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

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Physician Referral History Is Strongest Predictor of Enrollment of Hospice-Eligible Patients

Patients of physicians with the highest percentage of hospice referrals are 27% more likely to receive hospice care than those cared for by the lowest-referring physicians, Boston researchers have found. Further, individual physician referral pattern is a stronger predictor of hospice enrollment than other known drivers, such as geographic location or patient age, race, or comorbidities. That is according to a report published in *Health Affairs*.

"We found that the physician a patient sees is the single most important predictor we know of whether or not that patient enrolls in hospice care," says lead author Ziad Obermeyer, MD, of the Department of Emergency Medicine at Brigham and Women's Hospital in Boston. "This new information provides a clear policy target for improving and advancing the quality of care for patients at the end of their lives."

> *"As physicians, we need to have these conversations earlier. We need to know what our patients really want at the end of their lives. We need to remove the barriers to having these discussions and give our patients the care they actually want."*
>
> *— Ziad Obermeyer, MD, Brigham and Women's Hospital, Boston*

Investigators analyzed data on a nationally representative sample of Medicare beneficiaries with a diagnosis of poor-prognosis cancer (n = 198,948) who died between 2006 and 2011. All patients in the study sample (mean age, 78 years; white, 88%; male, 52%) lacked curative treatment options and would have been considered eligible for hospice care.

Patients were then attributed to "their physicians," i.e., those with whom they had the highest number of face-to-face encounters regarding their poor-prognosis cancer. Physicians (n = 70,073) were stratified into deciles according to the percentage of these patients in their care who were enrolled in hospice.

OVERALL FINDINGS

- 66% of all poor-prognosis cancer patients were enrolled in hospice.
- Patients who used hospice were more likely to be female, white, and to live in higher-income areas.
- Use of inpatient, emergency, and home health services were similar in both hospice and non-hospice patient groups.
- Patients in both hospice and non-hospice groups had the same comorbidity scores, indicative of similar disease burden.

KEY FINDINGS: PHYSICIAN FACTORS

- Patients seen by physicians ranked in the top 10% of hospice referrals were 27% more likely to enroll in hospice than those patients seen by physicians in the bottom 10%.
- Physician referral history was more strongly associated with hospice enrollment than other factors found to be associated with hospice entry, including older age, comorbidity, white race, and physician specialty.

Continued on Page 2

Inside:

Physician Referral History Is Strongest Predictor of Enrollment of Hospice-Eligible Patients (from Page 1)

- Patients of medical oncologists were significantly more likely to enroll in hospice, compared with patients of other medical subspecialists, surgeons, internists, or family practitioners.
- The proportion of eligible patients enrolled in hospice varied greatly across physicians, with 1.6% of physicians having fewer than 5% of their poor-prognosis patients in hospice, while 8.3% had more than 95% of such patients enrolled.
- A large number of patients were seen by a relatively small group of physicians; the top 10% of referring physicians cared for 47% of all study patients.

"These findings suggest that physician characteristics are among the strongest predictors of whether a patient receives hospice care — which mounting evidence indicates can improve care quality and reduce costs," the authors write.

"Although hospice use has grown over the past decades, there is substantial variation in use among patients with similar diagnoses and indications. Many experts and policy makers believe that hospice remains underused."

Factors known to influence hospice enrollment — such as patient clinical and demographic factors, geographic region, and health care system factors — explain only 10% of the observed variation in hospice use and end-of-life care patterns, note the authors. Further, the type of end-of-life care patients receive does not always reliably reflect their preferences.

Previous research has linked physician-level variation in hospice use to physician preferences and practice settings, note the authors. Thus, recommended structural changes, such as expanding Medicare eligibility criteria for hospice, could help increase hospice use, but "might be insufficient without concurrent efforts to change physicians' behavior." Based on their findings, they suggest several "focused interventions" for improving care.

> *"There is increasing evidence that hospice care addresses patients' needs and preferences at the end of life, improves care experiences for both patients and caregivers, is associated with decreased health care costs, and even prolongs survival in some populations."*
>
> — *Obermeyer et al,* Health Affairs

SUGGESTED INTERVENTIONS

- **Improve end-of-life care training** for physicians likely to care for large numbers of patients with poor prognoses. "Our data show that about 10% of physicians cared for about half of all patients," says Obermeyer. "This suggests that we can target a small group of physicians with interventions geared towards physician specialty and how often their patients enroll in hospice to improve end-of-life care."
- **Target interventions to increase rates of hospice referrals** among specific physician groups that currently underuse hospice, as measured by mean hospice days per patient or percentage of poor-prognosis patients referred to hospice. Accountable care organizations are increasingly using such population health management strategies.
- **Improve quality end-of-life care measurement** to incentivize changes in practice behavior among members of professional societies. For instance, the American Society for Clinical Oncology has recently launched an initiative that measures hospice use at the practice level.
- **Review payment structures** to identify any existing disincentives for conducting physician-patient discussions of hospice and end-of-life care, and remove such barriers. "This would give physicians — regardless of their personal beliefs — more incentive to engage in discussions about hospice care," the authors observe.

"As an emergency physician, I am often the first person to ask patients about what kind of care they want at the end of their life. In these situations, patients and their families often have only hours to make difficult and complex decisions," comments Obermeyer, who is also an assistant professor of emergency medicine and health care policy at Harvard Medical School, Boston.

"As physicians, we need to have these conversations earlier. We need to know what our patients really want at the end of their lives. We need to remove the barriers to having these discussions and give our patients the care they actually want."

Source: "Physician Characteristics Strongly Predict Patient Enrollment in Hospice," Health Affairs; *June 1, 2015; 34(6):993-1000. Obermeyer Z, Powers BW, Makar M, Keating NL, Cutler DM; Harvard Medical School; Brigham and Women's Hospital, both in Boston; Harvard University and National Bureau of Economic Research, both in Cambridge, Massachusetts.*

Greater Nursing Home Knowledge of Palliative Care Linked to Fewer Aggressive Measures at Life's End

Patients in nursing homes whose leadership had higher scores in palliative care knowledge were less likely to be hospitalized in the last month of life or to die in the hospital, and less likely to receive invasive interventions as death approached. Further, these patients were more likely to have documentation of end-stage disease with six-month prognosis, according to a report published in the *Journal of Palliative Medicine.*

"This study presents the first nationally representative survey data on palliative care knowledge and practice in nursing homes," write the authors. "Controlling for hospice use, in nursing homes with higher scores on relatively elementary palliative care knowledge items, dying residents had a higher likelihood of having a documented six-month terminal prognosis and a lower likelihood of receiving aggressive end-of-life care."

The presence of hospice services in nursing homes has been shown to have a spill-over effect, improving symptom management and lowering acute care utilization at the end of life, not just for those enrolled in hospice, but among residents overall. However, serious barriers to the timely use of hospice in nursing homes remain, note the authors. Thus, nursing homes are encouraged to expand both access to hospice care and internal delivery of palliative care.

Whether provided by hospice services or by nursing home programs, "[p]alliative care aims to optimize quality of life through an interdisciplinary care team who provides support for patients' and families' psychosocial needs and addresses patients' physical, intellectual, emotional, social, and spiritual needs while facilitating patient autonomy, access to information, and choice," explain the authors.

To determine how palliative care knowledge and practices are associated with residents' end-of-life health care use, investigators analyzed the 2009-2010 survey responses of directors of nursing from a nationally representative sample of 1981 nursing home facilities, as well as Medicare resident assessment and claims data on the 58,876 residents who died in those same facilities during 2009 and 2010.

OVERALL FINDINGS

- Mean palliative care knowledge score was 2.2 (out of a possible 0 to 3); median score was 2.
- Mean palliative care practice score was 28.1 (out of a possible 9 to 36).
- 21% of nursing homes had no survey items or only one item correct.
- High proportions of residents had injections (32.2%) and tube feeding (11.7%) near the end of life; 30.9% were hospitalized in their last month of life; and 15.0% died in the hospital.
- Only 15.8% of nursing home decedents had a six-month prognosis documented.
- An average 5.2% of resident days were spent on hospice (range, 0% to 38.1%).
- Nursing homes with higher hospice use also had higher mean palliative care knowledge scores.

KEY FINDINGS

- Residents in nursing homes with higher palliative care knowledge scores were 13% more likely per point increase to have a documented six-month terminal diagnosis; 7% less likely to be hospitalized in the last month of life; and 9% less likely to die in the hospital.
- These residents also had lower likelihood of having tube feedings, injections, restraints, and intravenous treatment near the end of life.
- Each point increase in palliative care practice scores decreased residents' likelihood of having a feeding tube insertion and emergency department visit in the last 30 days of life.

Although the finding that more than one-fifth of nursing homes answered none or just one palliative care question correctly is concerning, the authors find it promising that for each additional survey item answered correctly there was a lower likelihood of dying residents receiving aggressive end-of-life care and higher likelihood that their prognosis of six months or less would be recognized and documented.

"[T]he greater recognition of six-month terminal prognoses is an important precursor to initiation of end-of-life palliative care," the authors state. "While determining a six-month prognosis for most nursing home residents is difficult, it may be that facilities more attuned to the changing needs of their residents are also more likely to assess terminal prognoses, and to perhaps have meaningful end-of-life discussions that alter subsequent care choices."

Nursing homes have been recently tasked with a "culture change" challenge to implement the practice of person-centered care, note the authors. The resources used in this effort should also be used by hospices and palliative care organizations to help improve palliative care knowledge and practice among nursing home leaders and staff, the authors conclude.

Source: "End-of-Life Care in Nursing Homes with Greater Versus Less Palliative Care Knowledge and Practice," Journal of Palliative Medicine; *June 2015; 18(6):527-534. Miller SC, Lima JC, Thompson SA; Department of Health Services, Policy, and Practice, Brown University School of Public Health, Providence, Rhode Island.*

Earlier, Outpatient Discussions Lead to Less Aggressive End-of-Life Care among Gynecologic Cancer Patients

While the majority of gynecologic cancer patients who have an end-of-life conversation do so in an inpatient setting — and most often within 30 days of death — those who discuss end-of-life care with their physicians as outpatients are less likely to be hospitalized or present to an emergency department in the last 30 days of life.

They are also less likely to die in the hospital, less likely to receive chemotherapy in the last 14 days of life, and more likely to enter hospice, according to a report published in *Gynecologic Oncology,* the official journal of the Society of Gynecologic Oncology.

"Earlier initiation of end-of-life conversation, especially in the outpatient setting, resulted in less aggressive health care interventions, shorter length of stay in hospital, and higher quality end-of-life care according to NQF (National Quality Forum) metrics," write the authors. "An early end-of-life discussion not only allows for a better understanding of patients' goals of care, but it also opens the door for continued discussion as patients' prognoses become more terminal."

However, a large proportion of women in the study received aggressive care near the end of life. Nearly half were admitted to the hospital or visited the emergency department during the last 30 days of life. One-quarter had some procedure within the last month and 22% died in the hospital. Half of those who enrolled in hospice did so within the last two weeks of life.

"Hospice was significantly underutilized, both in the number of patients who participated, and in the relatively short number of days patients received hospice care," write the authors.

Investigators reviewed the electronic medical records and hospital and outpatient charts of 136 women with terminal gynecologic cancers treated in a high-volume tertiary care center who died between 2010 and 2012 (median age at death, 70 years). NQF end-of-life quality performance metrics were used to assess quality of care. Poor quality care is indicated by chemotherapy within the last 14 days of life; hospitalization, intensive care unit (ICU) admission, or emergency department visit within the last 30 days of life; inpatient death; and hospice underutilization (enrollment ≤ 3 days before death).

OVERALL FINDINGS

- In the last 30 days of life, 49% of patients were hospitalized (24% of these were admitted more than once), 40% of patients presented to the emergency department, and 12% were admitted to an ICU.
- Median length of hospital stay was 9 days; of ICU stay, 6 days.
- 10% received chemotherapy in the last 14 days of life.
- While 73% of patients had an advance directive in their medical records, only 29% overall had a documented code status at the time of death.
- 22% died in the hospital.
- 40% were enrolled in outpatient hospice care at the time of death, with 49% of these patients entering hospice within the last 14 days of life, and 16% within the last 3 days of life.
- The mean hospice stay was 28 days.

IMPACT OF DISCUSSION SETTING

- Although 71% of patients had a documented end-of-life conversation, only 19% of these were conducted in an outpatient setting. Median timing of these outpatient discussions was 64 days before death.
- Of the 81% of patients who had only an inpatient end-of-life discussion, 73% had these discussions within the last 30 days of life.
- Only 6% of those who had an outpatient end-of-life discussion died in the hospital, compared with 34% of those who had only an inpatient discussion. Median time from inpatient discussion to death for those who died in acute care was 3 days.
- 29% of end-of-life discussions were not with the patient — who was too ill by then to communicate — but rather with family or surrogates.

IMPACT OF DISCUSSION TIMING

- Overall, only 24% of patients had an "earlier" end-of-life discussion (i.e., more than 30 days before death).
- Patients with earlier end-of-life discussions documented in their medical records were less likely to be hospitalized or admitted to an ICU in the final 30 days of life.
- Those with earlier discussions were less likely to receive chemotherapy in the last 14 days of life (3% vs 12%) compared with those who had late or no discussions.
- Patients with earlier discussions had higher rates of hospice care and better utilization of hospice (i.e., more days in hospice).
- Compliance with NQF metrics of quality care was higher among those with earlier discussions (aggregate compliance, 67% vs 15%).
- Median overall survival did not differ significantly between groups: survival in patients with earlier end-of-life discussions was 881 days vs 658 days in those who had late or no discussions.

Continued on Page 5

Decision Aids Can Help 'Prepare and Empower' Seriously Ill Patients, Study Finds

Use of decision-making tools — aids that support current medical treatment decisions and advance care planning (ACP) tools for future decisions — may help seriously ill patients to participate in the decision-making process, according to a report published in the *Journal of the American Medical Association.*

"Clinicians can access and use evidence-based tools to engage seriously ill patients in shared decision making," write the authors. "These tools are not a substitute for clinical communication, but are intended to prepare and empower patients and their families for shared decision making with clinicians."

Investigators conducted a systematic review of published clinical trials, searching the literature from 1995 through 2014 to identify studies of tools relevant to treatment decision making by seriously ill patients and their caregivers. Seventeen randomized clinical trials were found and evaluated for quality of the evidence, effect on patient-centered outcomes, and accessibility of the tools for clinicians.

RESULTS

Whether presented in print, video, or web-based format, certain decision tools were found to improve patient knowledge and awareness of treatment choices. Others improved ACP documentation, promoted clinical decisions, and affected the treatment patients received. A small number of these tools are free and available for clinical practice. Links to the tools are included in the report.

This field of research is in an early stage, and further study is needed to evaluate outcomes beyond improved patient knowledge with the use of decision aids, outcomes such as care consistent with preferences and satisfaction with care, the authors note. Meanwhile, the use of currently available evidence-based tools should be a priority, they urge.

'ACTIVATED PATIENTS'

"Decision aids offer value to patients with serious illness, and this review provides insights into which approaches are more likely to work," writes James A. Tulsky, MD, former chief of Duke Palliative Care, Duke University Health System, Durham, NC, in his commentary accompanying the report. The findings of this "exhaustive and rigorous study" suggest that offering patients one or more of these evidence-based tools can result in "activated patients" and should be the standard of practice, he states.

However, notes Tulsky, the trials also found that these tools are imperfect and highly variable in quality. "None looked at the role of caregivers in decision making and how patients incorporate their loved ones' preferences into their own decisions," he points out. Neither did any address the issues of symptom management and quality of dying, outcomes of great importance to this population.

"A medical treatment is only as good as the quality of the life it improves," states Tulsky. "To provide care that truly matters, we must ensure that seriously ill patients receive treatment that matches their values and goals."

Source: "Tools to Promote Shared Decision Making in Serious Illness: A Systematic Review," Journal of the American Medical Association; *Epub ahead of print, May 18, 2015; Austin CA, Mohottige D, Sudore RL, Smith AK, Hanson LC; Center for Aging and Health, Division of Geriatrics, University of North Carolina, Chapel Hill; Department of Medicine, Duke University, Durham, North Carolina; "Decision Aids in Serious Illness: Moving What Works into Practice," ibid., DOI: 10.1001/jamainternmed.2015.1702. Tulsky JA; Department of Medicine, Duke University School of Medicine; and Duke Palliative Care, Duke University Health System, both in Durham, North Carolina.*

Gynecologic Cancer Patients (from Page 4)

"[A]s validated in this study, both location and timing of end-of-life discussions are important in maintaining compliance with palliative care guidelines," observe the authors. Poor compliance with these metrics may be due, in part, to oncologists' perceived lack of training in initiating end-of-life care conversations with gynecologic cancer patients, the authors suggest.

Both the American Society of Clinical Oncology and the National Comprehensive Cancer Network have published guidelines recommending that palliative care be offered to oncology patients early in their disease course. When treatment becomes ineffective, palliative care should be the focus.

"Having these discussions early in the disease course and simultaneously pursuing further cancer-directed therapy should not be mutually exclusive phenomena," note the authors. "An emphasis on palliative care may also help ease a physician into conversations about goals of care, quality of life, and shifting to less aggressive care at the end of life."

Source: "Too Much, Too Late: Aggressive Measures and the Timing of End-of-Life Care Discussions in Women with Gynecologic Malignancies," Gynecologic Oncology; *Epub ahead of print, June 3, 2015; DOI: 10.1016/j.ygyno.2015.06.001. Zakhour M, et al; Department of Obstetrics and Gynecology, Division of Gynecologic Oncology, Cedars-Sinai Medical Center, Los Angeles.*

Language and Cultural Barriers Top Physician-Identified Challenges to Effective End-of-Life Discussions

Nearly all physicians in a recent survey reported encountering barriers to conducting end-of-life conversations, with most finding it particularly challenging to hold these sensitive discussions when patients' and families' cultural or ethnic backgrounds differed from their own, a team of California researchers reports in the journal *PLoS One.*

The team identified six barriers most often cited by physicians as impeding communication needed to determine the kind of care patients want in their final days. The greatest barrier was communicating with a patient with whom the physician has no language in common.

As the U.S. population continues to age, it is also becoming increasingly diverse. An estimated 78% of costs of medical care in the last year of life occur in the final month, often spent on high-intensity treatments that are ineffective and burdensome, note the authors. Further, data show that ethnic minority patients are more likely than Caucasians to receive such aggressive end-of-life treatment, and less likely to use hospice.

"End-of-life conversations per se are very sensitive communication encounters, and conducting these may be very challenging," write the authors. "[T]here is an urgent need to train doctors in conducting culturally effective end-of-life conversations early in the trajectory of any chronic and serious illness, in order to facilitate dignity at the end of life for diverse Americans."

Investigators analyzed questionnaire responses of 1040 multi-ethnic, multi-specialty physicians from two large academic medical centers in California, from 2010 to 2012. The respondents, who were medical residents ending their last year of training, were from 11 medical specialties, with the majority in internal medicine (29.0%), surgery (18.9%), or pediatrics (14.1%).

FINDINGS

- **99.99% of physicians reported experiencing barriers to conducting end-of-life conversations.**
- 85.7% stated that conducting these discussions with ethnically different patients was "a great deal" or "quite a bit" challenging.
- Asian-American physicians experienced the most hindrances with cross-cultural discussions (91.3%), followed by African-American (85.3%), Caucasian (83.5%), and Hispanic physicians (79.3%).
- Physicians in all sub-specialties identified "language and medical interpretation issues" as the most problematic barrier.

TOP-RANKED PHYSICIAN-IDENTIFIED BARRIERS

- **Language and medical interpretation issues.** Physicians noted that medical terminology is not always accurately translated, or easily understood even by speakers of the same language. Further, the use of translators was felt to be psychologically distancing.
- **Patient/family's religious and spiritual beliefs about death and dying.** Physicians found it difficult when patients were guided by religious beliefs to choose life-sustaining treatments their care team considered futile, or to choose making no plans at all, in hopes of a miracle.
- **Physicians' unfamiliarity with patients' cultural beliefs, values, and practices.** Physicians sometimes struggled to understand and empathize with values underlying patient decisions, and were apprehensive of inadvertently causing offense by discussing what might be a taboo topic.

Other barriers to effective communication included cultural differences in truth handling and decision making, the patient/family's limited health literacy, and the patient/family's mistrust of doctors and the health system.

RECOMMENDATIONS FOR IMPROVEMENT

Based on their findings, the authors offer suggestions for improving end-of-life communication, especially across the physician-patient cultural divide. Their major emphasis is on the importance of training. For instance, they suggest that efforts be made to train physicians and medical interpreters to work together efficiently, following a standard set of guidelines.

Physicians are urged to avoid using medical jargon, and to be aware of common but ill-defined phrasing. "For example, oncologists often use the word 'cure' to indicate five years of cancer-free survival. However, to many cancer patients and families, the word 'cure' means eradication of cancer and restoration of normal health," point out the authors.

Another example is the English word "hospice," which can sound like *hospiscio,* the Spanish word for a place for orphans and the destitute. Thus, when a physician suggests a referral to hospice, an indigent Spanish speaker may understand it as a referral to a poorhouse, where expensive treatment will be withheld, the authors caution.

Source: "No Easy Talk: A Mixed Methods Study of Doctor Reported Barriers to Conducting Effective End-of-Life Conversations with Diverse Patients," PLoS One; *April 22, 2015; 10(4): e0122321. Periyakoil VS, Neri E, Kraemer H; Stanford University School of Medicine; and VA Palo Alto Health Care System, both in Palo Alto, California.*

Clinician Resources

Advance Care Planning Resources for Patients of All Ages

FIVE WISHES® *ONLINE*
www.agingwithdignity.org

Five Wishes, the advance directive first introduced nationally in 1998 and completed to date by more than 18 million adults in all 50 U.S. states and internationally, can now be accessed and completed online, according to Aging with Dignity, the nonprofit organization that created and distributes the documents designed to address "all of a person's needs: medical, personal, emotional, and spiritual."

The document meets the advance directive legal requirements in 42 U.S. states, and can be used in other states and regions as a resource for guiding discussions on palliative and end-of-life preferences. Available in 27 languages as well as Braille, the directive's translated versions are bilingual, providing the English text on each facing page, so that English-speaking health care professionals can clearly understand the patient's choices.

The online version includes explanatory video clips for each topic, and can be worked on and saved for 30 days. Upon completion, the document can be printed and emailed to designated family members and physicians. The fee for the first copy is $5.

VOICING MY CHOICES™:
A PLANNING GUIDE FOR ADOLESCENTS & YOUNG ADULTS
www.agingwithdignity.org/vmc

Aging with Dignity now also provides an end-of-life care planning guide for adolescents and young adults, designed to be used as a "legacy document that reaffirms the child's self-worth and fulfills their final wishes," according to the authors of an article published in *Palliative and Supportive Care.*

While young adults aged 18 years and older are encouraged to complete a legally valid advance directive, they and younger patients may find comfort and meaning in expressing their preferences for how they wish to be treated during their illness and how they want to be remembered.

Addressed to physicians, nurses, and other health care professionals caring for adolescents and young adults with a life-threatening illness, the article reviews the research that led to the document's creation, offers suggestions on how to incorporate end-of-life care planning into the practice setting, and identifies timepoints for such discussions.

Included are sample statements clinicians can use to initiate advance care planning conversations with their young patients, covering each section of the *Voicing My CHOICES* document. "[A]dolescents and young adults want to discuss end-of-life issues with the health care providers they trust and who have been honest with them from the inception of care," write the authors.

Voicing My CHOICES became available in 2012, and the document can be accessed, reviewed, and ordered online for $5.

Source: "Opening End-of-Life Discussions: How to Introduce Voicing My CHOICES™, an Advance Care Planning Guide for Adolescents and Young Adults," Palliative and Supportive Care; *June 2015; 13(3):591-599. Zadeh S, et al; The National Cancer Institute and the National Institute of Mental Health, National Institutes of Health, Bethesda, Maryland.*

End-of-Life Care Websites

American Academy of Hospice and Palliative Medicine
www.aahpm.org

American Hospice Foundation
www.americanhospice.org

Americans for Better Care of the Dying
www.abcd-caring.org

Caring Connections: National Consumer Engagement Initiative to Improve End-of-Life Care
www.caringinfo.org

Center to Advance Palliative Care
www.capc.org

The EPEC Project (Education in Palliative and End-of-Life Care)
www.epec.net

Fast Facts and Concepts in Palliative Care for Clinicians, hosted by the Center to Advance Palliative Care
www.capc.org/fast-facts

Hospice and Palliative Nurses Association
www.hpna.org

Hospice Foundation of America
www.hospicefoundation.org

Medical College of Wisconsin Palliative Care Center
www.mcw.edu/palliativecare.htm

National Hospice & Palliative Care Organization
www.nhpco.org

Pain Medicine & Palliative Care, Beth Israel Medical Center
www.stoppain.org

Promoting Excellence in End-of-Life Care
www.promotingexcellence.org

Resources for Patients and Families
www.hospicenet.org

University of Wisconsin Pain and Policy Studies Group
www.painpolicy.wisc.edu

End-of-Life Care Meetings for Clinicians

American Academy of Pain Management 26th Annual Clinical Meeting. September 17–20, 2015, Gaylord National Hotel, Suburban Washington, DC (National Harbor, MD). Website: www.aapainmanage.org

Palliative Care in Oncology Symposium: Patient-Centered Care across the Cancer Continuum. October 9–10, 2015, Boston Marriott Copley Place, Boston. Cosponsors: the American Academy of Hospice and Palliative Medicine, the American Society of Clinical Oncology, the American Society for Radiation Oncology, and the Multinational Association of Supportive Care in Cancer. Website: pallonc.org

National Hospice and Palliative Care Organization 16th Clinical Team Conference and Pediatric Intensive. October 15–17, 2015, Gaylord Texan Resort and Convention Center, Grapevine, TX. Website: www.nhpco.org

Palliative Medicine and End-of-Life Care: 2016 Update Including Related Topics in Neurology. February 14–21, 2016, Seven-night Eastern Caribbean cruise conference, from Fort Lauderdale, FL. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 800-422-0711; Website: www.continuingeducation.net

9th World Research Congress of the European Association for Palliative Care. June 9–11, 2016, University College, Dublin, Ireland. Co-sponsored by the Irish Association for Palliative Care. Website: http://www.eapcnet.eu/research2016

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17-2