

Quality of Life Matters[®]

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

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Increased Rate of Intensive Care Utilization Near the End of Life Raises Concerns

Although recent data from the Centers for Disease Control and Prevention (CDC) show a decrease in the number of hospital deaths over the past decade, new research demonstrates that during the same time period, the frequency of hospitalizations and intensive care unit (ICU) stays in the last months of life among Medicare patients increased. This is according to a report published in the *Journal of the American Medical Association (JAMA)*.

Further, while the use of hospice services grew from 2000 to 2009, so did the number of short (three days or less) hospice stays, often following several hospital admissions, an ICU stay, and other health care transitions near the end

of life, suggesting a care pattern that relocates terminally ill patients from home to hospital bed, to ICU, and then back home with hospice — all within days of death.

“The increased availability of palliative and hospice care services does not appear to have changed the focus on aggressive, curative care,” write the authors of a commentary accompanying the study. “Hospice services appeared to be tagged on to the last days of life.”

It is important to question whether such aggressive care for dying patients is congruent with their health goals, and whether acute care settings are the best place to provide the care these patients need and want, note commentators Grace Jenq, MD, and Mary E. Tinetti, MD, of the Yale School of Medicine and Yale-New Haven Hospital, both in New Haven, CT.

“If programs aimed at reducing unnecessary care are to be successful, patients’ goals of care must be elicited and treatment options such as palliative and hospice care offered earlier in the process than is the current norm,” the commentators state.

The current use of intensive care for patients who are near death needs to be assessed, Jenq and Tinetti urge. The study found that nearly 40% of patients with chronic obstructive pulmonary disease (COPD) had an ICU stay in the last months of life, and the proportion of dementia patients with ICU stays rose over the decade. Overall, 40% of patients referred to hospice within three days of death had a preceding ICU stay. “The current default as patients accumulate acute medical prob-

lems at the end of life remains transfer to an ICU,” they note.

Although Medicare and Medicaid have criteria governing care received in most settings, including skilled nursing facilities, acute care hospitals, rehabilitation facilities, and home settings with home health or hospice care, “there are no such requirements for intensive care,” observe Jenq and Tinetti. “Even though the ICU is the most expensive and burdensome site of health care, it remains one of the few places without restrictions on who receives care or what care they receive.”

The commentators urge that criteria be established for ICU utilization near the end of life. Recommendations include:

- Establish a threshold of likely benefit and life expectancy for ICU admission.
- Encourage research to improve prognostication. Although currently there is little accurate data for terminal diseases other than cancer, such a requirement “will likely drive the science.”
- Elicit the patient’s goals of care, and if intensive care is the optimal method for meeting those goals, document the reasons. This documentation should be a requirement for reimbursement for ICU care.

“Some might worry that these recommendations will lead to rationing ICU care,” note Jenq and Tinetti. “It is worth considering, however, whether providing unwanted intensive medical care that has little chance of success in lieu of timely access to symptomatic, emotional, spiritual and other supports that help patients and

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Multiple Components of Advance Care Planning All Contribute to Improved Quality of Care at the End of Life

With much of the current research focused on the importance of advance directives (ADs) in controlling costs at the end of life, a team of San Francisco researchers has turned its attention to evaluating the relationship between advance care planning (ACP) as a whole and the quality of care received at the end of life. They found that patients who participate in planning their end-of-life care are more likely to receive hospice care and less likely to enter hospice within 72 hours of death or die in the hospital.

“This study was the first to examine the relationship between ACP and the quality of end-of-life care, as measured according to rates of care consistent with pre-existing quality measures,” write the authors of a report published in the *Journal of the American Geriatrics Society*.

Investigators analyzed data on 4394 Medicare beneficiaries (mean age at death, 82.6 years; female, 54.7%) who died between 1993 and 2007 and had participated in the Health and Retirement Study, an ongoing biennial survey of Americans aged 50 years or older and their health care proxies.

Broadening the definition of ACP from a focus on ADs alone, the team assessed the relationship between having planned for or discussed care at the end of life and the quality of care actually received. Thus, ACP included not only having completed an AD, but also having designated a durable power of attorney for health care and/or engaged in discussion of end-of-life preferences with loved ones.

OVERALL:

- 76% of subjects engaged in at least one form of ACP, with 26% having all three components.
- Mean length of time from AD comple-

tion to death was 61 months (median, 37 months; range, 11 to 91 months).

- Mean time from assignment of a durable power of attorney to death was 56 months (median, 34 months; range, 10 to 80 months).
- 92% of those who completed an AD expressed a preference for comfort care over life prolongation; only 3% requested all care possible under any circumstances.

ACP became more common among this older population as the years progressed, note the authors. While fewer than half of those who died before 1997 had engaged in any form of ACP, nearly three-quarters (72%) of those who died in 2007 (the last year studied) had documented their end-of-life care wishes.

DECEDENTS WHO ENGAGED IN ACP WERE:

- Less likely than those with no ACP to die in the hospital (39.2% vs 49.0%; adjusted relative risk [RR], 0.87; 95% confidence interval [CI], 0.80 to 0.94)
- Less likely to spend > 14 days in the hospital in the last month of life (10.3% vs 14.1%; RR, 0.81; 95% CI, 0.66 to 0.99)
- More likely to be enrolled in hospice (33.3% vs 17.6%; RR, 1.68; 95% CI, 1.43 to 1.97)
- Less likely to enter hospice ≤ 3 days before death (71.9% vs 85.1%; RR, 0.88; 95% CI, 0.85 to 0.91)

However, there were no significant differences between the two groups in the proportion of decedents who had hospital or intensive care unit admissions or multiple emergency department visits in the last month of life. “These findings suggest that older adults who engage in ACP are often admitted to the hospital in

the last month of life but are more likely to be discharged to home or to a non-acute facility before their death, rather than remain in the hospital for their final days to weeks,” the authors observe.

“It is unclear how brief, non-terminal hospitalizations affect quality of life for the majority of people who prioritize comfort at the end of life. Given their frequency, this is an important topic for further study.”

Each component of the ACP process was found to be independently associated with a significant increase in hospice use ($P < .01$ for all). “There appears to be utility in each aspect of ACP that was studied — completing an advance directive, assigning a durable power of attorney, and having an ACP discussion with next of kin — albeit in somewhat different ways,” comment the authors. “Additionally, end-of-life care tends to correlate to the preferences expressed in subjects’ ADs.”

PREFERENCE FOR COMFORT CARE

Compared to those who did not engage in ACP, patients who documented a preference for comfort care in an AD were:

- Less likely to die in the hospital (RR, 0.78; 95% CI, 0.71 to 0.86)
- Less likely to spend > 14 days in the hospital in the last month of life (RR, 0.65; 95% CI, 0.50 to 0.85)
- More likely to enter hospice (RR, 1.88; 95% CI, 1.59 to 2.22)
- Less likely to enroll in hospice ≤ 3 days before death (RR, 0.84; 95% CI, 0.81 to 0.87)

“The finding that having an AD, a durable power of attorney, and an ACP discussion is each associated with end-

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Increased Rate of Intensive Care Utilization (from Page 1)

caregivers through the last phase of life already constitutes rationing.

“A more appropriate metric might be whether patients’ goals were elicited and care predicated on meeting those goals was instituted soon enough to make a difference in end-of-life care.”

STUDY FINDS AGGRESSIVE CARE PRIOR TO DEATH, DESPITE DECLINE IN HOSPITAL DEATHS

In its 2010 report on death and dying, the CDC identified a shift in the site of death for Americans aged 65 years or older: fewer were dying in the hospital and more at home.

A new study of more than 830,000 Medicare patients has confirmed this, according to a report published in *JAMA*.

But, rather than assessing only for site of death — i.e., where the patient was in the final moments — researchers also examined the health care experiences of patients in the last months, weeks, and days of life. They found that from 2000 to 2009, the rates of both ICU stays in the last month of life and potentially burdensome health care transitions, especially in the final few days of life, had increased.

“Our results confirm the previous CDC report that more persons are dying at home, and people are less likely to die in an acute care hospital,” says lead author Joan M. Teno, MD, MS, Warren Alpert Medical School of Brown University, Providence, RI, in a *JAMA* interview. “But, our results raise concerns with the pathway that people take to dying at home.

“We found, overall, the pattern of health care utilization for dying patients between 2000 and 2009 is best summarized by: more ICU utilization, more repeat hospitalizations, and more late transitions in the last three days of life,” Teno notes.

The researchers analyzed Medicare claims data for a random 20% of all fee-

for-service beneficiaries (mean age, 82.3 years) who died in 2000, 2005, and 2009. Patients were classified according to diagnosis of cancer, COPD, or dementia in the last 180 days of life.

OVERALL FINDINGS

- From 2000 to 2009, the percentage of deaths in acute care declined from 32.6% to 24.6%.
- Deaths at home increased from 30.7% to 33.5%.
- However, the percentage of patients who were hospitalized in the last 90 days of life increased from 62.9% to 69.3%, despite the decline in acute care as the site of death.
- In 2009, 80% of decedents with COPD or cancer and 65% of those with dementia were hospitalized in the last 90 days of life.

ICU UTILIZATION

- 29.2% of decedents experienced an ICU stay in the last 30 days of life in 2009, up from 24.3% in 2000.
- Increase in intensive care use in the last 30 days was greatest among patients with cancer (2000, 19.9%; 2009, 26.8%), followed by those with dementia (2000, 18.6%; 2009, 21.8%) and COPD (2000, 36.6%; 2009, 39.9%).
- Among patients who entered hospice

late (within 3 days of death), 40.3% were enrolled after an ICU stay in 2009.

The use of hospice services at the time of death increased from 21.6% in 2000 to 42.2% in 2009. However, the percentage of decedents with short hospice stays (those enrolled within three days of death) increased from 22.2% in 2000 to 28.4% in 2009. “Short hospice lengths of stay raise concerns that hospice is an ‘add-on’ to a growing pattern of more utilization of intensive services at the end of life,” comment the authors.

“The importance of our study is to reflect on how we’re taking care of dying patients in the United States,” Teno says, encouraging physicians to “talk openly with patients about their prognosis, about what their goals of care are, and to make sure they’re creating a care plan that honors that dying patient’s wishes.”

Sources: “Changes in End-of-Life Care over the Past Decade: More Not Better,” Journal of the American Medical Association; February 6, 2013; 309(5):489-490. Jenq G and Tinetti ME; Department of Medicine, Yale School of Medicine, and Yale School of Public Health, New Haven, Connecticut. “Change in End-of-Life Care for Medicare Beneficiaries,” ibid., pp. 470-477. Teno JM, Gozalo PL, Bynum JPW, et al; Warren Alpert Medical School of Brown University, Providence, Rhode Island; Dartmouth Medical School, Lebanon, New Hampshire. “Health, United States, 2010: With Special Feature on Death and Dying,” National Center for Health Statistics of the Centers for Disease Control and Prevention, Hyattsville, Maryland.

Advance Care Planning (from Page 2)

of-life care has implications for traditional practitioners, who have focused primarily on completing ADs, as well as for practitioners who see minority populations, where studies suggest a general preference for discussing ACP but reluctance to sign ACP documents,” comment the authors.

Source: “Advance Care Planning and the Quality of End-of-Life Care in Older Adults,” Journal of the American Geriatrics Society; February 2013; 61(2):209-214. Bischoff KE, Sudore R, Miao Y, Boscardin WJ, Smith AK; Department of Medicine and Division of Geriatrics, University of California at San Francisco, and Veterans Affairs Medical Center, San Francisco.

Higher Spending Not Linked to Survival for Advanced Cancer Patients

Although effective interventions to prolong survival in older patients with advanced cancer are limited, overall Medicare treatment costs in this population are high, with spending patterns that vary widely across geographic regions. Researchers have found that patients living in regions with higher cancer-care spending near the end of life do not live longer than those in regions that spend less.

“[M]ost new advanced cancer therapies provide survival gains of weeks to months, and many are associated with high costs,” write the authors of a report published in the *Journal of the National Cancer Institute*. “Despite substantial regional variation in Medicare spending for advanced cancer, we did not find a consistent or clinically meaningful association between spending and survival.”

Investigators analyzed data from the

Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute linked to Medicare claims data on patients (n = 116,523) diagnosed from 2002 to 2007 with advanced non-small cell lung, colon, breast, prostate, or pancreatic cancer. U.S. hospital referral regions (n = 80) were stratified into quintiles, based on mean regional Medicare spending from diagnosis until six months later (incident cohort), or throughout the six months or less prior to death (decendent cohort).

OVERALL:

- Mean regional spending increased by 32% (incident cohort) and 41% (decendent cohort) from the lowest to the highest spending quintile.
- Average cost of cancer care by quintile ranged from \$27,446 to \$38,630 in the

six months or less before death.

- High-spending regions were concentrated in Central New Jersey, Southern California, and Louisiana, while the low-spending regions were predominantly located in the Midwest and West.

KEY FINDINGS:

- No consistent survival trend by spending quintile was found for any cancer type in unadjusted analysis.
- After adjustment, no quintile strata for any cancer site showed a survival improvement compared with the lowest spending quintile.
- An inverse association was found between spending and regional rates of hospice use.

“This result is provocative in the con-

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Patient-Centered Care: Improving Value of Care at the End of Life

Care of patients nearing the end of life is often fragmented, and may be delivered without prior knowledge of an individual’s needs and wishes. Improving care requires that policy makers, medical facilities, educators, and clinicians place greater emphasis on patient-centered, value-congruent care, according to the authors of a perspective paper published in *JAMA Surgery* (formerly, *Archives of Surgery*).

“We can improve care while reducing costs by making sure that everything we do is centered on what the patient wants and what his or her specific goals are, and then tailoring a treatment plan to ensure we provide that specific care,” says co-author Jonathan Bergman, MD, Robert Wood Johnson Clinical Scholar at the Department of Urology, University of California, Los Angeles.

“Unfortunately, the opposite is usually what happens,” Bergman continues. “Patients come in with incurable diseases and there’s no discussion of prognosis and goals of care. Then a lot of very aggressive treatments can occur, due to inertia —

patients are placed in an intensive care unit with oxygen and feeding tubes, and that’s not always in line with their goals.”

Research has consistently demonstrated improvement in clinical care when end-of-life preferences are assessed, value-congruent care is delivered, and care recommended by different health care providers is coordinated, point out the authors, who are currently conducting a pilot study to integrate patient-centered care into the clinical practice at the West Los Angeles VA Medical Center. They suggest several policy changes for improving care nationwide.

RECOMMENDATIONS FOR IMPROVING END-OF-LIFE CARE

1. Medical residents should be educated in patient-centered care.

“Physicians will be better prepared to practice in the 21st century and maximize patient outcomes if they are guided toward

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Hospice Patients Found to Have Lower Medicare Costs, Reduced Use of Hospital Services, and Improved Care Quality

A New York research team has found that hospice enrollment not only improves the quality of care for patients and their families, but also saves money for Medicare by reducing hospital days, hospital and intensive care admissions, 30-day hospital readmissions, and in-hospital deaths.

The team's findings, published in *Health Affairs*, has been applauded by the National Hospice and Palliative Care Organization (NHPCO) for "adding to a growing body of research demonstrating the value of hospice care both in terms of high quality and cost savings."

Researchers evaluated data from 3069 patients aged 65 years or older who had participated in the National Institute of Aging's Health and Retirement Study, then merged the data with participants' individual Medicare claims.

Investigators found that Medicare savings were significant in every enrollment period studied, as follows:

- \$2650 in savings for patients enrolled in hospice for 1 to 7 days before death
- \$5040 for enrollment 8 to 14 days before death
- \$6430 for enrollment 15 to 30 days before death
- \$2561 for enrollment 53 to 105 days before death

"These findings...are of particular importance because they suggest that investment in the Medicare hospice benefit

translates into savings overall for the Medicare system," the researchers write.

In noting a significant reduction in hospital services for hospice patients, the authors comment, "Indeed our findings suggest that substantial reduction in hospital days — a primary goal of health care reform — is achieved regardless of the length of hospice enrollment." They add, "If 1,000 beneficiaries enrolled in hospice 15 to 30 days prior to death, Medicare could save more than \$6.4 million."

The NHPCO reports that more than 44% of dying Americans were cared for by hospice in 2011 (the most recent year for which data is available), and among these patients, 84% of hospice care was paid for through the Medicare hospice benefit.

NHPCO president and CEO J. Donald Schumacher notes, "We have an example of a care delivery model that not only scores high in patient and family satisfaction, reduces hospital services, and promotes the dignity of every person cared for, but also can be cost effective with regards to federal spending."

Source: "Hospice Enrollment Saves Money for Medicare and Improves Care Quality across a Number of Different Lengths-of-Stay," Health Affairs; March 2013; 32(3):552-561. Kelley AS, et al; Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai; Department of Economics, Hunter College, City University of New York; and Hertzberg Palliative Care Institute, Mount Sinai Hospital, all in New York City.

Patient-Centered Care (from Page 4)

appropriate care for their patients in life's final stages," write the authors.

2. Medicare should mandate that goals of care be addressed with all patients.

Medicare pays for the bulk of care at the end of life, but meaningful discussions of Medicare policy that address how we die have proven "elusive," note the authors.

"Given the disproportionate cost of care at the very end of life, the issue should be revisited," they write. "Addressing goals of care — not to deny aggressive care to those who want it, but to ensure that we deliver aggressive care only to those who do — reduces costs and improves outcomes."

3. Measures addressing the integration of care at the end of life and assessment of patient preferences should be added to the report of the Joint Commission.

End-of-life care and assessment of patient preferences are

not currently included among any of the Joint Commission's 44 accountability measures or six non-accountability measures comprising its annual report ranking hospitals on quality and safety.

"Adding such measures to the Joint Commission's report would improve practice, as well as inform patient-centered care by empowering individuals to make educated decisions about what care to receive in life's final stages," suggest the authors.

Ultimately, "better care in life's final stages should and can be led by physicians, who have accepted the mission of skillfully — and thoughtfully — caring for patients at every step of life's journey," the authors conclude.

Source: "A Call to Action: Improving Value by Emphasizing Patient-Centered Care at the End of Life," JAMA Surgery; March 2013; 148(3):215-216. Bergman J, Brook RH, Litwin MS; Departments of Urology and Health Services, and Jonsson Comprehensive Cancer Center, University of California, Los Angeles; VA Greater Los Angeles Healthcare System; University of California at Los Angeles/Robert Wood Johnson Clinical Scholars Program; and RAND Corporation, Santa Monica, California.

CLINICIAN RESOURCES

FREE END-OF-LIFE PATIENT GUIDEBOOK

The Conversation Project: How to Talk to Your Doctor

The second phase of a public engagement campaign to help Americans discuss and impart their end-of-life care wishes has been released by The Conversation Project, working in collaboration with the Institute for Healthcare Improvement (IHI) of Cambridge, MA. The first phase, launched in August 2012, consisted of a free starter kit to help patients begin “kitchen table” discussions of their wishes with loved ones. [See *Quality of Life Matters, Volume 14, Issue 3.*]

“Too many Americans spend the last days of their lives in a way they would never choose,” commented the IHI. “Silence on end-of-life preferences is a contributing factor.” The new companion booklet to the original kit serves as both a workbook and a guidebook to help patients take the next step in ensuring their end-of-life wishes will be respected: telling their physicians.

Entitled “How to Talk to Your Doctor (or any member of your health care team),” the free, downloadable booklet provides patients with worksheets, possible scenarios, and sample scripts to help them approach conversations on this dif-

icult topic with health care professionals.

In addition, the booklet explains common medical terms, while reassuring patients that their role is not to compile a list of possible medical interventions, but to help their physicians understand what is of greatest importance to them as individuals.

“Remember, you’re the expert about what matters most to you,” states the booklet. “Your health care team’s role is to listen carefully to your wishes, and then help you make the most appropriate decisions about your care.”

Those who have already completed the first step in the process — i.e., considering what is important to them and discussing their wishes with family and loved ones — are encouraged to take their completed starter kit workbooks with them on the initial office visit.

GUIDEBOOK TOPICS INCLUDE:

- How to prepare for and arrange an appointment for discussing end-of-life care wishes with a member of the health care team
- Questions to ask (e.g., “Can you tell me what I can expect from this illness? What is my life likely to look like six months from now, a year from now, and five years from now?” and, “I don’t understand. Can you explain it in a different way?”)
- What to do if two or more physicians have conflicting opinions, or if the health care proxy disagrees with the patient’s or other loved ones’ wishes
- The importance of having the discussion documented in the medical record
- When to consider follow-up conversations to revisit the issues, as preferences and/or medical conditions change

DON'T WAIT FOR A CRISIS

“Don’t wait for a medical crisis,” advises the booklet. “Talking with your doctor or nurse now makes it easier to make medical decisions when the time comes.”

Physicians are encouraged to suggest that their patients download these free planning tools from The Conversation Project website at: <http://theconversationproject.org/starter-kit/intro>.

Higher Spending Not Linked to Survival for Advanced Cancer Patients

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text of mounting evidence for the quality-of-life and possible survival benefits associated with hospice and palliative care,” note the authors.

The use of inpatient hospital services was found to be the “key driver” of regional variation in spending: patients in high-spending regions were substantially more likely to be hospitalized, to receive intensive care, and to die in the hospital, and less likely to enroll in hospice. In

contrast, little or no difference was found between spending areas in the use of chemotherapy or other outpatient services.

“The identification of inpatient hospitalization as a key driver of regional variation in advanced cancer spending is an important finding at a time when much attention on the cost of cancer care has been focused on the cost of chemotherapy,” observe the authors.

“Our findings suggest that health care providers should be incentivized to devel-

op strategies aimed at reducing potentially avoidable hospitalizations and increasing timely access to palliative care for patients with advanced cancer — goals that are consistent with patient-centered care.”

Source: “Regional Variation in Spending and Survival for Older Adults with Advanced Cancer,” Journal of the National Cancer Institute; Epub ahead of print, March 12, 2013; DOI: 10.1093/jnci/djt025. Brooks GA, et al; Department of Medical Oncology, Dana-Farber Cancer Institute, Boston, Massachusetts; and Division of Cancer Control and Population Sciences, National Cancer Institute, Bethesda, Maryland.

CLINICIAN RESOURCES

BOOK FOR CLINICIANS

Evidence-Based Practice of Palliative Medicine

Written by Nathan E. Goldstein, MD, and R. Sean Morrison, MD, of the Hertzberg Palliative Care Institute, Mount Sinai School of Medicine, New York, this textbook offers busy clinicians a user-friendly approach to finding answers to their questions on providing best-practice palliative care to their patients with serious illness.

Based on the most current literature available, the content is arranged in the form of frequently asked questions on issues surrounding the physical, psychological, and spiritual needs of seriously ill patients and their families. The 81 clinical questions also serve as chapter headings.

Each chapter discusses a topic in the context of the evidence and the expertise of the authors, who hail from a broad range of disciplines in clinical practice, academia, and research. At the end of each chapter is a table summarizing the key points and recommendations for best practice.

The text is divided into sections on symptom management, communication, disease-specific topics, and special topics — such as palliative care emergencies and models for the delivery of palliative and hospice care.

Chapter headings / clinical questions include:

SYMPTOM MANAGEMENT

- What nonopioid treatments should be used to manage dyspnea associated with COPD?
- What treatments are effective for anxiety in patients with serious illness?
- How do symptoms change for patients in the last days and hours of life?

COMMUNICATION

- What is known about prognostication in advanced or serious illness?
- What is a useful strategy for estimating survival for persons with advanced non-cancer-related illness in palliative care settings?
- What are the key elements to having a conversation about setting goals and communicating serious news?
- What elements are essential to effective advance care planning?
- What is the evidence that advance care plans change patient outcomes?

SPECIAL TOPICS

- What can be done to improve outcomes for caregivers?
- In what settings can hospice be provided?
- How can palliative care be integrated into home-based primary care programs?

“Health care professionals want and need to know the facts quickly and accurately as they contextualize medical information and plan strategies,” writes Kathleen Foley, MD, Weill Medical College of Cornell University, Ithaca, NY, in her foreword to the book. “This text provides a framework to make palliative medicine routinized, prescriptive, evidence based, and integrated.”

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ISBN-13: 978-1437737967 (Paperback); 528 pp.*

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

2013 Annual Scientific Meeting of the American Geriatrics Society. May 3-5, 2013, Gaylord Texan Resort & Convention Center, Grapevine, TX. Website: www.americangeriatrics.org/annual_meeting/2013_am

32nd Annual Scientific Meeting of the American Pain Society. May 8-11, 2013, New Orleans, LA. Website: www.ampainsoc.org/meeting/annual_13

13th World Congress of the European Association for Palliative Care. May 30-June 2, 2013, Prague Congress Centre, Prague, Czech Republic. Contact: Farina Hodiament. Email: farina.hodiament@ukb.uni-bonn.de. Website: www.eapc-2013.org

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

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