

Quality of Life Matters[®]

End-of-life care news & clinical findings for physicians

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Influential End-of-Life Care Guidelines for Clinicians and Institutions Updated and Expanded

A landmark set of consensus guidelines on the rights of patients to refuse unwanted treatment near the end of life and the importance of advance care planning has been updated and revised, The Hastings Center has announced. Originally issued in 1987 by the bioethics research institute, the work has been an important influence both in the U.S. and other countries in determining what is ethically and legally permissible when caring for seriously ill patients.

Entitled The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life, the new publication incorporates

“People with chronic or life-threatening illnesses often experience problems with their care, including confusion and conflict over how to make good decisions, poor communication with care providers, inadequate pain and symptom relief, and treatments with little or no benefit.... Poor care decreases patients’ quality of life, increases family stress, and adds cost but not value to health care...”

— The Hastings Center

empirical research findings and clinical and policy innovations from the past 26 years in the areas of quality improvement, patient safety, and palliative care.

“We wrote the new Guidelines for every health care professional responsible for the care of a patient facing decisions about life-sustaining treatment or approaching the end of life,” says co-author Nancy Berlinger, PhD, a Hastings Center research scholar and director of the project.

“The book is designed for practical use in hospitals, nursing homes, community health settings, or anywhere that professionals, patients, and loved ones need to discuss a patient’s values and preferences concerning different options for treatment and care.”

In addition to updating and clarifying the current ethical and legal landscape regarding the use of life-sustaining technologies in the U.S., the work offers recommendations for improving the delivery of care, and provides in-depth guidance for clinicians on conducting conversa-

tions with patients and surrogates.

COMMUNICATION GUIDELINES

Patients nearing the end of life are frequently offered life-sustaining technologies — such as cardiopulmonary resuscitation — simply “because it’s available,” and “because nobody is having a conversation with the patient and family about the longer-term trajectory of the illness, or about the likely prognosis, or helping them to see what’s likely to be in store for them,” says Mildred Z. Solomon, EdD, President and CEO of The Hastings Center, and a member of the project working group for the Guidelines.

“We need to have very nuanced and sophisticated conversations with patients who are gravely ill and help them understand their circumstances,” Solomon continues. “We know that when that’s done well, both patients and families are grateful. We also know it’s difficult. It’s difficult for clinicians to hold those kinds of conversations, they don’t have

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Coordination of Primary and Specialty Palliative Care Needed

All clinicians must develop a skill set in palliative care, experts urge

Many elements of palliative care can be provided by existing generalist or specialist clinicians, with palliative medicine specialists consulted for managing the more complex and difficult cases. But a concerted effort will be needed to develop the best model for coordinating delivery of both primary and specialty palliative care to patients with serious illness, according to an article published in *The New England Journal of Medicine*.

“We believe that each medical specialty and each health system needs to delineate basic expectations regarding primary palliative care skills to be learned and practiced by its members, plus a triage system for calling on palliative care specialists when necessary,” write Timothy E. Quill, MD, Palliative Care Division of the Department of Medicine, University of Rochester Medical Center, Rochester, NY, and Amy P. Abernethy, MD, Duke Cancer Care Research Program, Duke University School of Medicine, Durham, NC.

Research has shown that palliative care

delivered early in the course of a serious illness leads to better quality of life, less depression, and in some cases, even longer survival, note the authors. But although palliative care is seen as a fundamental part of the care of the seriously ill, the authors hold that the current system for its delivery is sub-optimal.

“[T]he current model adds another layer of specialized care for seriously ill patients on top of an already complex, expensive health care environment,” the authors state. They call for a care model that “distinguishes primary palliative care skills that all clinicians should have from specialist palliative care, so that they can coexist and support each other.” Their article includes a breakdown of skills into sets for both primary and specialty palliative care. [See sidebar, below.]

GENERALIST PLUS SPECIALIST PALLIATIVE CARE

In a coordinated, generalist plus specialist palliative care model, the primary care

or treating specialist would manage many of the palliative care problems, initiating a palliative care consultation for more complex or refractory problems, according to the authors. The patient could then return to the care of the treating physician.

Benefits of a coordinated palliative care model include:

- Delivery of primary palliative care by all clinicians caring for the patient
- Increased access to specialty palliative care consultation
- Simplification of the multi-layered health care system
- Reinforcement of existing physician/patient relationships

Expecting specialists in palliative medicine to handle all aspects of palliative care for all seriously ill patients is not an optimal approach, observe the authors. Not only does it add yet another specialist to those caring for the patient, but there simply will not be enough palliative care providers to satisfy the increasing demand for this type of care.

Other drawbacks to expecting delivery of palliative care only by experts include:

- The risk of undermining existing therapeutic relationships, if addressing patient suffering is no longer seen as a part of routine patient care
- Further fragmentation of care, if primary care physicians and other specialists come to view basic symptom management and psychosocial support as the responsibility of someone else
- Restricted access to any palliative care, as the demand outstrips the supply of providers

The increasing demand for palliative care requires a “reenergized, concerted effort spanning the health care system,” state

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Representative Skill Sets for Primary and Specialty Palliative Care

Primary Palliative Care:

- Basic management of pain and symptoms
- Basic management of depression and anxiety
- Basic discussions about prognosis, goals of treatment, suffering, and code status

Specialty Palliative Care:

- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment within families, between staff and families, and among treatment teams
- Assistance in addressing cases of near futility

— Quill and Abernethy, *The New England Journal of Medicine*

Influential End-of-Life Care Guidelines for Clinicians and Institutions Updated and Expanded (from Page 1)

adequate training to do so.”

The publication devotes one of its three major parts to the communication skills needed by clinicians caring for seriously ill patients, offers a framework for conducting end-of-life decision-making conversations, and suggests how these skills can be obtained.

The three major parts of the Guidelines are titled:

- Framework and Context
- Guidelines on Care Planning and Decision Making
- Communication Supporting Decision Making and Care

“The guidelines offer a reliable framework for these discussions, and for education, policy making, and redesign of care,” states The Hastings Center. “They also encourage health care lead-

ers and administrators to support better outcomes for patients by building more effective forms of care delivery and integrating care near the end of life into organizational safety and improvement initiatives.”

Section titles include:

- Communication with Patients, Surrogates, and Loved Ones
- Psychological Dimensions of Decision Making about Life-Sustaining Treatment and Care Near the End of Life
- Decision Making Concerning Specific Treatments and Technologies

“This new resource comes at a time of many challenges in our health care system,” says Solomon. “Advances in medicine have created both benefits and burdens, including problems of quality, safety, access, and cost. We need to help

patients and families better navigate their choices, and physicians and health care leaders must build systems of care that are wiser and more compassionate.”

Kathleen M. Foley, MD, of the Pain & Palliative Care Service, Memorial Sloan-Kettering Cancer Center, New York City, adds, “It is the sourcebook for how the ethics of life-sustaining treatment and care at the end of life should be taught, institutionalized, and translated into clinical teaching and practice.”

The 264-page book was published by Oxford University Press, May 2013; ISBN-10: 0199974551 (Hardcover); ISBN-13: 978-0199974559 (Paperback).

For more information, visit www.the-hastingscenter.org/hastings-center-guidelines.

Coordination of Primary and Specialty Palliative Care Needed (from Page 2)

the authors. Abernethy, who is also president of the American Academy of Hospice and Palliative Medicine (AAHPM), was the principal investigator for a recent initiative to incorporate palliative care into medical oncology practice.

INITIATIVE TO IMPROVE PALLIATIVE CARE FOR CANCER PATIENTS LAUNCHED

The American Society of Clinical Oncology (ASCO) and AAHPM recently announced a joint initiative to support delivery of high-quality palliative care in medical oncology. The three-year project, which is funded by the Agency for Health Care Research Quality, will include 20 oncology practices in its pilot project.

Using a web-based platform, the project will provide learning modules, social networking capabilities, and a toolbox of

evidence-based resources that oncologists and practices can use to implement local improvements in their delivery of palliative care. The aim is to provide a proven palliative care toolbox for practicing oncologists, then to address other targets for practice improvement.

“Better symptom control, defining and aligning goals of care, and attention to the needs of the family are just some of the fundamental principles of palliative care to be included in the generalist and specialist palliative care toolbox,” says Abernethy.

Despite the growing consensus concerning the benefits of routine palliative care in oncology, there is a “demonstrated need for improved symptom management, greater attention to psychosocial issues, discussions about goals of care, and appropriate referral to hospice — all core skills of palliative care,” according to the

ASCO statement.

“We recognize that palliative care is an essential component of care for patients with cancer,” says ASCO president Sandra M. Swain, MD. “This partnership will help get the latest palliative care evidence directly into the hands of oncologists so that palliative care can be provided as early as possible.”

For more information on the ASCO-AAHPM initiative, visit www.asco.org.

Source: “Generalist Plus Specialist Palliative Care — Creating a More Sustainable Model,” The New England Journal of Medicine; March 28, 2013; 368(13):1173-1175. Quill TE and Abernethy AP; Department of Medicine, Palliative Care Division, University of Rochester Medical Center, Rochester, New York; the Duke Center for Learning in Health Care and the Duke Cancer Care Research Program, Duke University School of Medicine, Durham, North Carolina; and the American Academy of Hospice and Palliative Medicine.

Revised Guideline for Care of Patients with Heart Failure Emphasizes Quality of Life and Palliative Care

The American College of Cardiology (ACC) and the American Heart Association (AHA) have jointly issued an updated clinical practice guideline for the management of patients with heart failure (HF), with renewed and increased emphasis on patient-centric outcomes such as quality of life, shared decision making, coordination and transition of care, and palliative care.

The guide expands the definition of HF, and employs “guideline-directed medical therapy,” a new designation for optimal treatment, which is aimed at helping clinicians to more easily determine the specific course of care considered most important in the management of the disease.

OVERALL CARE OF A HF PATIENT SHOULD FOCUS ON:

- Quality of life improvement as well as on survival and performance metrics
- Patient education, informed decisions, and advance directive documentation
- Shared decision making
- Coordination and transition of care among primary care physicians and cardiologists, and to palliative care and hospice

Regarding transitions from inpatient to outpatient care, the guideline points out that “the prognosis of patients hospitalized with heart failure, especially those with serial readmissions, is suboptimal. Hence, appropriate levels of symptomatic relief, support, and palliative care for patients with chronic HF should be addressed as an ongoing key component of the plan of care.”

For care of patients with advanced HF, the document recommends the involvement of a multidisciplinary HF team, including a palliative care team. “The HF team can help patients and their families explore treatment options and prognosis,” states the report. Assessment for frailty and dementia should also be included in the decision care process. “The HF and palliative care teams are best suited to help patients and families decide when end-of-life care (including hospice) is appropriate.”

ONGOING PALLIATIVE CARE SHOULD ADDRESS:

- Symptom control
- Psychosocial distress
- Health-related quality of life
- Preferences about end-of-life care

- Caregiver support
- Assurance of access to evidence-based disease-modifying interventions

“Access to formally trained palliative care specialists may be limited in ambulatory settings,” states the guideline. “Therefore, cardiologists, primary care physicians, physician assistants, advanced practice nurses, and other members of the HF health care team should be familiar with these local treatment options.”

The full guideline has been published in the *Journal of the American College of Cardiology*. Co-published in *Circulation*, the document was developed in collaboration with the American Academy of Family Physicians, the American College of Chest Physicians, and the Heart Rhythm Society. It has been endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation.

Source: “2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines,” *Journal of the American College of Cardiology*; June 5, 2013; Epub ahead of print; DOI: 10.1016/j.jacc.2013.05.019. Yancy CW, Jessup M, Bozkurt B, Butler J, et al.

End-of-Life Wishes of Hospitalized Elderly Patients Inaccurately Documented in Medical Records

In what the authors call “the first large-scale evaluation of advance care planning (ACP) from a patient and family perspective in the acute care setting,” Canadian researchers have found only a 30% concordance between seriously ill, elderly patients’ end-of-life care preferences as expressed in real time and the documented goals-of-care orders in their medical records, according to a report published in *JAMA Internal Medicine*.

Researchers conducted face-to-face interviews with 278 patients (mean age, 80.0 years) newly admitted to one of 12 large hospitals and 225 of their family members. All patients were at high risk of dying in the next six months. Expressed wishes for end-of-life care were compared with the orders of care documented in the medical record.

KEY FINDINGS:

- Before hospitalization, 76.3% of patients had thought about their wishes for medical care, but only 30.3% had discussed their preferences with a family physician. Only 17% had discussed preferences with a specialist.
- 47.9% had previously completed an advance directive; 73.3% had named a surrogate decision maker.
- Only 24.8% of patients with oral or written directives had been asked about them at hospital admission.
- Agreement between patients’ expressed preferences and documentation in the medical record was 30.2%.
- The area of greatest discordance was among those desiring

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While Hospice Use Rises and Hospital Deaths Decline, 'Invisible' Variations in Patterns of Care Persist

Compared with those who died in 2007, Medicare beneficiaries who died in 2010 were more likely to be enrolled in hospice, less likely to be hospitalized during the last six months of life or to die in the hospital, but just as likely to spend time in an intensive care unit (ICU), according to a report from the Dartmouth Atlas Project.

While this trend is encouraging, outcomes and quality of care varied markedly across regions and hospitals. There were substantial changes during the three years within individual hospitals and regions, but the changes were not consistent; some hospitals increased the intensity of care, while others delivered care that was less intensive than in previous years.

"This report shows rapid improvement in many places, although patients in some hospitals continue to receive more aggressive and less palliative care than others," states the report. "The health care delivered to these patients frequently falls short of the care they need and want. These differences are invisible to patients and providers, but have been revealed in a series of reports."

The most recent report is titled "Tracking Improvement in the Care of Chronically Ill Patients: A Dartmouth Atlas Brief on Medi-

care Beneficiaries Near the End of Life." Researchers analyzed Medicare billing records to track changes in care delivered to patients near the end of life, and to identify differences in care across hospital referral regions.

OVERALL, FROM 2007 TO 2010:

- The percentage of hospital deaths decreased by 11% (from 28.1% to 25%).
- The number of hospital days per patient in the last six months of life fell by 9.5% (from 10.9 days to 9.9 days).
- The percentage of patients enrolled in hospice increased by 13.3% (41.9% to 47.5%).
- Average number of hospice days rose by 15% (18.3 days to 21 days).

The number of days spent by patients in an intensive care unit (ICU) changed little, which the report views as reflecting "a leveling off of the rising ICU use seen prior to 2007." Similarly, the number of physician visits made per patient in the last months of life remained stable. However, the percentage of patients who saw ten or more different physicians in the last six months of life rose by 16.5%, from 36.1%

in 2007 to 42% in 2010.

As in previous reports, the highest rates of death in a hospital were found in regions in and around New York City, with Manhattan having the highest percentage (43.7%). Regions with the lowest percentage of hospital deaths included Dubuque, IA (15.2%), Cincinnati, OH (16.8%), and Fort Lauderdale, FL (17%).

Yet, it was an academic medical center (AMC) in New York City that showed the greatest improvement in lowering the number of hospital days spent by patients in the last six months of life (a 29% decrease). In contrast, the number of patient days rose alarmingly — by over 30% — at AMCs in Irvine, CA, and Portland, OR.

"The problem shown in these analyses is now well recognized: the quality and efficiency of the care patients receive is often determined by the accident of where they live and seek care," states the report. The reasons for this regional variation are not well understood, it notes. "Still, tracking care helps inform health systems, patients, and policy makers about patterns of care that can be invisible 'on the ground.'"

The Dartmouth Atlas brief is available at www.dartmouthatlas.org.

End-of-Life Wishes of Hospitalized Elderly Patients (from Page 4)

comfort care: 28.1% wanted comfort care only, but this was documented for only 4.5%.

"Most commonly, patients and family members preferred less aggressive care than what was prescribed," write the authors. "However, communication with health care professionals and documentation of these preferences remains inadequate. Efforts to reduce this significant medical error of omission are warranted."

CODE STATUS AND DISCUSSION: A CENTRAL SAFETY ISSUE

"Discussions about goals of care and code status constitute a medical procedure every bit as important to patient safety as a central line placement or a surgical procedure," write the authors of a commentary accompanying the report.

"If we are truly committed to improving patient safety and reduc-

ing medical errors, then we have found a worthy new target: the inpatient code status discussion and accurate medical documentation of real-time patient preferences."

The authors suggest that although several aspects of the health care system will need to be addressed, standardizing both the content of clinician discussions and the documentation of patient preferences upon admission may be an important first step "to fix this common and consequential medical error."

Source: "Failure to Engage Hospitalized Elderly Patients and Their Families in Advance Care Planning," *JAMA Internal Medicine*; May 13, 2013; 173(9):78-787. Heyland DK, et al; for the ACCEPT (Advance Care Planning Evaluation in Elderly Patients) Study Team and the Canadian Researchers at the End of Life Network (CARENET). "Disregard of Patients' Preferences Is a Medical Error," *ibid.*, pp. 787-788. Allison TA and Sudore RL; San Francisco VA Medical Center; and Division of Geriatrics, University of California, San Francisco.

CLINICIAN RESOURCES

Clinicians Offered Step-Wise Approach to Communicating Uncertain Prognoses

Prognostic information is of key importance for most clinical decisions and life choices in elderly patients and those with terminal illness. But because even the best estimates of prognosis and life expectancy are inherently uncertain, physicians can help patients and families manage uncertainty through more effective communication, according to an article published in *The New England Journal of Medicine*.

“We believe that at least as much attention should be paid to clinicians’ communication about the uncertainty associated with prognostication as to the search for better prognostic models,” write lead author Alexander K. Smith, MD, MPH, University of California, San Francisco (UCSF), and colleagues.

Improving the accuracy of prognostic estimates is of critical importance in helping both patients and clinicians, affirm the authors. However, it is also important to acknowledge that, “no matter what we do, there will always be some uncertainty in prognosis.” The authors suggest a framework of “three central tasks” clinicians can perform to help patients and families manage uncertainty. [See sidebar.]

EFFECT OF UNCERTAINTY ON PATIENTS

Patients and their families often find dealing with uncertainty psychologically difficult, and can react by worrying about an unknowable future rather than enjoying what time they have left with their loved ones. When faced with uncertainty, patients may become excessively aware of small physical changes, or they and their families may become narrowly focused on acquiring more information about medical details. “Rather than view uncertainty as part of the human condition, they view it — and therefore their life — as terrifying,” write the authors.

For those patients who find their present reality is already terrifying, clinicians can offer brief counseling sessions, or refer the patients to experts who can help them cope with the psychological and emotional stress that comes with facing the end of life, the authors suggest.

EFFECT OF UNCERTAINTY ON PHYSICIANS

Prognostic uncertainty profoundly affects physicians as well as patients, the authors point out. The tendency of physicians — particularly those with a long-term patient-physician relationship — to overestimate survival has been well documented, for example. “We believe that physicians need to recognize their reaction to uncertainty and how these reactions may influence their conversations with patients,” the authors write.

POSSIBLE PHYSICIAN REACTIONS TO UNCERTAINTY

- Physicians may themselves ignore the inherent uncertainty in prognostication, ordering more and more tests in the hopes of improving their predictions.
- Some physicians find it difficult to discuss uncertainty. When patients respond

emotionally to nebulous prognostic information, physicians may answer briefly, then turn the conversation to more comfortable territory, such as treatment options.

- Some physicians, by suggesting a “wait and see” approach, can be complicit in encouraging patients to focus anxiously on an uncertain future, rather than on living in the here and now, note the authors.

“In many respects, the primary communication task of clinicians is the management of uncertainty, and perhaps nowhere is this clearer than in communication about prognosis,” observe the authors. “By normalizing uncertainty and attending to the affective response to living in the face of an uncertain future, we may help our patients and their families enjoy the time they have now.”

Source: “Uncertainty—The Other Side of Prognosis,” The New England Journal of Medicine; June 27, 2013; 368(26):2448-250. Smith AK, White DB, Arnold RM; Department of Medicine, Division of Geriatrics, University of California, San Francisco, and the San Francisco Veterans Affairs Medical Center, both in San Francisco; Department of Critical Medicine and Division of General Internal Medicine, University of Pittsburgh, Pittsburgh.

Helping Patients to Manage Uncertainty

- 1. Normalize the uncertainty of prognosis.** Reset patient expectations for definitive answers by being honest about the boundaries of knowledge. “I understand that you want more accurate information about the future. The reality is that it’s like predicting the weather — we can never be absolutely certain about the future. I wish I could be more certain.”
- 2. Address the patient’s emotional response to uncertainty.** Acknowledge how difficult it can be not to know, and invite the patient/family to discuss their reactions. Responding to emotional distress can help avoid poor medical decisions that can be made when patients are distressed or anxious. “It is tough not knowing what the future is going to bring.”
- 3. Help the patient/family focus on living in the present.** Instead of saying, “We need more time to be sure,” or, “We have to wait and see,” physicians can say, “What can we do to help you now, given that we are unsure of exactly what the future will bring?”

— Adapted from Smith et al, *The New England Journal of Medicine*

CLINICIAN RESOURCES

FREE PATIENT BROCHURES

Joint Commission's Speak Up™ Program Adds Palliative Care to Series

The latest entry in the patient education campaign from The Joint Commission is entitled "Speak Up: What You Need to Know about Your Serious Illness and Palliative Care." Offered in the form of a free, downloadable and printable brochure, the information is available in both English and Spanish.

"Seriously ill patients have special physical, emotional, and spiritual needs," says Ronald M. Wyatt, MD, MHH, medical director of The Joint Commission's Division of Healthcare Improvement. "By considering the option of palliative care, these patients and their families may find that palliative means a way to prevent or relieve suffering."

BROCHURE TOPICS INCLUDE:

- Who can be helped by palliative care
- How, when, and where to obtain care
- Similarities and differences between palliative care and hospice
- Questions palliative care providers may ask, and what to ask them
- Sources of more information on palliative care

The current campaign was developed in collaboration with such professional organizations as the American Academy of Hospice and Palliative Medicine, the Hospice and Palliative Nurses Association, the Association of Professional Chaplains, and the National Hospice and Palliative Care Organization (NHPCO).

"Hospice palliative care is an essential component of the health care system, helping patients and families well before the final days of life, from diagnosis through the course of an illness, through death and grief with an ongoing focus on compassion and quality," says J. Donald Schumacher, PsyD, NHPCO president and CEO.

The palliative care material is the most recent addition in the Speak Up's ongoing program "to help patients and their advocates become more informed and involved in their health care." Launched in 2002, the program has now grown to include 20 campaign brochures, with free and downloadable files of all brochures, as well as many of the program's videos and posters.

An earlier brochure, "Speak Up: Tips for Your Doctor's Visit," includes patient tips on thinking and asking about end-of-life care.

SUGGESTIONS FOR PATIENTS

Suggestions for patients considering care near the end of life include:

- Involve your family
- Find out about the benefits and burdens of any treatment
- Make decisions based on what is best for you
- Share your decisions with your family and health care team
- Ask if you can get hospice care to help you with side effects or symptoms of your illness or treatments

The brochures are available at: www.jointcommission.org/topics/speakup_brochures.aspx.

End-of-Life Care Websites

www.aahpm.org

American Academy of Hospice and Palliative Medicine

www.eperc.mcw.edu

End-of-Life/Palliative Education Resource Center (EPERC)

www.epec.net

The EPEC Project (Education in Palliative and End-of-Life Care)

www.nhpc.org

National Hospice & Palliative Care Organization

www.caringinfo.org

Caring Connections: National Consumer Engagement Initiative to Improve End-of-Life Care

www.promotingexcellence.org

Promoting Excellence in End-of-Life Care

www.hospicefoundation.org

Hospice Foundation of America

www.americanhospice.org

American Hospice Foundation

www.hpna.org

Hospice and Palliative Nurses Association

www.hospicenet.org

Resources for Patients and Families

www.abcd-caring.org

Americans for Better Care of the Dying

www.mcw.edu/palliativecare.htm

Medical College of Wisconsin Palliative Care Center

www.painpolicy.wisc.edu

University of Wisconsin Pain and Policy Studies Group

www.capc.org

Center to Advance Palliative Care

www.stoppain.org

Pain Medicine & Palliative Care, Beth Israel Medical Center

End-of-Life Care Meetings for Clinicians

National Hospice and Palliative Care Organization 14th Clinical Team Conference and Pediatric Intensive. September 26–28, 2013, Sheraton Kansas City/Westin at Crown Center Hotels, Kansas City, MO. Website: www.nhpc.org

American Academy of Pain Management 24th Annual Clinical Meeting. September 26–29, 2013, JW Marriott Orlando Grande Lakes, Orlando, FL. Website: www.aapainmanage.org

Hospice and Palliative Nurses Association 7th Annual Clinical Practice Forum: Integration of Palliative Care Concepts: Neurological Conditions. October 3–5, 2013, Sheraton Square Hotel, Pittsburgh, PA. Website: www.hpna.org

Primary Care Geriatrics Review. February 22–March 1, 2014, 7-night Hawaiian Islands cruise conference from Honolulu, Hawaii. Topics include: Hospice and Palliative Care — Prognostication and Communication and Transitions in Care. Sponsor: Continuing Education, Inc. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 800-422-0711; Email: 022214Geriatrics@continuingeducation.net; Website: continuingeducation.net

2014 Annual Scientific Meeting of the American Geriatrics Society. May 15–17, 2014, Walt Disney World Swan and Dolphin, Orlando, FL. Website: www.americangeriatrics.org

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Mail: 6210 Shirley St., Ste. 112
Naples, FL 34109

Phone: 239-513-9907
Toll Free: 1-877-513-0099

Email: info@QoLpublishing.com



Karla Wheeler
Editor & Founder

Jan Carlton Doetsch
Clinical Editor

Gretchen Landolt
Chief Executive Officer

Kelly Brachle
Chief Operating Officer

Dashia Larimer
Vice President of
Customer Relations

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