THE ARIZONA GWEP MONTHLY NEWSLETTER

NOVEMBER 2026



ABOUT

The mission of the Arizona Geriatrics Workforce Enhancement Program (AZ-GWEP) is to provide the best possible care through an interprofessional approach to individual, system, community and population level education, training and models of care innovations.

The AZ-GWEP Newsletter is an important forum to share AZ-GWEP activities and highlight your valuable work. Please use this form by the 10th of each month to be featured in the next issue:

SUBMIT INFO FOR OUR NEXT ISSUE



November is National Hospice and Palliative Care Month, a time to recognize the clinicians, caregivers, volunteers, and families who make sure people facing serious illness are cared for with dignity, comfort, and respect. The AZ-GWEP is committed to preparing health professionals across Arizona to start these conversations early, coordinate care across settings, and meet patients where they are. This month, we invite you to explore the resources, trainings, and stories in this issue, and to take one step toward bringing palliative principles into your own practice.

Turn to Page 4 to view an infographic dispelling **Four Myths About Palliative and Hospice Care** from the National Institute on Aging. On Page 5, you'll find an Elder Care Interprofessional Provider Sheet on **Palliative Care vs. Hospice Care** This provider sheet, along with others, is available to download on the Arizona Center on Aging website.

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PARTNER SPOTLIGHT

MEET COLLEEN FROM THE AZ-GWEP LEAD TEAM



Dr. Christmas graduated from the University of Connecticut School of Medicine and completed her internal medicine residency training at the Medical College of Virginia before embarking on a 3-year fellowship in geriatric medicine at Johns Hopkins School of Medicine. She then joined the faculty at Hopkins, focusing on clinical education, leadership development, and the care of older adults in primary care settings. At Hopkins, she was the internal medicine residency director at the Hopkins Bayview IM program for 9 years, then developed and ran a primary care track for the medical school for a decade. After nearly 30 years at Johns Hopkins, in the summer of 2026, she moved to Tucson to join the division at U of A where she hopes to continue to teach and work towards improving the care of older adults. Dr. Christmas has also been committed to physician advocacy as a means to better care for our people, our communities, and each other. She served as the Governor for the Maryland Chapter of the American College of Physicians for 4 years and is current the Chair of the Board of Governors for that organization.

Dr. Christmas lives with her husband in Tucson and both are obsessed with their older dog, Bubba, who brings wisdom, joy, and love to every day. In addition, she is the proud parent of 2 adult children. In addition to her passion for teaching and clinical medicine, she loves to exercise, get outdoors, and cook for anyone who is willing to consume.

MARK YOUR CALENDARS

ADVANCES IN AGING LECTURE SERIES

November 9th
12 - 1 pm (MST)

LATE - Limbic-predominant Age-related TDP-43 Encephalopathy
April Ehrlich MD, MHS

VIEW PRESENTATION

View archived presentations here

Download the event flyer below.



Connect with our AZ-GWEP community on LinkedIn

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Dementia Friends Champion Training

Does the Dementia Friends philosophy speak to you? Are you interested in being trained to facilitate sessions in your networks or the broader community? **NEXT TRAINING: DECEMBER 10TH @10-11:30 AM MST**

Register

Join the GWEP-CC Online Community

GWEPOnline is the central hub for the GWEP-CC Age-Friendly Health Systems Continuous Action Community and for all GWEP directors, team members, and partners.

Members will have access to resources such as the American Geriatrics Society Age-Friendly Resource Library, GWEP CC Newsletter, GWEP-CC Coaching Calls (slides and recordings), Community Catalyst's 4Ms Consumer Tools, GWEP- CC Age-Friendly Health Systems Case Studies, and much more. Coaching Call slides are available under Tools and Resources on the GWEP Online Community site (see below on how to register).

NEXT CALL: DECEMBER 10TH AT 12:00 PM MST

If you would like to join the GWEP Online Community (login required) **please contact Lisa O'Neill at loneill@arizona.edu** who will submit your name for account creation.



Register

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Myths About Palliative and Hospice Care

Palliative care

Focuses on improving quality of life for people with serious illnesses and their care partners.



Myth: When I begin palliative care, I can no longer receive treatment for my disease.

Fact: Palliative care can be provided along with curative treatment.



Myth: I can no longer see my primary doctor when I start palliative care.

Fact: Palliative care teams work with primary doctors.

Hospice care

Focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life.



Myth: In hospice care, I can't receive any treatments.

Fact: People may receive medications to help manage symptoms but not treatments to help cure their illness.



Myth: Hospice care is only provided in a hospital or hospice facility.

Fact: It can be provided at home, in a hospital or nursing home, or in a separate hospice center.

Learn more about palliative and hospice care at: **www.nia.nih.gov/palliative-hospice-care**.

NIH National Institute on Aging

YOU MAY ALSO BE INTERESTED IN:

- READING MORE ABOUT PALLIATIVE AND HOSPICE CARE
- LEARNING ABOUT DIFFERENT CARE SETTINGS AT THE END-OF-LIFE

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THE UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE TUCSON
Center on Aging
www.aging.arizona.edu

June 2023

ELDER CARE

A Resource for Interprofessional Providers

Differentiating Palliative Care and Hospice Care

Qi T Yu, DO, Loma Linda University Health
Paul E Stander, MD, MBA, FACP, Banner University Medical Center, University of Arizona, Phoenix

It is not uncommon for patients and clinicians alike to equate hospice care and palliative care, believing they are the same thing. While both modes of care are designed to maximize a patient's quality of life and functional status by focusing on symptom relief and patient comfort, the two modes of care are different.

What's the Difference?

Hospice care is a type of bundled care, which is prognosis-dependent, provided to patients with a life expectancy of six months or less and who are no longer receiving any active or curative treatment of their underlying life-limiting illness. Palliative care, on the other hand, is prognosis-independent. While provided to patients with serious illnesses, the care is provided in conjunction with active therapies that may have curative or disease-modifying intent. See Table.

Why Does It Matter?

Lack of understanding of the difference between the two forms of care (i.e., a belief that palliative care is only given as part of hospice care during terminal phases of an illness) leads to delay in instituting palliative treatments to patients who might benefit from them. Often, clinicians wait to enlist palliative care services until the late stages of an illness when patients are eligible for hospice care.

Indeed, a survey of physicians providing care to patients with lung cancer found that most physicians refer only a small percentage of patients for palliative care consultation, often because of concern that the term "palliative care" is equated with hospice care, and will alarm patients and families. Thus, most physicians preferred to refer patients for palliative care consultation only when death was imminent.

Similar findings were noted in another study of lung cancer patients seen in hospital and outpatient settings. Only 13% of the patients were receiving support from a palliative care service in the year after their diagnosis.

What Are The Benefits of Palliative Care?

There is increasing evidence supporting early institution of palliative care, particularly for patients with advanced illness (both cancer and non-cancer illnesses) even if not in the terminal phases of their disease. In an important study of patients with Stage IV lung cancer, patients who received palliative care in addition to conventional cancer treatments had increased survival compared to those who only received conventional cancer treatments.

In addition to potential survival advantages, other studies demonstrate improved outcomes such as lower rates of depression, improved quality of life, improved patient/family experience, and less use of resuscitation efforts at the final stage of life. There are even data to support the benefit of palliative care consultation in intensive care units (ICUs) leading to shorter ICU stays, transfer of appropriate patients to lower-intensity care sites, and emotional support for ICU staff dealing with challenging and/or morally distressing situations. Several studies have shown that instituting palliative care prior to the terminal stage of an illness results in lower costs of care.

As the evidence of clinical benefits and cost savings from palliative care continues to mount, an increasing number of hospitals and health systems are implementing palliative care consultation services. Some of these services include interprofessional palliative care teams that assist and co-manage patients throughout treatment of their terminal illness.

Although palliative care services are increasingly available in hospitals, they are less common in outpatient and home settings. A major reason for this is the limited reimbursement and insurance coverage for such services. As the U.S. healthcare system continues to evolve from a "volume-based" to a "value-based" system, those financial barriers should diminish, particularly as palliative care services continue to show both cost and value benefits.

TIPS ABOUT WHEN TO CONSULT PALLIATIVE CARE VS HOSPICE CARE

- Palliative care should be considered for any person of any age, at any stage of a serious illness, and regardless of life expectancy, ideally at the time of diagnosis.
- Hospice services should be offered to patients with a life-limiting illness who are expected to survive for no more than six months.
- Not sure how long a patient will survive? Ask yourself "would I be surprised if this patient dies in the next six months?" If the answer to that question is "no," then a hospice referral is indicated.

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ELDER CARE

Continued from front page

Palliative Care vs Hospice Care: How to Decide

All patients experiencing poor symptom control or uncontrolled pain due to cancer, chronic disease or other complex issues are candidates for palliative care consultation. Hospice care, on the other hand, should be considered for patients with an estimated survival of 6 months or less.

The 6-month time interval as a requirement for hospice services is an arbitrary criterion established by Medicare. Because establishing a firm life expectancy is difficult, it can be challenging for clinicians to determine exactly when to refer a patient for hospice care. In fact, clinicians frequently overestimate life expectancy, which often results in delays in referring patients to hospice. A better approach is to ask the "surprise" question – "would I be surprised if this patient dies in the next six months?" If the answer to that question is "no," then a hospice referral is indicated. But, if the answer is "yes" and the patient nonetheless has a life-limiting illness, palliative care consultation should be considered because of its potential to improve symptom control and quality of life.

Table. Contrasting Palliative Care and Hospice Care

Characteristic	Palliative Care	Hospice Care
Timing of Care	Begins with diagnosis of a debilitating or life-limiting illness and poor symptom or pain control	During terminal phase of illness
Eligibility Criteria	No eligibility criteria	Prognosis for life-expectancy of 6 months or less
Site of Care	Home, outpatient clinics , hospital, extended-care facility	Home, inpatient hospice unit, extended-care facility
Treatment	Provide symptom support and comfort care, concurrently with all other care, including curative care and disease-modifying treatments	Focus on comfort without seeking curative or disease-modifying treatment
Payment	• Medicare, Medicaid, and private insurance cover palliative care. • Patients are responsible for insurance co-payments (20% under Medicare).	Adults: • Medicare benefit provides full coverage (through Medicare Part A and Part D) for hospice services related to terminal diagnosis. • Medicaid also provides full coverage for hospice services. Children under age 21: • Medicaid and Children's Health Insurance Program (CHIP) provide coverage for hospice care, and also covers concurrent curative and hospice care.

References and Resources

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Interprofessional care improves the outcomes of older adults with complex health problems.

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