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Quality of Life Matters®

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

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Many Family Physicians See Themselves as Providers of Palliative Care

One-third of U.S. family physicians report providing palliative care as part of their routine practice, although this provision varies widely by geographic region, physician characteristics, and care setting, according to a research letter published in the *Journal of the American Board of Family Medicine*.

Palliative care, which entered the U.S. medical care system with the mission of improving quality of life for patients

facing the end of life and their families, has expanded its focus to providing such care and support along the entire trajectory of serious illness. The authors note that since the number of older adults with chronic conditions is expected to increase in the coming decades, “medical advances will create for many of these patients a prolonged trajectory of dying, in which primary care physicians will play critical roles in care coordination and front-line management.”

Investigators analyzed data reported by 10,894 family physicians (the equivalent of about 10% of all U.S. family physicians) in the 2013 American Board of Family Medicine Maintenance of Certification Demographic Survey, a requirement for family physicians applying for recertification.

OVERALL

- 33.1% of family medicine respondents reported providing palliative care.
- Of those, most indicated they did so in non-clinic-based settings, such as patients’ homes (45%), nursing homes (30%), or hospice facilities (17%).
- Only 241 of the 10,894 respondents reported being certified in hospice and palliative medicine.

KEY FINDINGS

- Palliative care provision was more likely among rural vs urban physi-

cians (odds ratio [OR], 2.38; 95% confidence interval [CI], 1.61 to 3.50; $P < 0.001$) and in western vs southern U.S. regions (OR, 1.16; 95% CI, 1.03 to 1.32; $P < 0.05$).

- Physicians in practice more than 30 years were more likely to provide palliative care than those in practice 10 years or less (OR, 1.36; 95% CI, 1.15 to 1.60; $P < 0.001$).
- Compared to white physicians, provision of palliative care was less likely among black (OR, 0.36; 95% CI, 0.28 to 0.46), Asian American (OR, 0.62; 95% CI, 0.53 to 0.73) or Hispanic (OR, 0.74; 95% CI, 0.60 to 0.92) physicians.

“This study raises questions about what family physicians perceive as their role in providing palliative care and what they need in order to better engage in palliative care,” the authors conclude. They suggest further research to examine barriers family physicians face to providing palliative care to an increasing population of older adults.

Source: “Provision of Palliative Care Services by Family Physicians Is Common,” *Journal of the American Board of Family Medicine*; March–April 2017; 30(2):255–257. Ankuda CK, Jetty A, Bazemore A, Patterson S; the Robert Wood Johnson Clinical Scholars Program and the Department of Family Medicine, University of Michigan, Ann Arbor; and the Robert Graham Center for Policy Studies in Family Medicine and Primary Care, Washington, DC.

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NEWSLINE

Oncologists Describe a Need for More Outpatient Specialist Palliative Care

Oncologists appreciate the value of palliative care (PC), but they perceive various challenges in their interactions with PC specialists. They call for the establishment of more outpatient PC services, and suggest ways in which collaboration with PC teams could be improved, according to a report published in the *Journal of Palliative Medicine*.

“Oncologists in our sample were supportive of PC, but they reported obstacles related to care coordination and inpatient PC,” write the authors. “Inpatient PC posed some unique challenges with respect to conflicting prognoses and care practices that would be mitigated through the increased availability and use of outpatient PC.”

Investigators analyzed responses to in-depth qualitative interviews conducted in 2015 with a national sample of oncologists (n = 31; male, 52%) caring for patients with advanced solid tumors (late stage III or stage IV) in the general community (n = 9), academic medical centers (n = 11), and the Veterans Health Administration (n = 9), as well as two oncologists in administrative roles. Most respondents were full-time practicing oncologists, with professional experience ranging from four to 40 years.

Recent research shows gaps persisting between the recommended provision and the receipt of PC among patients with cancer, despite practice guidelines recommending delivery of PC from diagnosis through death, note the authors. “These recommendations stem from robust evidence establishing the ability of PC to improve patient satisfaction, quality of life, and overall survival,” they write. “Although PC is not simply end-of-life care, it is certainly recommended and appropriate for patients in their terminal stages.”

Suggested reasons for the low receipt of PC by cancer patients include:

- The under-availability of PC specialists
- A lack of patient understanding of PC
- Patient/family reticence regarding PC
- Oncologist-related factors, such as oncologists themselves providing PC and their perceptions of the merits of PC

“Oncologists are key stakeholders in improving how PC is delivered to advanced cancer patients. They serve as both gatekeepers to referral and the most common primary PC providers,” write the authors. “Their views of the major barriers and potential solutions to gaps in PC are thus important in their own right and in guiding quality improvement efforts.”

KEY FINDINGS

Oncologists’ views of their role in providing PC were divided into three categories:

1. **The oncologist refers all patients to specialist PC** for provision of care beyond anti-neoplastic treatment.
2. **The oncologist provides primary PC, referring patients to specialists** when more intensive PC is needed, or when focus on the growing complexity of cancer treatment options causes time constraints for the oncologist.
3. **The oncologist provides all PC**, from pain and/or symptom management to more complex care such as goals-of-care discussions. Oncologists who provided all PC themselves did so because of inadequate access to PC specialists, or because they believed PC to be an integral part of high-quality oncologic care and that they possessed the necessary skill set for delivering such care.

Several major themes emerged regarding oncologists’ perceptions of and experience with PC. These included:

- Oncologists perceived PC as an impor-

tant “extra layer” of support that was appropriate throughout the disease trajectory, from diagnosis through bereaved family support. However, due to its limited availability, specialist PC was generally provided to their patients only at the very end of life.

- Oncologists stressed a great need for PC in the outpatient setting, which would provide the benefits of earlier access, improved care coordination and continuity, and increased physician rapport with patients and PC teams. However, due to the under-availability of outpatient PC, most specialist PC is delivered late and in the hospital, which one respondent deemed “the wrong place at the wrong time.”
- Poor communication between medical oncologists and PC care teams about prognosis and care plans can send mixed messages to hospitalized patients and hinder care coordination.
- PC specialists are seen as having a positive influence on patients’ comfort by talking openly about goals and treatment preferences. On the other hand, oncologists sometimes believe that the PC team lacks the big picture needed for shared decision making.
- Some oncologists thought that the focus of PC was too narrow, offering services that they believed they could handle themselves.
- Because evidence-based PC is derived from research conducted in tertiary care centers, it is not always generalizable to oncology practice in public hospitals or the community at large, some respondents noted. “This finding has important implications for future research not only regarding PC [for cancer], but regarding other medical conditions as well,” comment the authors.

Continued on Page 3

NEWSLINE

Older Japanese Americans Open to Considering Hospice Care

In an apparent shift in cultural attitudes surrounding death, members of the current generation of older Japanese-American adults expressed a willingness to discuss end-of-life care and an interest in learning more about hospice, according to a research letter published in the *Journal of Palliative Medicine*.

“[T]hese results underline the importance of acknowledging within-group differences and caution against stereotyping...” write the authors. “This is especially important for healthcare providers caring for older adults and those with serious illness.”

Asians and Pacific Islanders in the U.S. use hospice at a very low rate (3.1%), according to the report for 2015 from the National Hospice and Palliative Care

Organization, although it is identified by the U.S. Census Bureau as the nation’s fastest growing racial group from 2000 and 2010, the authors note.

Researchers conducted focus groups in both English and Japanese among community-dwelling older adults (n = 20; age, ≥ 65 years) recruited from a social service agency in San Francisco. Their findings revealed that despite initial misconceptions held regarding hospice care, participants were open to discussing prognosis and advance care planning with their families and clinicians, and interested in gaining more information about hospice.

“When I heard the word ‘hospice,’ I thought it had something to do with the hospital, but I’m surprised you can do it

at home. People will like it and be interested,” said one participant.

Participants’ cultural considerations included not wanting to be a burden and a preference for family decision making. Because it provides support for loved ones and joint decision making, “hospice care may serve as a culturally parallel response to relieving family burden among Japanese Americans,” suggest the authors.

Source: “Unless You Bring It Up, You Won’t Know the Reactions of the People: Older Japanese Americans’ Perceptions toward Hospice Care and Advance Care Discussion and Planning,” Journal of Palliative Medicine; May 2017; 20(5):445–447. Coulourides Kogan A et al; Department of Family Medicine and Geriatrics, Keck School of Medicine of USC, University of Southern California, Alhambra.

Oncologists Describe a Need for Outpatient Palliative Care (from Page 2)

IMPROVING COLLABORATION

Oncologists identified three main ways for facilitating the working relationship between oncologists and PC specialists and improving the delivery of PC to their patients:

- 1. Establish clear divisions of responsibility.** Oncologists suggested that patient confusion or clinician friction might be minimized by specifying the services desired from a PC consult (such as pain management and/or psychological support). In addition, communicating the oncologist’s prognosis and the patient’s awareness of that prognosis to the PC team might prevent the patient from receiving contradictory or surprising information. “Other work evaluating provider perceptions of PC on heart failure has also found that clarity regarding PC physicians’ responsibilities is crucial to

physician acceptance of PC providers,” note the authors.

- 2. Foster in-person collaboration between oncologists and PC specialists.** Rather than reliance on written or telephone communication, oncologists suggested several different forms of in-person collaboration that could be used between primary oncologists and PC physicians. These include joint patient visits, meetings of both teams to discuss multiple patients, the inclusion of PC specialists in cancer committee meetings, and locating PC clinics in close proximity to oncology clinics.
- 3. Share PC support staff.** As an alternative to direct collaboration between oncology and PC physicians, oncologists suggested that nonphysician PC practitioners could serve as members of both the oncology and PC teams.

“As the demand for PC outpaces its supply, further work is needed to understand

whether the components of PC assessment and intervention can be disaggregated and appropriately provided by other nonphysician practitioners, including nurses and social workers,” write the authors.

“The aim of this work is to provide a rich and nuanced understanding of the range of ways in which oncologists think about primary and specialist PC and the integration of PC in oncology,” comment the authors. They consider their findings to be a foundation for further exploration of how these attitudes and opinions hold across different care settings and practitioner types.

Source: “The Appropriate Provision of Primary versus Specialist Palliative Care to Cancer Patients: Oncologists’ Perspectives,” Journal of Palliative Medicine; April 2017; 20(4):395–403. Gidwani R et al; Health Economics Resource Center and Center for Innovation to Implementation, VA Palo Alto Health Care System, Palo Alto, California.

RESEARCH MONITOR

Advance Directives for Kidney Failure Patients Are Seldom in Place, Although Linked to Fewer In-Hospital Deaths and Greater Use of Hospice

Patients with end-stage renal disease (ESRD) residing in nursing homes are less likely than residents with other advanced illnesses to have completed an advance directive (AD) or to have designated a surrogate, yet when these directives are in place, 92% of patients receive end-of-life care concordant with their preferences, a nationwide study has found.

“Patients with a treatment-limiting directive were less likely to be hospitalized, receive intensive procedures, and die in the hospital, and more likely to receive hospice care and discontinue dialysis compared with patients without a treatment-limiting directive,” write the authors of a report published in the *Clinical Journal of the American Society of Nephrology*.

More than 800,000 Americans with ESRD die each year while receiving dialysis, and more than one-third of Medicare patients with ESRD reside in a nursing home near the end of life, the authors note.

Low prevalence of ADs in this population has been documented, but little is known of how effective such directives may be in helping patients to avoid unwanted interventions at the end of life.

“Surveys suggest that a majority of patients receiving dialysis would prefer care focused on maintaining comfort rather than prolonging life if they were to become seriously ill,” write the authors. “Yet many patients with ESRD receive treatments near the end of life that are aimed at prolonging life rather than maximizing comfort, and family members rate the quality of death for patients with ESRD lower than for other serious illnesses.”

Investigators compared the prevalence and content of ADs among nursing home residents with ESRD receiving dialysis (n = 30,716) with those of residents with other serious illnesses (n = 30,825) in the

year before death, using national data for 2006 and 2007. AD content was linked to Medicare claims to determine treatment received in the last month of life.

OVERALL

- 47% of residents with ESRD had treatment-limiting ADs, fewer than those with cancer (59%), advanced COPD (61%), or advanced dementia (70%).
- 42% of ESRD patients receiving dialysis died in the hospital.
- 26% of ESRD patients enrolled in hospice; 32% discontinued dialysis.
- Among those ESRD patients with a treatment-limiting AD, 92% received care in the last month of life that was concordant with their preferences.

ADJUSTED ANALYSES

- 36% of ESRD patients receiving dialysis had a treatment-limiting directive (an estimate lower by 13% to 27% than for those with other serious illnesses).
- 22% had a surrogate decision maker (lower by 5% to 11%).
- 13% had both (lower by 6% to 13%).
- ESRD patients receiving dialysis who had both a treatment-limiting directive and a surrogate decision maker had lower frequency of hospitalization (by 13%), ICU admission (by 17%), intensive procedures (by 13%), and inpatient death (by 14%) compared with ESRD patients lacking both measures.
- Dialysis patients with both an AD and surrogate had a higher rate of hospice use (by 5%) and discontinuation of dialysis (by 7%) compared with ESRD patients lacking both components.

Current barriers exist to engagement in advance care planning (ACP) and sub-

sequent documentation of AD for ESRD patients, leading to missed opportunities for identifying patient preferences and addressing goals of care, the authors note.

BARRIERS

- Misplaced financial incentives favoring the use of high-cost acute care
- Fragmentation of care, contributing to a lack of clarity as to which provider should initiate an ACP discussion
- Poor communication of prognosis
- Failure to recognize when the end of life is approaching

ADDRESSING BARRIERS

- Systematic screening of dialysis patients to identify those with a poor prognosis who may benefit from ACP and hospice care
- Implementing culturally sensitive ACP interventions
- Using functional decline and/or transitions in care as triggers for ACP

“Efforts to increase engagement in advance care planning and expand the use of advance directives among patients receiving dialysis may offer untapped opportunities to better align end-of-life care with patient preferences and values,” conclude the authors.

Source: “Advance Directives and End-of-Life Care among Nursing Home Residents Receiving Maintenance Dialysis,” *Clinical Journal of the American Society of Nephrology*; March 7, 2017; 12(3):435–442. Kurella Tamura M et al; Geriatric Research and Education Clinical Center, Palo Alto Veterans Affairs Health Care System, Palo Alto, California; Division of Nephrology, Stanford University School of Medicine, Palo Alto; Department of Medicine, Group Health Cooperative, Seattle; and Department of Medicine, Kidney Research Institute, University of Washington, Seattle.

RESEARCH MONITOR

Early Integrated Palliative Care Improves Quality of Life, Increases Care Discussions among Advanced Cancer Patients

The early integration of palliative care (PC) and oncology care improves self-reported quality of life (QOL), reduces symptoms of depression, and enhances adaptive coping with discussions of prognosis and goals of care among patients newly diagnosed with incurable lung or gastrointestinal (GI) cancer, according to a report published in the *Journal of Clinical Oncology*.

“The results from this trial add to the growing literature on the benefits of integrating PC services earlier in the course of disease for patients with advanced cancer,” write the authors. “We not only confirmed previous findings that early integrated PC improves QOL and mood in patients with incurable cancers, but also that these positive effects on patient outcomes vary by cancer.”

Between May 2011 and July 2015, 350 patients (male, 54.0%; white, 92.3%) with newly diagnosed incurable lung cancer or non-colorectal GI cancer were randomly assigned to receive either early PC integrated with oncology care (n = 175) or usual oncology care (n = 175). Patients in the early-PC group met with a member of an outpatient PC team at least once per month until death, while those receiving usual care met with a PC clinician only upon request.

All patients completed questionnaires measuring their QOL, mental wellness, and understanding of and communication about end-of-life (EOL) care preferences at baseline. Follow-up assessments were performed at 12 weeks and 24 weeks. Questionnaires included the Functional Assessment of Cancer Therapy-General (FACT-G) scale, which measures QOL with regard to physical, functional, emotional, and social well-being; the Patient

Health Questionnaire-9 (PHQ-9), which measures symptoms of major depressive disorder; and the Hospital Anxiety and Depression Scale, which detects both depression and anxiety symptoms.

FINDINGS AT 24 WEEKS

- **Better QOL.** Early-PC patients had a mean 1.59-point increase in FACT-G scores, compared with a mean 3.40-point decrease among usual care patients. This effect was especially significant after controlling for baseline variables ($P = 0.002$).
- **Fewer symptoms of depression.** When controlled for baseline variables, the PHQ-9 scores of early-PC patients at 24 weeks were significantly lower than for the usual-care group, indicating fewer depression symptoms ($P = 0.048$).
- **More EOL discussions.** Twice as many early-PC patients reported discussing EOL wishes with clinicians than did usual-care patients (30.2% vs 14.5%; $P = 0.004$).

OUTCOMES VARY BY CANCER TYPE

The effects of early PC differed over time between lung cancer and GI cancer patients. While lung cancer patients in the early-PC group had significantly improved QOL and mood by week 24 compared with the usual-care group, the QOL and mood assessment of GI cancer patients improved by week 24 regardless of group assignment.

The authors note that more work is needed to understand the differences in benefits of early PC between lung cancer and GI cancer patients, but that a possible explanation for the differences may be the greater amount of time GI cancer patients spent in the hospital, which could have an

effect on those patients' QOL and mood.

“In future work, investigators should explore the role of targeted PC interventions to address the specialized needs of specific cancer populations with particular attention to appropriate timing for PC integration within the context of patients' illness trajectories,” they suggest.

COMMUNICATION ENHANCED

“This trial is the first, to our knowledge, to show an effect of early PC on patients' communication about EOL care preferences,” observe the authors. In addition to being twice as likely to have a conversation with their oncologist about EOL care preferences, patients receiving early PC intervention were also more likely to report that knowing their prognosis was “very helpful” or “extremely helpful” for making decisions about treatment and coping with their illness. With recent reports highlighting the necessity for greater patient-clinician communication about EOL care, the authors describe this new link between early PC and EOL care discussions as “notable and timely.”

“These findings provide further evidence to support early integrated PC as the standard of care for patients with newly diagnosed incurable cancers,” conclude the authors. “[F]urther research is needed to define optimal PC delivery models that target the specific needs of different patient populations in the modern era of cancer therapeutics.”

Source: “Effects of Early Integrated Palliative Care in Patients with Lung and GI Cancer: A Randomized Clinical Trial,” Journal of Clinical Oncology; March 10, 2017; 35(8):834–841. Temel JS, Greer JA, El-Jawahri A, et al; Massachusetts General Hospital and Harvard Medical School, both in Boston; University of Washington, Seattle; Geisel School of Medicine at Dartmouth, Lebanon, New Hampshire.

CLINICIAN RESOURCES

Easy-to-Use Advance Directive Tool Improves Documentation, Requires no Physician or System Intervention

www.prepareforyourcare.org

PREPARE, a free online advance care planning (ACP) tool for patients, has been found to significantly increase documentation of end-of-life care preferences in the electronic health records of chronically ill patients in primary care clinics, and was deemed easy to use by older adults with serious illness in an emergency department (ED) setting, two studies have found.

Requiring no clinician or system-level involvement or education, PREPARE is an interactive, patient-centered ACP website designed to motivate and prepare individuals to discuss their values and care preferences with family, friends, and clinicians. The five-step process takes about 10 minutes per module, walking users through the process by using large text, an audio track, and “how-to” videos, explaining how to talk to one’s physician and ask questions.

Also available on the website, and also free of charge, is an easy-to-read advance directive (AD) booklet, written at a fifth-grade reading level in both English and Spanish, and designed with input from older adults of diverse backgrounds to be culturally appropriate.

TOOL FOR CLINICAL SETTING

PREPARE may help “overcome barriers to planning in busy primary care settings,” note the authors of a report published in *JAMA Internal Medicine*. Such barriers include lack of physician time and system resources, and patient difficulty understanding AD forms or feeling unprepared to consider making medical decisions.

Investigators analyzed results of a comparative effectiveness clinical trial conducted among older veterans with at least two chronic or serious conditions (n

= 414; mean age, 71.1 years; nonwhite, 43%; women, 9%) cared for at one of several general medicine clinics from 2013 to 2016. Participants were randomized to review the ACP on the PREPARE website plus the AD booklet, or the AD alone.

About half (51%) of participants had prior ACP documentation; 20% had limited literacy.

Patients were given reminder calls several days before their next primary care visits, suggesting they take their PREPARE-generated action plans and/or completed ADs with them.

KEY FINDINGS, FIRST STUDY

- The mean ACP documentation rate six months prior to the study’s intervention was 0.8%.
- At a 9-month follow-up, the rate of new documentation increased in both study arms, but was significantly higher in the PREPARE-plus-AD arm (35% vs 25%; $P = 0.04$). Results included higher documentation for legal forms and orders (20% vs 13%; $P = 0.04$) and for documented discussions (26% vs 20%; $P = 0.13$).
- Those in the PREPARE-plus-AD arm had higher process and action scores ($P < 0.001$) in self-reported ACP engagement at each of the 1-week, 3-month, and 6-month follow-ups.
- Participants rated both tools highly in terms of ease of use, satisfaction, and helpfulness.

POTENTIAL IN THE ED SETTING

“With appropriate implementation, PREPARE has the potential to engage older adults who are not acutely ill in ACP during their ED visits,” write the authors of another report published in the

Journal of Palliative Medicine.

“The ED is an increasingly important setting to introduce ACP,” because although about 75% of older adults visit the ED in the last six months of life, the majority do not have their goals of care documented in their medical records, the authors note. In addition, even if patients’ values and goals are documented, these can change, meaning that ED physicians may need to help patients revisit them.

Investigators conducted a feasibility study of the PREPARE tool as accessed online from a tablet computer in the ED. Participants were older adults enrolled in a larger survey on geriatric ED care in late 2014 and early 2015. Following the survey, 24 subjects (median age, 75 years; female, 67%; nonwhite, 54%) agreed to participate in the PREPARE substudy. Participants were encouraged to complete as few or as many of PREPARE’s five modules as they chose.

KEY FINDINGS, SECOND STUDY

- 70.8% of participants completed one or more modules.
- On a 10-point scale, participants rated the website as easy to use for themselves (mean, 8.4; standard deviation [SD], 2.39) and for others (mean 7.3; SD, 2.31).

Source: “Effect of the PREPARE Website vs an Easy-to-Read Advance Directive on Advance Care Planning Documentation and Engagement among Veterans: A Randomized Clinical Trial,” *JAMA Internal Medicine*; Epub ahead of print, May 18, 2017; DOI: 10.1001/jamainternmed.2017.1607. Sudore RL et al; Department of Medicine, University of California, San Francisco. “Preparing Older Adults with Serious Illness to Formulate Their Goals for Medical Care in the Emergency Department,” *Journal of Palliative Medicine*; April 2017; 20(4):404–408. Ouchi K et al; Department of Emergency Medicine, Brigham and Women’s Hospital and Harvard Medical School, Boston.

CLINICIAN RESOURCES

Online Resources for Physicians Caring for Seriously Ill and Dying Patients

Experts tackle difficult questions
<http://aahpm.org/education/hpmq>

A new video series from the American Academy of Hospice and Palliative Medicine (AAHPM) addresses critical topics in palliative care and aims to answer some of the tough questions physicians may encounter while caring for patients with serious illness or for those nearing the end of life.

Entitled “Hospice and Palliative Medicine Questions” (HPMQ), the series of brief videos is accessible at no charge from the AAHPM website or on YouTube (www.youtube.com/user/AAHPM), where the three-to-five-minute discussions featuring experts in the field are uploaded monthly. For example, the question for June 2017 is: How should we treat dyspnea in advanced disease and at the end of life?

Other topics include dialysis discussions, advance care planning tools, advance care planning billing codes, deprescribing, medical decision making for the unbefriended, and when it’s not Alzheimer’s.

Self-study program in palliative medicine revamped
<http://aahpm.org/self-study/essentials>

AAHPM’s comprehensive self-study series for clinicians interested in incorporating the principles of hospice and palliative medicine into their practices has been updated by experts in the field and rebranded as “Essential Practices in Hospice and Palliative Medicine.” Formerly known as UNIPAC, the new series is slated for availability in August 2017.

Each of the nine softcover books in the series addresses a specific topic, and as such can stand alone. In addition, each book has an accompanying “confidence-based learning module,” which can be ordered and used online to test a learner’s level of knowledge integration and confidence in its application to real-world situations. Once mastery of the topic is achieved, the module will remain accessible.

According to the series editors, the program is appropriate for any healthcare professional caring for patients with a life-limiting illness, including physicians, nurses, and social workers. Physicians and physician assistants can earn continuing medical education (CME) credits for each module completed.

Module titles include:

- Medical Care of People with Serious Illness
- Psychiatric, Psychological, and Spiritual Care
- Pain Assessment and Management
- Nonpain Symptom Management
- Communication and Teamwork
- Ethical and Legal Practice
- Pediatric Palliative Care and Hospice
- COPD, Heart Failure, and Renal Disease
- HIV, Dementia, and Neurological Conditions

End-of-Life Care Websites

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

American Hospice Foundation
www.americanhospice.org

Information and Support for End-of-Life Care from the National Hospice and Palliative Care Organization
www.caringinfo.org

Center to Advance Palliative Care
www.capc.org

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

Palliative Care Fast Facts and Concepts, a clinician resource from the Palliative Care Network of Wisconsin
www.mypcnow.org

Hospice and Palliative Nurses Association
www.hpna.org

Hospice Foundation of America
www.hospicefoundation.org

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

National Hospice & Palliative Care Organization
www.nhpc.org

Division of Palliative Care Mount Sinai Beth Israel
www.stoppain.org

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

Resources for Patients and Families
www.hospicenet.org

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

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End-of-Life Care Meetings for Clinicians

National Hospice and Palliative Care Organization 2017 Interdisciplinary Conference. September 18–20, 2017, San Diego Marriott Marquis and Marina, San Diego, CA. Website: www.nhpco.org/IDC2017

28th Annual Clinical Meeting of the Academy of Integrative Pain Management (formerly the American Academy of Pain Management). October 19–22, 2017, San Diego, CA. Accredited by the Accreditation Council for Continuing Medical Education. Website: www.integrativepainmanagement.org/page/annualmeeting

Palliative Care in Oncology Symposium: Patient-Centered Care across the Cancer Continuum. October 27–28, 2017, San Diego, CA. Cosponsors: the American Academy of Hospice and Palliative Medicine, the American Society of Clinical Oncology, the American Society for Radiation Oncology, and the Multinational Association of Supportive Care in Cancer. Website: pallonc.org

American Pain Society 2018 Scientific Summit: Understanding Pain Mechanisms. March 4–6, 2018, Disneyland Hotel, Anaheim, CA. Website: <http://americanpainsociety.org/annual-meeting/2018-scientific-summit>

Topics in Primary Care, Hospice, Palliative Care, Impaired Healthcare Professionals, Hematology, Oncology, and the History of Medicine. May 7–17, 2018, 10-night Western Mediterranean cruise conference from Rome (Civitavecchia), Italy, to Barcelona, Spain. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 800-422-0711; Website: www.continuingeducation.net

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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.

Quality of Life Matters® is recommended as an educational resource by the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

Quality of Life Matters®

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