional Districts



TEXAS

Louisiana 2009 Medicare Data
 4,492,076 Population
 41,778 Total Deaths
 705,508 Medicare Beneficiaries
 29,359 Medicare Beneficiary Deaths
 17,195 Medicare Hospice Admissions
 11,017 Medicare Hospice Deaths
 38% LA Hospice Utilization
 126 Medicare Certified Hospices
 29 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous



Rep. Charles Boustany, Jr.
LA District 7: 2009 Medicare Data
 680,081 Population
 6,286 Total Deaths
 108,879 Medicare Beneficiaries
 4,688 Medicare Beneficiary Deaths
 2,801 Medicare Hospice Admissions
 1,962 Medicare Hospice Deaths
 42% LA Hospice Utilization
 17 Medicare Certified Hospices
 25 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental

National 2009 Medicare Data
 307,006,550 Population
 2,486,097 Total Deaths
 47,645,019 Medicare Beneficiaries
 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental

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TEXAS

Louisiana 2009 Medicare Data
 4,492,076 Population
 41,778 Total Deaths
 705,508 Medicare Beneficiaries
 29,359 Medicare Beneficiary Deaths
 17,195 Medicare Hospice Admissions
 11,017 Medicare Hospice Deaths
 38% LA Hospice Utilization
 126 Medicare Certified Hospices
 29 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous



Rep. William Cassidy
LA District 6: 2009 Medicare Data
 786,947 Population
 6,375 Total Deaths
 106,152 Medicare Beneficiaries
 4,366 Medicare Beneficiary Deaths
 2,877 Medicare Hospice Admissions
 1,822 Medicare Hospice Deaths
 42% LA Hospice Utilization
 22 Medicare Certified Hospices
 39 Days Median Length of Stay
 Top 3 DX: Circulatory, Cancer, Mental

National 2009 Medicare Data
 307,006,550 Population
 2,486,097 Total Deaths
 47,645,019 Medicare Beneficiaries
 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental

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Louisiana Hospice Utilization by Congressional Districts



Rep. John Fleming, Jr.

LA District 4: 2009 Medicare Data
 662,733 Population
 6,480 Total Deaths
 112,582 Medicare Beneficiaries
 4,726 Medicare Beneficiary Deaths
 2,488 Medicare Hospice Admissions
 1,453 Medicare Hospice Deaths
 31% LA Hospice Utilization
 19 Medicare Certified Hospices
 42 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Ill-defined

Louisiana 2009 Medicare Data
 4,492,076 Population
 41,778 Total Deaths
 705,508 Medicare Beneficiaries
 29,359 Medicare Beneficiary Deaths
 17,195 Medicare Hospice Admissions
 11,017 Medicare Hospice Deaths
 38% LA Hospice Utilization
 126 Medicare Certified Hospices
 29 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous

National 2009 Medicare Data
 307,006,550 Population
 2,486,097 Total Deaths
 47,645,019 Medicare Beneficiaries
 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental



Rep. Jeff Landry

LA District 3: 2009 Medicare Data
 1,133,492 Population
 9,985 Total Deaths
 174,174 Medicare Beneficiaries
 7,043 Medicare Beneficiary Deaths
 4,066 Medicare Hospice Admissions
 2,741 Medicare Hospice Deaths
 39% LA Hospice Utilization
 20 Medicare Certified Hospices
 25 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous

Louisiana 2009 Medicare Data
 4,492,076 Population
 41,778 Total Deaths
 705,508 Medicare Beneficiaries
 29,359 Medicare Beneficiary Deaths
 17,195 Medicare Hospice Admissions
 11,017 Medicare Hospice Deaths
 38% LA Hospice Utilization
 126 Medicare Certified Hospices
 29 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous

National 2009 Medicare Data
 307,006,550 Population
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 47,645,019 Medicare Beneficiaries
 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental



Louisiana Hospice Utilization by Congressional Districts



TEXAS

Louisiana 2009 Medicare Data
 4,492,076 Population
 41,778 Total Deaths
 705,508 Medicare Beneficiaries
 29,359 Medicare Beneficiary Deaths
 17,195 Medicare Hospice Admissions
 11,017 Medicare Hospice Deaths
 38% LA Hospice Utilization
 126 Medicare Certified Hospices
 29 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous



Rep. Cedric Richmond

LA District 2: 2009 Medicare Data
 198,192 Population
 7,770 Total Deaths
 118,758 Medicare Beneficiaries
 4,568 Medicare Beneficiary Deaths
 2,751 Medicare Hospice Admissions
 1,948 Medicare Hospice Deaths
 43% LA Hospice Utilization
 16 Medicare Certified Hospices
 20 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous

National 2009 Medicare Data
 307,006,550 Population
 2,486,097 Total Deaths
 47,645,019 Medicare Beneficiaries
 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
 752,943 Medicare Hospice Deaths
 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental

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TEXAS

Louisiana 2009 Medicare Data
 4,492,076 Population
 41,778 Total Deaths
 705,508 Medicare Beneficiaries
 29,359 Medicare Beneficiary Deaths
 17,195 Medicare Hospice Admissions
 11,017 Medicare Hospice Deaths
 38% LA Hospice Utilization
 126 Medicare Certified Hospices
 29 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous



Rep. Stephen Scalise

LA District 1: 2009 Medicare Data
 395,852 Population
 3,631 Total Deaths
 64,711 Medicare Beneficiaries
 2,716 Medicare Beneficiary Deaths
 1,711 Medicare Hospice Admissions
 1,153 Medicare Hospice Deaths
 42% LA Hospice Utilization
 14 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Nervous

National 2009 Medicare Data
 307,006,550 Population
 2,486,097 Total Deaths
 47,645,019 Medicare Beneficiaries
 1,899,969 Medicare Beneficiary Deaths
 1,079,676 Medicare Hospice Admissions
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 40% National Hospice Utilization
 3,336 Medicare Certified Hospices
 24 Days Median Length of Stay
 Top 3 DX: Cancer, Circulatory, Mental

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70 Minutes
1.1 contact hours /Continuing Nursing Education/
Social Work Clock Hours/ Counseling Clock Hours

ELNEC Core Curriculum

Pain Management in Palliative Care (819)
68 Minutes
1.1 Contact Hours / Continuing Nursing Education /
Social Work Clock Hours

ELNEC – For Veterans Curriculum

Module 2 Pain Management (1533) 67 minutes
1.1 contact hours/Continuing Nursing Education/
Social Work Clock Hours/Continuing Education
Clock Hours

ELNEC Pediatric Curriculum

Pain Management (1308) 90 Minutes
1.5 contact hrs / Continuing Nursing Education /
Social Work clock hrs / Continuing Education clock
hrs

ELNEC Geriatric Curriculum

Module 2 - Pain Assessment and Management
(1333) 73 minutes
1.2 contact hours/Continuing Nursing Education/
Social Work Clock Hours/Continuing Education
Clock Hours

Advanced Symptom Management (1198)

66 minutes
1.1 contact hours / Continuing Nursing Education

See explanations and course objectives for each course below.

JCAHO: Going beyond Medicare Certification to Joint Commission Accreditation (817)

80 minutes
1.2 contact hours / Continuing Nursing Education

Lorna Hearn,
RN, BSN, MS, CLNC

Description:

Joint Commission accreditation challenges an organization to establish systems and processes that create an organizational environment in which state-of-the art hospice care can be provided. This presentation will provide an overview of Joint Commission's focus and efforts to enhance patient safety, quality of care, and performance improvement.

Pain Management in Hospice: 3-Part Series

Gail Gazelle, MD, FACP, FAAHPM
Assistant Clinical Professor, Harvard Medical School
Part 1 (544) 55 minutes
0.9 contact hours / Continuing Nursing Education

Description:

This three part series on pain management in hospice and palliative care is especially useful for physicians and advanced practice nurses. Part 1 provides an overview of the principles of pain management that includes information on the use of the WHO Pain Ladder, distinguishing between nociceptive and neuropathic pain, and the definition of addiction and how it differs from physical dependence.

Objectives:

Learner will be able to distinguish between nociceptive and neuropathic pain.
Learner will be able to utilize the World Health Organization's (WHO) Pain Ladder in managing pain.
Learner will be able to define addiction and differentiate from physical dependence.

Part 2 (546) 43 minutes

0.7 contact hour/ Continuing Nursing Education
Part 2 of this three part series provides the viewer a comprehensive overview of the use of opioid administration and delivery routes. Dr. Gazelle presents the pharmacological differences between the various strong opioids including and discusses common opioid side effects that patients may experience and their management.

Objectives:

Learner will be able to describe principles of opioid administration and delivery routes.
Learner will be able to describe the pharmacologic differences between the various strong opioids.
Learner will be able to list at least two common

opioid side effects and their management.

Part 3 Case Studies (547) 57 minutes

0.9 contact hour / Continuing Nursing Education
Dr. Gazelle completes her three part series with a comprehensive overview of opioid conversion including a discussion of the complexity of methadone conversion. She presents the reasons for converting from one opioid to another and walks the viewer through the process of opioid conversion using hospice specific case studies.

Objectives:

Learner will be able to describe reasons for converting from one opioid to another.
Learner will be able to convert from one opioid to another.
Learner will begin to appreciate complexity of converting from a traditional opioid to methadone.

Principles of Pain & Symptom Management (198)

70 Minutes
1.1 contact hours /Continuing Nursing Education/
Social Work Clock Hours/ Counseling Clock Hours

Rita Wells,
RN, MSN, CLNC

Seasons Hospice

Description:

All hospice team members and volunteers need a basic understanding of pain management principles. The program reviews the different types of pain; barriers to effective pain management; techniques for effective pain control; and the use of adjuvant therapies in managing pain at the end of life.

Objectives:

Participant will name and describe three (3) different types of pain
Participant will identify four (4) barriers to effective pain control
Participant will explain two (2) principles of effective pain control
Participant will describe and/or demonstrate four (4) key components for pain assessment
Participant will define and name two (2) Adjuvant therapies and their use in pain management

ELNEC Curricula

Judith Paice
RN, MN, OCN
Core Curriculum
Pain Management in Palliative Care (819)



hospice education network, inc.

Brought to you by Weatherbee Resources

68 Minutes
1.1 Contact Hours / Continuing Nursing Education /
Social Work Clock Hours

Description:

This presentation reviews basic principles of pain assessment and management with a focus on pain at the end of life. Comprehensive pain assessment is essential to adequate pain relief. Yet there are many barriers that impede pain assessment and treatment. It is vital that nurses work collaboratively with the patient, their family and the interdisciplinary team toward optimum use of drug and non-drug interventions. Treatment of pain at the end of life also includes attention to suffering.

Objectives:

- Identify barriers to adequate pain relief at the end of life for patients across the life span
- List components of a thorough pain assessment
- Describe pharmacological and nonpharmacological therapies used to relieve pain
- Discuss the role of the nurse involved with pain assessment and management at the end of life

Veterans Curriculum

Module 2 Pain Management (1533) 67 minutes
1.1 contact hours/Continuing Nursing Education/
Social Work Clock Hours/Continuing Education
Clock Hours

Description:

This module reviews basic principles of pain assessment and management with a focus on pain at the end of life.

Objectives:

- Identify barriers to adequate pain relief at the end of life for Veterans across the life span and to improve pain through VHA programs.
- List components of a thorough pain assessment.
- Describe pharmacological and nonpharmacological therapies used to relieve pain.

Discuss the role of the nurse involved with pain assessment and management at the end of life.

ELNEC PPC: Pain Management (1308) 90 Minutes
1.5 contact hrs / Continuing Nursing Education /
Social Work clock hrs / Continuing Education clock
hrs

Joetta Wallace
RN, MSN, FNPC

Description:

This module reviews basic principles of pain assessment and management in infants, children, and adolescents with a focus on pain in palliative care.

Objectives:

- Identify barriers to adequate pain relief in palliative care.
- List components of a thorough pain assessment.
- Describe pharmacological and non-pharmacological therapies used to relieve pain.

ELNEC Geriatric Palliative Care: Module 2 - Pain Assessment and Management (1333) 73 minutes
1.2 contact hours/Continuing Nursing Education/
Social Work Clock Hours/Continuing Education
Clock Hours

Carol Long, PhD, RN, FPCN

Description:

This module reviews basic principles of pain assessment and management in the older adult with a focus on pain at the end of life. Comprehensive pain assessment is essential to adequate pain relief in the elderly. There are many barriers impeding pain assessment and treatment in the older adult. Nurses should work collaboratively with the older adult, their family and interdisciplinary colleagues toward best use of drug and non-drug interventions. Treatment of pain at

the end of life also includes attention to suffering.

Objectives:

- List components of a thorough pain assessment geared towards geriatric patients and residents of nursing homes.
- Identify barriers to adequate pain relief at the end of life for the older adult.
- Describe pharmacological and non-pharmacological therapies used to relieve pain.
- Discuss the roles of the nurse and nursing assistants involved with pain assessment and management for older adults at the end of life.

Advanced Symptom Management (1198)

66 minutes

1.1 contact hours / Continuing Nursing Education
Janet Bull, MD

Description:

Advanced symptom management is necessary to provide the best in end of life care. In this presentation we will discuss the role cytokines and the different symptom clusters that have been identified. We will discuss treatment options of both clusters and individual symptoms based on the evidence in the literature. A framework of addressing treatment of symptoms based on their etiology will be explored, as opposed to a shotgun approach. Symptoms including fatigue, anorexia, nausea and vomiting, constipation, dyspnea, delirium, and terminal restlessness will be covered. Bowel obstruction and spinal cord compression will also be discussed.

Objectives:

- Participant will define symptom clusters and the role of cytokines
- Participant will identify different clusters and treatment options
- Participant will describe individual symptoms and management based on evidence

LMHPCO Calendar Events of Interest (www.LMHPCO.org)

MARCH

March 24, 2011

Hospice Aide Training
Shreveport, LA

Details and Registration available at:
<http://tinyurl.com/4n3mktf>

APRIL

April 7-9, 2011

NHPCO 26th Management and
Leadership Conference
Gaylord National Resort and
Convention Center
National Harbor, Maryland (A suburb
of Washington, DC)
www.nhpc.org

April 11, 2011

Education Committee Conference Call
10:15-11:15 am

April 12, 2011

601 Area Code Meeting
Location TBD

April 13, 2011

662 Delta Area Code Meeting
Sherman's Restaurant
1400 S. Main Street
Greenville, MS

April 13, 2011

225 Area Code Meeting
Drusilla's Seafood Restaurant
3482 Drusilla Lane
Baton Rouge, LA 70809

April 14-15, 2011

LMHPCO Board of Directors Meeting
Natchez, MS

April 19, 2011

504/985 Area Code Meeting
Location TBD

April 19, 2011

Hospice Aide Training
Natchitoches, LA
Details and Registration available at:
<http://tinyurl.com/4mv3tp2>

April 20, 2011

318 Alexandria Area Code Meeting
Cajun Landing at Best Western Hotel
2720 North Mac Arthur Drive
Alexandria, LA

April 26, 2011

318 Shreveport Area Code Meeting
Zocolo's
436 Ashley Ridge Blvd.
Shreveport, LA 71106

April 27, 2011

337 Lafayette Area Code Meeting
Location TBD

April 28, 2011

Area Code 337 Lake Charles Area
Code Meeting
Location TBD

April 28, 2011

Area Code 662 North Area Code
Meeting
Location TBD

April 29, 2011

Area Code 228 Meeting
Location TBD

JULY

July 27-29, 2011

LMHPCO Annual Leadership
Conference
Loews New Orleans Hotel

OCTOBER

October 20-21, 2011

SW End-of-Life Education Project
Jackson, MS
Location TBD

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 At Home Hospice Care, Fayette, MS
 Christus Hospice & Palliative Care – St Frances Cabrini, Alexandria, LA
 Circle of Life Hospice, Inc, Shreveport, LA
 Clarity Hospice of Baton Rouge, LA
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 Community Hospice, Inc, Batesville, MS
 Community Hospice, Inc, Hattiesburg, MS
 Community Hospice, Inc, Verona, MS
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 Deaconess Hospice, Hattiesburg, MS
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 Generations Hospice Service Corporation, Denham Springs, LA
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 Harmony Life Hospice, Shreveport, LA
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