

Quality of Life Matters[®]

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

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Cancer Patients Have Improved Survival, Better Quality of Life with Early Palliative Care

Patients with non-small-cell lung cancer who received early palliative care in addition to standard cancer therapies reported better quality of life, lower rates of depressive symptoms, received less aggressive care at the end of life, and had longer survival, according to results of a study reported in *The New England Journal of Medicine*.

“Early integration of palliative care with standard oncologic care in patients with metastatic non-small-cell lung cancer resulted in survival that was prolonged by approximately two months and clinically

“With earlier referral to a hospice program, patients may receive care that results in better management of symptoms, leading to stabilization of their condition and prolonged survival.”

— Temel et al, *The New England Journal of Medicine*

meaningful improvements in quality of life and mood,” write the authors.

Metastatic non-small-cell lung cancer is the leading cause of cancer death worldwide, with an estimated prognosis after diagnosis of less than one year. However, palliative care has traditionally been delivered late in the course of the disease, despite previous research suggesting that “late referrals to palliative care are inadequate to alter the quality and delivery of care provided to patients with cancer,” note the authors.

Researchers analyzed patient-reported outcomes and electronic medical records of use of health services for 151 patients newly diagnosed with non-small-cell lung cancer (mean age, 65 years; white, 70% to 77%) between June 2006 and July 2009 at a thoracic oncology care site in Boston. Patients were randomly assigned to receive either early palliative care integrated with standard oncological care, or standard oncological care only.

- Fewer patients in the palliative care group than in the standard care group received aggressive end-of-life care (33% vs 54%).
- Palliative care patients had significantly higher scores in measures of quality of life compared with those receiving standard care (98.0 vs 91.5, on a scale of 0 to 136).
- Half as many patients in the palliative care group as in the standard care group reported depressive symptoms, despite no between-group difference in the use of antidepressants.
- Patients in the palliative care group were more likely to have their resuscitation preferences documented compared with those in the standard group (53% vs 28%).
- Median duration of hospice care, although short in both groups, was nearly three times longer in the palliative care group than in the standard group (11 days vs 4 days).

“Previous data have shown that a lower quality of life and depressed mood are associated with shorter survival among patients with metastatic non-

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KEY FINDINGS

- Patients receiving palliative care lived nearly two months longer than those in the standard care group (11.6 months vs 8.9 months).

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Treating Pneumonia in Patients with Advanced Dementia: A 'Double-Edged Sword'

Although the use of antibiotic therapy for advanced dementia patients with suspected pneumonia was found to extend the number of days lived, it did not improve comfort, a team of Boston researchers has found. Further, greater aggressiveness of care caused progressively greater discomfort without increasing survival benefit.

“[O]ur results indicate that antimicrobial treatment for suspected pneumonia may be a double-edged sword, as it was associated with both survival and discomfort,” write the authors of a report published in the *Archives of Internal Medicine*.

“Comfort is often a main goal of care in advanced dementia, and it is an important concern when treatment options are being considered. Interventions such as parenteral therapy and hospital transfers can be burdensome for the frail elderly,” they add.

Investigators analyzed data on 323 nursing home residents with advanced dementia (mean age, 86 years; female, 81%) in 22 facilities from 2003 to 2009. Follow-up was for up to 18 months or until death. Of the 225 suspected pneumonia episodes experienced by 41% of these residents, 91% were treated with antimicrobial agents.

KEY FINDINGS INCLUDE:

- Antimicrobial therapies used to treat pneumonia episodes were: none, 8.9%; oral only, 55.1%; intramuscular, 15.6%; and intravenous or hospitalization, 20.4%.
- All antimicrobial treatments improved survival after pneumonia, compared with no treatment.
- There was no statistical difference in survival among the three antimicrobial treatment routes.
- Nursing home residents receiving any form of antimicrobial treatment had lower scores for comfort, compared with untreated residents.
- Comfort scores were highest among those not treated, and progressively lower for increasing aggressiveness of care.

“Our results suggest that when the most important goal for a resident with advanced dementia is to prolong survival, even if treatment may cause discomfort, the antimicrobial treatment may extend life by as much as nine months,” comment the authors. However, they suggest confining therapy to the oral route (or the intramuscular, if necessary), which achieved the same survival benefit without the heavier burden and costs of the more aggressive approaches.

“On the other hand,” they continue, “our results suggest that for residents with advanced dementia and suspected pneu-

Hospice Criteria for Advanced Dementia Include:

- Inability to ambulate independently
- Urinary and fecal incontinence
- Dependence in activities of daily living

— Givens et al, *Archives of Internal Medicine*

monia for whom the primary goal of care is comfort, or for whom it is thought that an additional few months of life with advanced dementia will not outweigh the potential burdens of antimicrobial treatment, these agents should be withheld and palliation provided.”

SEEING ADVANCED DEMENTIA AS A TERMINAL ILLNESS

The first step toward improving the end-of-life care delivered to nursing home residents with advanced dementia is recognizing that in this population, dementia is a terminal illness, state the authors of a commentary accompanying the study.

“Recognizing dementia as a terminal illness in nursing home residents and understanding which therapies improve quality of life provide the basis for initiating and guiding advance care discussions about prognosis, expected outcomes of therapy, and goals of care,” the authors comment.

“Patients and families need to know that when goals are to ‘treat the pneumonia,’ more time is spent administering medications and less time is focused on therapeutic touch, listening, comforting, and interacting.”

Because 96% of health care proxies for nursing home patients with dementia believe that comfort should be the primary goal of care, when a resident with advanced dementia develops pneumonia, discussions should focus on what the authors call the “big picture questions: Where are we now in the patient’s disease trajectory? What are the risks and benefits of the proposed therapies? What are his or her goals of care?”

Discussions of advance care planning with patients “are not limited to code status discussions about whether cardiopulmo-

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small-cell lung cancer,” write the authors. “We hypothesize that improvements in both of these outcomes among patients assigned to early palliative care may account for the observed survival benefit.”

THE BENEFITS OF USING MODERN PALLIATIVE CARE TEAMS

The use by physicians of palliative care services delivered simultaneously with disease-focused treatment remains low, note the authors of an editorial accompanying the study. “This study is an example of research that shifts a long-held paradigm that has limited access to palliative care to patients who were predictably and clearly dying.

“The new approach recognizes that life-threatening illness, whether it can be cured or controlled, carries with it significant burdens of suffering for patients and their families and that this suffering can be effectively addressed by modern

“We now have both the means and the knowledge to make palliative care an essential and routine component of evidence-based, high-quality care for the management of serious illness.”

— Kelley and Meier,
The New England Journal of Medicine

palliative care teams.”

PALLIATIVE CARE SUPPORTS PATIENTS AND FAMILIES BY:

- Assessing and treating symptoms
- Providing support for decision making and assistance in matching treatments to informed patient and family goals
- Offering practical aid for patients and their family caregivers

- Mobilizing community resources to ensure a safe living environment
- Ensuring collaborative and seamless models of care across care settings

“Perhaps unsurprisingly, reducing patients’ misery may help them live longer,” comment the authors. “The fact that palliative care improved quality-of-life outcomes is consistent with the results of other studies of both nonhospice and hospice palliative care.”

*Source: “Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer,” The New England Journal of Medicine; August 19, 2010; 363(8):733-742. Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ; Massachusetts General Hospital, Boston; State University of New York, Buffalo; Adult Palliative Medicine, Department of Anesthesiology, Columbia University Medical Center, New York City; Yale University, New Haven, Connecticut. “Palliative Care — A Shifting Paradigm,” *ibid.*; pp. 781-782. Kelley AS and Meier DE; Department of Geriatrics and Palliative Medicine, Mount Sinai School of Medicine, New York City.*

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nary resuscitation and intubation should be attempted,” the authors declare. “They are discussions that uncover a person’s core values.”

Patients can be asked to consider what is most important and meaningful to them, for example: the enjoyment of a favorite meal, decreasing their pain, interacting with others, or decreasing the care burden on loved ones.

Although 70% of dementia-related

deaths in this country occur in nursing homes, only 10% to 30% of nursing home residents who die of advanced dementia are enrolled in hospice, with more than half receiving hospice services for fewer than 90 days, note the authors.

In addition, the development of pneumonia and/or other medical problems is associated with roughly 50% six-month mortality in these patients, the authors point out. “A major barrier to improving end-of-life care is that very few nursing home residents with advanced dementia are rec-

ognized as being at high risk for death.”

*Source: “Survival and Comfort after Treatment of Pneumonia in Advanced Dementia,” Archives of Internal Medicine; July 12, 2010; 170(13):1102-1107. Givens JL, Jones RN, Shaffer ML, Kiely DK, Mitchell SL; Division of Gerontology, Beth Israel Deaconess Medical Center and Hebrew SeniorLife Institute for Aging Research, Boston; Department of Public Health Sciences, Penn State College of Medicine, Hershey, Pennsylvania. “Recognizing Dementia as a Terminal Illness in Nursing Home Residents,” *ibid.*; pp. 1107-1109. Chang A and Walter SC; Division of Geriatrics, Department of Medicine, University of California, San Francisco, and San Francisco Veterans Affairs Medical Center, San Francisco.*

Intensity of ESRD Patients' End-of-Life Care Linked to Regional Treatment Practices

Variations in care practice not explained by patient characteristics, national study finds

Patients with end-stage renal disease (ESRD) who are cared for in hospital referral regions with overall higher Medicare spending during the last six months of life — indicating a higher intensity of end-of-life care — are less likely to be prepared for the end stage of their disease, less likely to discontinue dialysis or enter hospice before death, and more likely to die in the hospital than are those in lower-spending regions, researchers have found.

“[T]hese findings highlight an urgent need for efforts to evaluate and optimize the quality of end-of-life care for older patients with ESRD to ensure provision of care that is congruent with patient preferences and values,” state the authors of a report published in the *Journal of the American Medical Association*.

The team analyzed data from the U.S. Renal Data System, a national ESRD registry, and the Dartmouth Atlas of Healthcare to determine variations in treatment practices for 41,420 older adults (mean age, about 76 years) who began long-term dialysis or received a kidney transplant between June 2005 and May 2006. Hospital referral regions were categorized by quintile according to the end-of-life expenditure index, which reflects spending attributable to the overall quantity of medical services provided.

KEY FINDINGS: PREPAREDNESS FOR ESRD

Patients living in regions in the highest compared with the lowest quintile of end-of-life intensity of care were:

- Less likely to have been under the care of a nephrologist before the onset of ESRD (62.3% vs 71.1%)
- Less likely to initiate hemodialysis with a fistula vs graft or catheter (11.2% vs 16.9%)
- Less likely to select peritoneal dialysis (vs hemodialysis) as their initial modality (2.6% vs 5.9%)
- Less likely to receive a preemptive transplant (0.4% vs 1.0%)

KEY FINDINGS: END-OF-LIFE CARE PRACTICES

Compared with those in the lowest quintile, patients living in regions in the highest quintile of intensity of end-of-life care were:

- Less likely to have discontinued dialysis before death (22.2% vs 44.3%)
- Less likely to have received hospice care (20.7% vs 33.5%)

“A better understanding of why a substantial number of older adults are not adequately prepared for dialysis — particularly in higher intensity-of-care regions in which dialysis treatment practices may be the most aggressive — may help to identify opportunities to improve the quality of advance care planning and share decision making related to ESRD.”

— O'Hare et al, *Journal of the American Medical Association*

- More likely to have died in the hospital (67.8% vs 50.3%)

Overall, 51% of patients died within two years of ESRD onset, ranging from 47.1% in the lowest quintile to 52.6% in the highest expenditure quintile. Life expectancy for very elderly patients on dialysis is often extremely limited, note the authors. Although there was a higher incidence of ESRD in the highest compared to the lowest quintile, there was also less evidence of patient preparedness.

“Almost one-third of patients in this cohort were not under the care of a nephrologist before the onset of ESRD,” note the authors. “Referral to a nephrologist before the onset of ESRD should allow patients to receive information about prognosis and treatment choices and to engage in a process of shared decision making.”

“There is substantial unexplained regional variation in the care of older adults with ESRD, both prior to ESRD onset and prior to death,” the authors conclude. “This finding underlines the importance of a comprehensive informed and ongoing consent process for ESRD treatment based on available evidence and clinical practice guidelines. Such efforts will help to ensure that treatment decisions — including those to initiate and to discontinue dialysis — are based on patient preferences and values rather than regional practice style.”

Source: “Regional Variation in Health Care Intensity and Treatment Practices for End-Stage Renal Disease in Older Adults,” *Journal of the American Medical Association*; July 14, 2010; 304(2):180-186. O'Hare AM, Rodriguez RA, et al; Department of Medicine, University of Washington, Seattle; Department of Medicine and HSR&D Center of Excellence, VA Puget Sound Healthcare System.

Successful Nursing Home-Hospice Collaborations Continue to Grow, Despite Design of Medicare Hospice Benefit

The use of the Medicare hospice benefit by residents dying in nursing homes has more than doubled over the past decade, researchers from Brown University have found, thus providing more patients with the documented benefits of better pain management, fewer hospitalizations, and greater family satisfaction that hospice care provides in this setting.

“At present, given current understanding of nursing home end-of-life care and of the benefits and use of hospice in nursing homes, the provision of nursing home-hospice collaborative care appears to be the most feasible option for widespread improvement of dying residents’ quality of care and life,” write the authors of a report on the study in the *Journal of the American Geriatrics Society*.

“The current study provides new information showing that almost one-third of Medicare beneficiaries dying in nursing homes accessed Medicare hospice in 2006, and given the observed trends, this growth in use is probably continuing,” they add.

The team analyzed nursing home assessment data from the Minimum Data Set and Medicare claims and enrollment data on

all persons who died in nursing homes in the U.S. from 1999 through 2006.

FINDINGS INCLUDE:

- The rate of nursing home decedent hospice use more than doubled (from 14.0% to 33.1%) from 1999 to 2006.
- During that same period, the number of hospices providing care in nursing homes rose from 1850 to 2768.
- The proportion of nursing home hospice decedents with noncancer diagnoses grew from 69.2% to 82.6%.
- There was significant growth in the proportion of all nursing home decedents with diagnoses of cancer (from 23% to 51.3%) and noncancer (from 11.9% to 31.4%) who accessed hospice from 1999 to 2006.
- While the proportion of nursing home decedents with longer hospice stays (more than 180 days) rose from 6.6% to 15.6%, the proportion of those with stays of 7 days or less remained steady over time at about 30%.

“[C]alls for elimination of Medicare hospice in nursing homes based on its underuse appear unfounded,” state the au-

thors. “Additionally, the notion that the complexity of nursing home-hospice collaborations is a major obstacle to the viability of hospice care in nursing homes also appears unfounded, given the high proportion of the U.S. nursing homes contracting with hospice providers and the documented outcomes resulting from this collaborative care.

“Nevertheless, the argument that the design of the Medicare hospice benefit creates barriers to its access is undeniable,” they continue, influencing as it does the timing of referral for patients with noncancer diagnoses, who comprised 83% of all nursing home decedents in 2006.

“The challenge in nursing homes is how to balance the need for hospice access with the timing of referral for nursing home residents in the last stages of (noncancer) chronic terminal illnesses for which predicted survival is poor at best.”

Source: “The Growth of Hospice Care in U.S. Nursing Homes,” *Journal of the American Geriatrics Society*; August 2010; 58(8):1481-1488. Miller SC, Lima J, Gozalo PL, Mor V; Center for Gerontology and Healthcare Research and Department of Community Health, Alpert Medical School, Brown University, Providence, Rhode Island.

Palliative Care Consultations Found to Significantly Lower Hospital Costs and Improve Patient Care and Satisfaction

Care of inpatients with serious, life-limiting illness by a palliative care team substantially reduces overall hospital costs, laboratory and radiology testing costs, and utilization of intensive care units (ICUs), a team of researchers report in the *Journal of Palliative Medicine*.

“Hospital-based palliative care programs, focused on pain and symptom management, communication and goals of

care, and assistance with transitions among sites of care, have become an increasingly common way to improve hospital care for patients with advanced disease and their families,” write the authors of the report.

“This study adds to prior research on the benefits of palliative care consultation by showing that palliative care is associated with substantial reductions in hospital costs...”

Their study is the first to compare average direct hospital costs and to examine the relationship between palliative care consultation and ICU admission (which in itself usually accounts for approximately 20% of overall hospital costs) by using an instrumental variables approach to produce unbiased estimates of the treatment effect, the authors point out.

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CLINICIAN RESOURCES

Standardized Form Documenting End-of-Life Wishes as Medical Orders More Effective Than Traditional Methods

Patients who document their wishes using Physician Orders for Life-Sustaining Treatment (POLST), a brightly colored, standardized medical order form that transfers across care settings, are more likely to receive their preferred level of end-of-life care than are patients using more traditional methods, researchers have found.

The authors of a report published in the *Journal of the American Geriatrics Society* examined the records of 1711 patients (mean age, 84.2 years) from a random sample of 90 nursing facilities in Oregon, Wisconsin, and West Virginia, states in which similar versions of the POLST program are in use.

Key findings include:

- Patients with POLST forms were more likely to have treatment preferences beyond CPR documented as medical orders compared with patients with traditional advance directives (98.0% vs 16.1%).
- Those residents whose POLST orders

indicated comfort measures only were significantly less likely to receive life-sustaining medical interventions than were those who had traditional full code orders, traditional DNR orders, POLST full treatment orders, and POLST limited intervention orders (71%, 59%, 67%, and 42% less likely, respectively).

“Advance directives and CPR status orders often fail to take into account a person’s specific medical condition, and lack an immediate effect on treatment,” the authors state. Patient-generated directives — such as living wills — are generally too vague to be helpful in the clinical setting and rarely indicate when a patient’s preferences are to be acted upon, they add, while DNR orders are relevant only for patients in cardiopulmonary arrest.

“The POLST program is built upon a coordinated system of care across treatment settings that includes emergency services, hospitals, primary care practices, hospices, and nursing facilities, and relies on stan-

dardized, specific orders for a range of treatments, which makes the POLST program unique and may explain its apparent success,” the authors suggest.

Initially developed in Oregon, the POLST program — or versions similar to it in design — is now used in more than 30 states. The border along the top of the form states prominently: “HIPAA permits disclosure of POLST to other health care professionals as necessary,” while the bottom border reads: “Send form with person whenever transferred or discharged.”

For information on states with active or developing POLST programs, visit www.polst.org.

Source: “A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program,” Journal of the American Geriatrics Society; July 2010; 58(7):1241-1248. Hickman SE, Nelson CA, et al; School of Nursing, Indiana University, Indianapolis; Schools of Medicine and Nursing, Oregon Health & Science University, Portland.

Palliative Care Consultations Found to Significantly Lower Hospital Costs

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The team analyzed data on all adult patients (n = 3321) who were admitted to five Veterans Affairs (VA) hospitals between October 2004 and September 2006 with one of seven advanced diseases considered appropriate for palliative care.

RESULTS

- 18% of patients admitted with advanced disease were referred to palliative care by their attending physicians, while most patients (82%) received usual hospital care.
- Hospital total direct costs (including pharmacy, nursing, laboratory, and ra-

diology costs) were \$464 per day lower for patients receiving palliative care compared to usual care.

- Palliative care patients were 43.7% less likely to be admitted to ICUs during hospitalization than were usual care patients.

“We think it likely that palliative care consultation during an inpatient stay for advanced disease influences costs, in part, through the focus of palliative care providers on meeting with patients and/or families and the medical team to establish goals of care and treatments that are concordant with the goals, including lower intensity treatments,” the authors suggest.

The authors caution that their results may

not generalize to palliative care programs that are relatively new or less well organized than that of the VA health system, which — as the largest integrated health care system in the nation — has a well established palliative care program with relatively consistent operating parameters.

Nevertheless, they believe that their “findings provide support for expansion of hospital-based palliative care consultation teams.”

Source: “Hospital-Based Palliative Care Consultation: Effects on Hospital Cost,” Journal of Palliative Medicine; August 2010; 13(8):973-979. Penrod JD, Deb P, Dellenbaugh C, et al; Health Services REAP/GRECC, James J. Peters VA Medical Center, Bronx, New York; Department of Economics, Hunter College, New York City.

CLINICIAN RESOURCES

New Tip Sheet on Prescribing Controlled Substances Available

AMA and four other medical societies encourage compassionate and high-quality care by providing needed medications

Five medical societies have collaborated to develop and distribute a guide for the proper prescribing of controlled substances for their patients in long-term care, in order to better address patients' health needs while dealing with aggressive enforcement actions taken currently by agents of the federal Drug Enforcement Administration (DEA).

"Currently, DEA interpretation of the existing regulation means that patients are going without needed pain relief," says Cheryl Phillips, MD, board chair of the American Geriatrics Society. "This simply should not be happening."

The tip sheet, entitled "Prescribing Controlled Substances in Long-Term Care: Tips for Practicing Clinicians on the Go," has been approved by the American Medical Association, the American Geriatrics Society, the American Academy of Family Physicians, the American Academy of Hospice and Palliative Medicine (AAHPM), and the American Medical Directors Association.

Under current law, a prescription for a controlled substance must be written by the prescriber him- or herself, stresses the tip sheet. Because the DEA agents' recent actions have caused medical professionals to modify long-standing prescription procedures, there is often a delay in the dispensing of controlled substances to patients in need.

TIPS ON EXPEDITING THE FILLING OF A CONTROLLED SUBSTANCE PRESCRIPTION

- Always carry a prescription pad that meets state requirements.
- Know the information required for a prescription to be legal. (The required elements are listed in the tip sheet.)
- Write the prescription at a facility with a fax machine; then fax — rather than phone — it into the pharmacy.
- Purchase a home fax machine for use on weekends and after hours.
- In emergency situations, if faxing is not an option or a prescription pad is not available, phone the pharmacist directly with the order, in addition to providing it to the nurse.

The tip sheet also recommends that physicians become "agents of change" by reaching out to local hospitals to ensure that hospital staffers know to discharge patients with a hard copy prescription for several days' worth of their needed medication. The prescription should both name the drug and also state, "or formulary equivalent."

"Especially when treating patients facing serious, life-limiting illness, there is no time to waste in providing needed medications," says AAHPM president R. Sean Morrison, MD. "By helping physicians and other prescribers navigate DEA requirements, these guidelines are key to ensuring our members do not unintentionally impede care of vulnerable patients."

The tip sheet is available online at: www.americangeriatrics.org/files/documents/tip_sheet_fly.pdf.

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.nhpco.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.medicaring.org

Palliative Care Policy Center

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

Geriatric Medicine Review. February 11-18, 2011, 7-night Caribbean cruise conference from Ft. Lauderdale, FL. Accredited by the Accreditation Council for Continuing Medical Education. Website: www.continuingeducation.net

Annual Assembly of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association. February 16-19, 2011, Vancouver, Canada. Phone: 847-375-4712; Fax: 847-375-6475; Email: info@aaahpm.org; Website: www.aaahpm.org

Program in Palliative Care Education and Practice. Part I: Teaching and Learning in Palliative Care; Part II: Building a Future in Palliative Care. April 5-12, 2011, and November 2-8, 2011, Royal Sonesta Hotel, Cambridge, MA. Sponsor: Harvard Medical School Center for Palliative Care. Website: www.hms.harvard.edu/pallcare/pcep.htm

Annual Scientific Meeting of the American Geriatrics Society. May 11-14, 2011, Gaylord National Resort and Convention Center, National Harbor, MD. Website: www.americangeriatrics.org

30th Annual Scientific Meeting of the American Pain Society. May 19-21, 2011, Austin Convention Center, Austin, TX; Website: www.ampainsoc.org

National Hospice and Palliative Care Organization 12th Clinical Team Conference, Scientific Symposium and Pediatric Intensive. October 6-8, 2011, Town and Country Resort and Convention Center, San Diego, CA. Website: www.nhpco.org

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For more information about hospice and palliative care, or to make a referral, please contact your local hospice and palliative care organization.

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Quality of Life Matters®

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