

Provided as an educational service by

Quality of Life Matters®

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

Vol. 15, Issue 4 Feb/Mar/Apr 2014

Hospice Use Remains Steady, But Median Length of Service Continues to Decrease

'Quality of life for patients and family caregivers can be greatly improved'

The number of patients receiving hospice care in 2012 remained essentially unchanged from the previous year, but the growing proportion of patients receiving short lengths of service is a continuing concern, according to a report from the National Hospice and Palliative Care Organization (NHPCO). In 2012, more than one-third of hospice enrollees died within one week of admission.

"The unique interdisciplinary team of hospice is equipped to aid patients through the last *months* of life," states NHPCO. "Earlier access to hospice care can reduce emergency room visits and hospitalizations. Additionally, quality of

Care from a Hospice Team Includes:

- Management of pain and symptoms
- Assisting the patient with the emotional, psychosocial, and spiritual aspects of dying
- Providing needed drugs, medical supplies, and equipment
- Instructing the family on how to care for the patient
- Delivering special services such as speech and physical therapy, when needed
- Making short-term inpatient care available for management of pain or symptoms that cannot be addressed in the home, or when caregivers need respite
- Providing bereavement care

— NHPCO's Facts and Figures, 2013 Edition

Inside:

NewsLine..... 2-3

- ✓ The Value of Palliative Care: Ten Points Specialists Want All Clinicians to Know

Research Monitor..... 4-5

- ✓ First National Profile of Long-Term Care Services and Users Released
- ✓ Despite Their End-of-Life Care Concerns, Few U.S. Adults Have Advance Directives
- ✓ Physicians' Personal Preferences Influence Timing of Hospice Discussions

Clinician Resources..... 6-7

- ✓ Expressed Preferences Versus Best Interests: A Five-Step Approach to Resolution
- ✓ PREPARE: Free Online Advance Care Planning Tool for Patients

life for patients and family caregivers can be greatly improved."

The NHPCO publication, titled "Facts and Figures: Hospice Care in America," reports that in 2012 an estimated 1.5 to 1.6 million patients received services from more than 5500 hospice programs in all 50 states, as well as the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. The organization had reported 1.65 million enrollees for 2011, but has since revised the methodology used, for what is considered a more accurate representation.

KEY FINDINGS FOR 2012

- Median length of service was 18.7 days, a decrease from 19.1 days in 2011 and 21.2 days in 2009.
- 35.5% of hospice patients died or were discharged within seven days of

admission to hospice.

- 79.9% of patients received care for less than 90 days.
- Only 11.9% received care for more than 180 days.
- 66% of hospice care was provided in the location the patient called home; 27.4% of care took place in a hospice inpatient facility.
- Cancer was the most common admitting diagnosis at 36.9% of patients, a drop from 37.7% in 2011.

PRIMARY NON-CANCER ADMITTING DIAGNOSES INCLUDED:

- Debility, 14.2%
- Dementia, 12.8%
- Heart disease, 11.2%

Continued on Page 3

NEWSLINE

The Value of Palliative Care: Ten Points Specialists Want All Clinicians to Know

About 90 million Americans currently live with a serious, life-threatening illness, and that number is expected to increase. With a focus on aggressive symptom management, psychosocial and spiritual support, and aligning the patient's goals of care, the subspecialty of hospice and palliative medicine has grown rapidly to meet the needs of this population. Yet palliative care is still often misunderstood and underutilized, according to an article published in the *Mayo Clinic Proceedings*.

"As this subspecialty grows, it is important for referring clinicians to understand the scope, timing, and misconceptions about palliative care referrals," write the authors. "[P]alliative care teams are available to help clinicians care for patients and their families at any age and any stage of a serious illness, including those who are actively undergoing disease-targeted therapies."

Palliative care has been found to deliver greater benefit for patients and their families when it is involved early in the disease course. "This involvement leads to more effective and efficient care associated with cost savings, not less care," state the authors. The article presents ten important aspects of palliative care the authors say they "wished everyone knew."

1. Palliative care can help address the multifaceted aspects of care for patients facing a serious illness.

An interdisciplinary team of health professionals — including physicians, nurses, advanced practice clinicians, social workers, chaplains, and pharmacists — aims to improve quality of life for both patient and family by targeting all aspects of a patient's disease experience. "Understanding how illness affects patients' lives, both mentally and physically, is a critical aspect of a palliative

care evaluation," the authors note.

2. Palliative care is appropriate at any stage of serious illness.

Tailored to the needs of the patient and family, palliative care aims to improve the quality of life of patients at any stage of serious illness, whether or not they are receiving disease-modifying therapies. When introduced early, palliative care's attention to symptom management and advance care planning has been found to minimize risk for invasive interventions in the late stages of illness, and may have a measurable mortality benefit.

3. Early integration of palliative care is becoming the new standard of care for patients with advanced cancer.

Organizations such as the American Society of Clinical Oncology, the National Comprehensive Cancer Network, and the World Health Organization all recommend early involvement of palliative care in tandem with cancer-targeted therapy.

4. Moving beyond cancer: Palliative care can be beneficial for many chronic diseases.

Heavy symptom burden is common for patients with many serious illnesses, such as chronic obstructive pulmonary disease, advanced congestive heart failure, pulmonary hypertension, end-stage renal disease, and neurodegenerative diseases. The benefit of early palliative care for patients diagnosed with these illnesses is increasingly recognized by a variety of specialty medical societies.

5. Members of the interdisciplinary palliative care team manage total pain.

With their training and expertise in the management of syndromes associated with chronic and severe illness, palliative care physicians can help when dealing not only with pain, but also with concomitant

nonpain symptoms that affect the patient's experience of pain. Palliative care teams are prepared to address "total pain," or the physical, social, psychological, and spiritual suffering related to serious illness that can impact a patient's pain.

6. Patients with a serious illness have many symptoms that palliative care teams can help address.

The quality of life of many patients with chronic or severe illness is diminished by a number of distressing nonpain symptoms, such as nausea, delirium, fatigue, and dyspnea. Palliative care clinicians are prepared to help identify and address these symptoms, as well as to ameliorate the effect these symptoms can have on caregivers.

7. Palliative care can help address the emotional impact of serious illness on patients and their families.

Distinguishing between normal preparatory grief and clinical depression is clinically challenging. While preparatory grieving is common among dying patients as they mourn impending losses, clinical depression is not. Palliative care teams can help providers to identify depression so it can be treated promptly.

In addition, palliative care aims to build pathways of good communication and trust among the patient, family, and clinical team, and to provide opportunities for the patient to share fears and concerns.

"The opportunity for patients to share hopes, worries, and what their illness means to them is therapeutic for many patients," write the authors. "It is this combination of meticulous attention to both psychosocial distress and physical symptoms that is at the heart of palliative care."

Continued on Page 3

NEWSLINE

Hospice Use Remains Steady, But Median Length of Service Continues to Decrease (from Page 1)

- Lung disease, 8.2%
- Stroke or coma, 4.3%

Patients of non-Caucasian race continued to account for less than one-fifth of hospice users in 2012, but there was a slight rise in their proportion of enrollees, from 17.2% in 2011 to 18.5%. Many people are unaware of the comprehensive services offered by the hospice

interdisciplinary team to patients and their families, notes NHPCO. The team's responsibilities cover a spectrum of care from immediate attention to symptom management to bereavement support for a minimum of one year following a loved one's death. [See sidebar, Page 1.]

"As hospice and palliative care professionals, we need to continue reaching

out to patients and family caregivers to help them understand all the benefits that hospice care brings," says J. Donald Schumacher, PsyD, NHPCO president and CEO. "And as part of our ongoing engagement efforts, we must continue our efforts to reach communities that are underutilizing hospice care."

For information, visit www.nhpc.org.

The Value of Palliative Care: Ten Points Specialists Want All Clinicians to Know (from Page 2)

8. Palliative care teams assist in complex communication interactions.

Responding to emotion and demonstrating empathy are important communication skills for all clinicians, note the authors. "Patients' emotions are important pieces of clinical data that can teach us what patients understand about their medical circumstances and what kind of additional support or information they might need."

When patients and families are grappling with stressful, life-changing news, the words clinicians use must be clear and in alignment with the patient. Such phrases as "there is nothing more we can do" or "withdrawing care" should be avoided, as they are not only damaging to the patient-physician relationship, but also clinically inaccurate.

"We are always providing care and working to optimize quality of life, regardless of whether or not further life-prolongation is possible." Palliative care clinicians can work with collaborating providers to reinforce the idea of ongoing care by helping to manage distressing

symptoms and to provide support to the patient and family.

9. Addressing the barriers to palliative care involvement: Patients' hopes and values equate to more than a cure.

Most of the public and even many in the health care community misunderstand the role of palliative care. Just as choosing hospice care is frequently misconstrued as "giving up," seeking a palliative care consult is often mistakenly seen as suggesting the "beginning of the end," and thus causing the patient to lose hope.

While all providers need to develop basic competency in assessment and initial management of symptoms for the increasing numbers of patients facing serious illness, there are practical reasons for calling on those with both the specialty training and dedicated time and space for focusing on the more complex concerns of these patients.

Subspecialty palliative care is needed for the following:

- Assistance with complex pain and non-pain symptom management
- Managing complex or highly conflict-

rich communication with patients and families

- Responding to complicated, multifaceted psychosocial and/or spiritual distress

10. Palliative care enhances health care value.

Research demonstrates that palliative care involvement is associated not only with savings in health care costs, but also with improvement in the quality of care in such areas as patient quality of life and patient and family satisfaction. As the number of Americans living with serious illness continues to climb, "palliative care will play an integral role in a changing health care landscape that is increasingly focused on providing higher-quality care at a lower cost."

Source: "Top 10 Things Palliative Care Clinicians Wished Everyone Knew about Palliative Care," Mayo Clinic Proceedings; Epub, August 2013; DOI: 10.1016/j.mayocp.2013.05.020. Strand JJ, Kamdar MM, Carey EC; Department of Internal Medicine, Palliative Care Section, Mayo Clinic, Rochester, Minnesota; Department of Internal Medicine, Palliative Care Service, and Department of Anesthesia, Critical Care, and Pain Medicine, Massachusetts General Hospital, Boston.

RESEARCH MONITOR

First National Profile of Long-Term Care Services and Users Released

In 2012, 8.3 million people — mostly aged 65 years and over — received services from one of 58,500 long-term care providers in the U.S., according to a groundbreaking report released in December 2013 by the federal Centers for Disease Control (CDC). The new initiative aims to monitor and report on emerging trends in the long-term care field every two years.

The report is based on the National Study of Long-Term Care Providers (NSLTCP), which delivers “a current national picture of providers and users” of paid, regulated long-term care services. “These findings can inform policy and planning to meet the needs of an aging population,” states the report.

The NSLTCP notes that due to the desire of many older patients to stay in their own homes, the use of home- and community-based services is increasing.

Although there were regional variations, both the overall supply and use of nursing homes continue to be greater than those of other long-term care options. In 2012, there were about 1.4 million residents in nursing homes and 713,000 people living in residential care communities each day. In 2011, some 1.2 million patients received services from hospices.

FINDINGS INCLUDE:

- The percentage of long-term care users with a diagnosis of depression was lowest among hospices (22.2%) and highest among nursing homes (48.5%).
- A higher proportion of both hospices (97.2%) and nursing homes (86.6%) offered mental health and counseling services than did other providers.
- The percentage of patients with dementia was highest among nursing homes (48.5%) and hospices (44.3%) and

lowest among home health agencies (30.1%).

- Hospice services were offered by a larger percentage of residential care communities (89.4%) than nursing homes (78.6%). The lowest rate of hospice services was found among adult day services centers (24.4%) and home health agencies (5.6%).
- Hospices and home health agencies had the largest percentage of registered nurses (RNs) as full-time nursing employees, at 54.7% and 54.4%, respectively. Only 11.7% of nursing staff at nursing homes were RNs.
- Most hospices were in the South (42.4%); the fewest were in the Northeast (12.6%).

For more information and to view the full report, visit www.cdc.gov/nchs/nsltcp.htm.

Despite Their End-of-Life Care Concerns, Few U.S. Adults Have Advance Directives

More than two-thirds of Americans aged 18 years or older are concerned about their care at the end of life, yet only about one-quarter have completed an advance directive. For racial and ethnic minorities, the proportion is even lower, according to a report published in the *American Journal of Preventive Medicine*, the official journal of the American College of Preventive Medicine and the Association for Prevention Teaching and Research.

The use of advance directives is associated with reduced Medicare spending, a lower likelihood of in-hospital death, and greater use of hospice, the authors point out. However, there has been a lack of population-based data on adults' attitudes and behaviors regarding advance direc-

tives and the factors associated with their completion.

“Prior studies have focused on clinical populations, state samples, or certain age groups,” write the authors. “Given the current discussions about implementing various models of health care delivery..., end-of-life issues need to come to the forefront of planning efforts. Hopefully, these findings will contribute to the current national conversations about end-of-life care.”

Investigators analyzed the responses of 7946 adults aged 18 years and older who had participated in the nationally representative HealthStyles surveys, updated in 2009 and 2010 to include five questions on end-of-life issues and the factors that influence the completion of advance directives.

OVERALL FINDINGS

- 67.8% of participants reported having concerns about end-of-life care, such as the cost of care, the pain they might experience, or issues of comfort and dignity.
- Nearly half (48.7%) reported having discussed with someone the types of medical treatment they wished to receive in the event of serious illness.
- Only 26.3% of participants had completed an advance directive.
- The top two reasons given for not having an advance directive were lack of awareness and the belief that their families already knew their wishes.

Continued on Page 5

RESEARCH MONITOR

Physicians' Personal Preferences Influence Timing of Hospice Discussions

Although most physicians say they would personally choose hospice care if terminally ill with cancer, only one-quarter would discuss hospice care immediately with a patient having four to six months to live, and nearly half report that they would delay such a discussion until all treatment options had been exhausted.

"Most physicians reported they would enroll in hospice if they were terminally ill with cancer," write the authors of a research letter published in *JAMA Internal Medicine*. "Physicians with strong personal preferences for hospice were more likely than others to report discussing hospice with their patients earlier."

Researchers analyzed the survey responses from 4368 physicians (primary care, 41%; male, 80%) of more than 10,000 patients enrolled from 2003 to 2005 in the national Cancer Care Outcomes Research and Surveillance (CanCORS) study. Physicians were asked to indicate whether they would choose hospice care for themselves if terminally ill, and what would prompt them to introduce the topic of hospice to a

hypothetical asymptomatic cancer patient with four to six months to live.

PHYSICIANS' PERSONAL VIEWS

- 64.5% of physicians strongly agreed that they would enroll in hospice if terminally ill with cancer; 21.4% somewhat agreed.
- Physicians were more likely to strongly agree if they were female, had cared for more than 12 terminally ill patients in the past year, or worked in a managed-care or primary-care setting
- Radiation oncologists and surgeons were less likely than primary care physicians or medical oncologists to report they would enroll in hospice.

HOSPICE DISCUSSION TIMING

- Only 26.5% of physicians would discuss hospice "now" with a patient who had four to six months to live.
- 48.7% would not discuss hospice until there were no more nonpalliative treatments to offer.
- 4.3% would discuss hospice only if the

patient or family brought the topic up.

- 1.7% would introduce hospice only if the patient were hospitalized.

Physicians who strongly agreed they would seek hospice care themselves were more likely than others to discuss hospice "now" with patients with four to six months to live (odds ratio, 1.7; 95% confidence interval, 1.5 to 2.0).

"Physicians should consider their personal preferences for hospice as a factor as they care for terminally ill patients with cancer," write the authors. "Physicians with negative views of hospice may consider pursuing additional education about how hospice may help their patients."

Source: "Physicians' Preferences for Hospice If They Were Terminally Ill and the Timing of Hospice Discussions with Their Patients," *JAMA Internal Medicine*; Epub, December 16, 2013; DOI: 10.1001/jamainternmed.2013.12825. Chinn GM, et al; Division of General Medicine, Department of Medicine, Massachusetts General Hospital, and Harvard Medical School, Boston; Division of Cancer Control and Population Sciences, National Cancer Institute, Bethesda, Maryland.

Advance Directives (from Page 4)

"Interestingly, those who reported not knowing if they had an end-of-life concern were less likely to have an advance directive," observe the authors. "People who lack the knowledge to have end-of-life concerns or discussions or about the role of advance directives in facilitating end-of-life decisions may represent potential targets for intervention."

RACIAL/ETHNIC DIFFERENCES

- Advance directives were more frequent among participants who were older, female, more highly educated, or at a higher income level, yet ethnic and racial disparities persisted.
- While 30.6% of white participants had

completed an advance directive, only 17% of black participants and 16.7% of Hispanic participants had done so.

- Among college graduates, 33.7% of whites, 23.2% of blacks, and 18% of Hispanics reported having an advance directive.

"For black and Hispanic respondents, advance directives were less frequent across all educational groups," comment the authors.

Tools have been developed to help people and their families understand end-of-life issues and to aid in medical decision making, the authors note. A broader dissemination of these tools would be helpful

in increasing their use.

Although survey data suggest that most people would prefer receiving end-of-life information from providers, physicians can often experience barriers to these conversations. "Communication interventions may help improve physicians' skills in discussing end-of-life issues with patients."

Source: "Completion of Advance Directives among U.S. Consumers," *American Journal of Preventive Medicine*; January 2014; 46(1):65-70. Rao JK, Anderson LA, et al; Gillings School of Global Public Health, University of North Carolina at Chapel Hill, North Carolina; Healthy Aging Program, Applied Research and Translation Branch, Division of Population Health, Centers for Disease Control and Prevention, Atlanta.

CLINICIAN RESOURCES

Expressed Preferences Versus Best Interests: A Five-Step Approach to Resolution

Advance directives can ease the burden of making medical decisions on behalf of an incapacitated patient, but they are not all-inclusive. Surrogates and physicians are often faced with making clinical decisions in situations that were not foreseen. A framework for balancing the patient's present best interests with previously stated values and goals is presented in an article published in *JAMA Internal Medicine*.

"Conflicts between a patient's previously expressed preferences and what is thought to be in his or her current best interest often create confusion, ambivalence, and substantial emotional and moral burden for surrogates and physicians," write the authors. "It is often difficult to know how best to proceed."

There is a lack of practical guidance for clinicians on how to honor a patient's preferences while acting in his or her best interests, note the authors. Using two hypothetical case reports, they illustrate how an ethical framework for addressing unforeseen issues can be used when the patient's surrogate is present.

"While there are no absolute right answers that apply to all patients, we propose a new five-question framework and show how it can be applied in specific cases to help clinicians and surrogates think through the relevant issues and come to an ethically appropriate decision."

1. Is the clinical situation an emergency? Does it allow no time for deliberation? Is there a clear code status order?

Most clinical situations allow at least some time for deliberation. When advance directives contain vague language and unclear instructions, these will need to be interpreted. In an emergency situation, if the surrogate can provide immediate, clear, and unambiguous information on the patient's do-not-resuscitate wishes, for example, those wishes must be honored. However, in

the absence of such clarification, the best interests of the patient are served by prolonging life until there is time for deliberation.

2. In view of the patient's values and goals, how likely is it that the benefits of the intervention will outweigh the burdens?

Before taking action to override a patient's previously expressed preferences, the benefits and burdens of the proposed intervention must be evaluated and, in collaboration with the surrogate, guided by the patient's underlying goals. Physicians can:

- Obtain key medical information and advice from specialists.
- Discuss the clinical situation with the surrogate in terms he or she can understand.
- Invite the surrogate to ask questions.

3. How well does the advance directive fit the situation at hand?

When the exact words of an advance directive are at odds with the patient's best interests, they may refer to radically different circumstances. Physicians can explore with the surrogate the values and goals that lie behind the patient's earlier choices. "Respecting [the patient's] values and goals may be more ethically defensible than following literally previously stated preferences in an advance directive that were meant to apply to different circumstances," write the authors.

4. How much leeway did the patient provide the surrogate for overriding the advance directive?

The authors strongly recommend that physicians discuss decision-making leeway with their patients during advance care planning, because of its importance in granting a trusted surrogate the flexibility to adapt decisions to unforeseen circumstances, and because only a few advance directive forms currently capture a patient's preferences for leeway.

There are pros and cons to allowing leeway. Some view it as an erosion of the extended patient autonomy that advance directives were created to honor; on the other hand, when a patient trusts the surrogate to understand and honor his or her values, leeway can be considered an extension of that autonomy.

Currently, however, it is unlikely that a patient will have previously discussed leeway. Therefore, the physician and surrogate would require a compelling reason, in the context of the patient's values and goals, to modify specific written directives in the patient's best interest.

5. How well does the surrogate represent the patient's best interests?

Surrogates may sometimes be so overwhelmed by their own emotional needs that they lose sight of the patient's best interests in favor of their own. Physicians need to address issues such as anticipatory grief and the angst of decision making before discussing how the patient would wish to be treated in the current circumstances. Physicians can:

- Use open-ended questions and empathic comments.
- Summarize the surrogate's statements about the patient's values.
- Link those values to the current situation.
- Offer to make a recommendation.

The authors suggest future research to test the helpfulness of their framework in clinical practice and to discover if refinements are needed.

Source: "When Previously Expressed Wishes Conflict with Best Interests," JAMA Internal Medicine; July 8, 2013; 173(13):1241-1245. Smith AK, Lo B, Sudore R; Division of Geriatrics and Division of General Internal Medicine, Department of Medicine, University of California, San Francisco; San Francisco Veterans Affairs Medical Center, San Francisco; and The Greenwall Foundation, New York City.

CLINICIAN RESOURCES

PREPARE: Free Online Advance Care Planning Tool for Patients

www.prepareforyourcare.org

A recently launched website has been designed to prepare patients for advance care planning by helping them acquire the skills needed to identify which treatments or types of care are most consistent with their current goals and to communicate these beliefs effectively.

The focus of the PREPARE program is not merely on selecting which specific medical procedures people may wish to receive or forgo in the future so they can sign a form, but also on deciding what is important, having the necessary conversations, and communicating with surrogates and clinicians.

The interactive, step-by-step process aims to help patients learn how to make informed medical decisions in the present, preparing them to make more complex, in-the-moment decisions in the context of their beliefs and values, as conditions change and crises arise in the future.

The easy navigation format provides clear instructions, beginning with such basics as how to use a mouse to navigate the website, then proceeds with video demonstrations and examples of conversations.

Participants who sign in are kept abreast of the steps they have thus far completed, then encouraged to make an action plan and share it with their family and clinicians.

THE FIVE-STEP PROCESS TEACHES PATIENTS HOW TO:

1. Choose a medical decision maker and ask the person to serve in that role
2. Decide what matters most in life
3. Discuss flexibility for the surrogate decision maker
4. Tell others about their wishes
5. Ask clinicians the right questions for making informed medical decisions

A pilot test of the website found that it significantly increased engagement in advance care planning behavior change within one week. The cohort of racially and ethnically diverse older adults, many of whom had limited health and computer literacy, gave the website an ease-of-use rating of nine on a ten-point scale.

“The PREPARE website was found to be easy to use by diverse, older adults, and our preliminary findings show that PREPARE positively affects behavioral change in advance care planning,” write Rebecca L. Sudore, MD, and colleagues, authors of the study report and designers of the website. A randomized, controlled trial is currently being conducted to assess the website’s effectiveness in clinical practice.

Source: “A Novel Website to Prepare Diverse Older Adults for Decision Making and Advance Care Planning: A Pilot Study,” Journal of Pain and Symptom Management; Epub, August 21, 2013; DOI: 10.1016/j.painsymman.2013.05.023. Sudore RL, Knight SJ, McMahan RD, Feuz M, Farrell D, Miao Y, Barnes DE; San Francisco Veterans Affairs Medical Center, San Francisco; Division of Geriatrics, Departments of Psychiatry and Epidemiology & Biostatistics, University of California, San Francisco; Health Services Research & Development Service, Veterans Administration, Washington, DC; and People Designs, Inc., Durham, North Carolina.

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.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

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

2014 Annual Assembly of the American Academy of Hospice and Palliative Medicine (AAHPM) and the Hospice and Palliative Nurses Association (HPNA). March 12–15, 2014, San Diego, CA. Website: www.aahpm.org/learn/default/meetings.html

NHPCO 29th Management & Leadership Conference. March 25–26, 2014, Gaylord National Resort and Convention Center, National Harbor, MD. Website: www.nhpc.org

33rd Annual Scientific Meeting of the American Pain Society. April 30–May 3, 2014, Tampa Convention Center, Tampa, FL. Website: www.americanpainsociety.org/meeting/content/conferencehome.html

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

Quality of Life Matters®

Now entering its 16th year of publication, Quality of Life Matters **is recommended as an educational resource by the American Academy of Hospice and Palliative Medicine**. The periodical is dedicated solely to end-of-life care news and clinical findings and is researched and written by professional medical journalists specializing in covering palliative care issues. It is an independent publication; it is not affiliated with any health care organization or company. The quarterly newsletter is published by Quality of Life Publishing Co., a firm dedicated to easing the way for patients with life-limiting illnesses and their families.

We customize copies of the newsletter for hospices and other organizations to provide as an educational service for their local clinicians. For information and rates:

TOLL FREE

1-877-513-0099

www.QoLpublishing.com

**CALL TO LEARN ABOUT OUR FULL
LINE OF BRANDED EDUCATIONAL
BOOKLETS, AVAILABLE IN ENGLISH
AND SPANISH, WHICH NOW MEET
HEALTH LITERACY STANDARDS.**

© 2014 by Quality of Life Publishing Co. All rights reserved. No part of this newsletter may be reproduced without prior permission of the publisher. For reprint requests or information:

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

Phone: 239-513-9907

Toll Free: 1-877-513-0099

Email: info@QoLpublishing.com



Karla Wheeler
Editor & Founder

Jan Carlton Doetsch
Clinical Editor

Gretchen Landolt
Chief Executive Officer

Kelly Brachle
Chief Operating Officer

Dashia Larimer
Vice President of
Customer Relations

Katie Jensen
Production Coordinator

Mike Schadler
Billing Associate

Natasha Krishna
Sales and Marketing
Associate

Quality of Life Matters® is a registered trademark of
Quality of Life Publishing Co.

15-4