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Quality of Life Matters®

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

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Vast Majority of Bereaved Family Caregivers Would Recommend Hospice

Most informal caregivers give hospice high ratings following the death of a loved one under Medicare hospice care, and say they would recommend this supportive end-of-life care to their relatives and friends. In addition, nearly all hospices report that patients were asked about their care preferences upon admission according to two quality-of-care datasets released in December 2016 by the Centers for Medicare & Medicaid Services (CMS).

CAHPS SURVEY DATASET

The first dataset is from the Consumer Assessment of Healthcare Providers and

Systems (CAHPS®), which is a survey designed to measure and assess the experiences of patients who died while receiving hospice care, along with the experiences of their informal primary caregivers. The 2016 report provides the national averages of respondents who gave most favorable scores on each of eight National Quality Forum (NQF)-endorsed hospice measures from April 2015 through March 2016.

CMS developed the CAHPS survey with input from the healthcare industry, key groups involved in hospice care, other government agencies, and consumer groups. “Since the CAHPS Hospice Survey focuses on experiences of care, implementation of the survey supports the following national priorities for improving care: involving patients and families in care and promoting effective communication and coordination,” states the CAHPS Survey Project Team.

Responses from the CAHPS survey, ranked by percentages, included:

- Patient was treated with dignity and respect, 90%
- Emotional and religious support was provided, 89%
- Caregivers were willing to recommend hospice, 85%
- Rating of hospice care received, 80%
- Communication with the hospice team was effective, 80%
- Access to care was timely, 78%

HIS MEASURES DATASET

The second dataset, the National Hospice Item Set (HIS), reflects provider performance on NQF-endorsed quality-of-care measures from July 2015 through June 2016. Under the Affordable Care Act, hospices are required to participate not only in the CAHPS survey, but also to submit nationally endorsed quality-of-care data to CMS via the HIS.

The results of the HIS measures, in order of percentages, included hospice patients who:

- Were asked about their preferences for life-sustaining treatments, such as cardiopulmonary resuscitation, ventilator support, hospitalization, etc., within five days of admission, 98.4%
- Were screened for dyspnea at hospice admission, 97.7%
- Received timely treatment when experiencing dyspnea, 94.8%
- Were offered a treatment option when at risk for opioid-induced constipation, 94.1%
- Were screened for pain upon admission to hospice, 94%
- Were invited to discuss spiritual or religious concerns or values, 93.3%

The datasets can be found online at <https://data.medicare.gov/data/hospice-directory>.

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NEWSLINE

Oncology Practices Offered First Formal Guidance for Primary Palliative Care

End-of-life care and hospice referral strongly recommended

An “actionable resource” for improving the delivery of high-quality palliative care (PC) to patients with advanced cancer or high symptom burden has been released as a joint guidance statement from the American Society of Clinical Oncology (ASCO) and the American Academy of Hospice and Palliative Medicine (AAHPM).

Heralded as “the first clearly itemized consensus definition of what elements should be a part of primary palliative care delivery within medical oncology practice in the United States,” the resource has been published as a guidance statement in the *Journal of Oncology Practice*, a journal of ASCO.

“Serious illness is hard, and there’s a lot we want our medical team to do for us,” says lead author Kathleen E. Bickel, MD, MPhil, assistant professor of medicine, White River Junction Veterans Affairs Medical Center, White River Junction, VT, and Geisel School of Medicine at Dartmouth, Hanover, NH. “This guidance statement is intended to represent what oncology clinic stakeholders feel right now is reasonable, important, and feasible to implement in current practice.

“We’re not saying that everyone must do these things starting tomorrow,” Bickel adds. “But this is what a group of real people in the trenches thought to be a reasonable starting place for oncologists to try to start doing palliative care themselves.”

A multidisciplinary panel of 22 physicians and nine other experts (healthcare professionals or patient advocates) from across the U.S. and Puerto Rico assessed over 900 PC-related service items; ranking them according to the importance, feasibility, and reasonability of expecting each service item to be provided within the scope of medical oncology practices. To be considered “included” in primary oncology PC, an item required a median rating of 7 to 9 on a 9-point scale.

HIGH CONSENSUS IN END-OF-LIFE CARE

Among the nine domains assessed, those with the highest proportions of endorsed or “included” items were related to end-of-life care (81%), communication and shared decision-making (79%), and advance care planning (78%). Those domains with the lowest proportion of endorsed service items were in the psychosocial (39%) and spiritual and cultural (35%) domains.

The panel’s recommendations corroborate findings from other studies indicating that oncologists consider PC services

to be within the scope of quality medical oncology practice, note the authors. Their hope is that, based on their findings, oncology practices “will consider incorporating some of these service items as internal process goals and begin closing local gaps in end-of-life care.”

The following palliative care domains are ranked according to the percentage of service items endorsed by the multidisciplinary panel.

END-OF-LIFE CARE (81%)

This was the domain with the highest proportion of endorsed items. Panelists agreed that practices should have processes in place to evaluate symptoms, advise medication changes, and provide 24/7 on-call coverage, whether or not hospice is involved. “For patients on hospice, practices should collaborate with the hospice team for questions and issues.”

COMMUNICATION AND SHARED DECISION MAKING (79%)

Patients and families should be assessed regarding how patients want to receive information and who is to participate in medical decision making. Verbal reinforcement and written documentation of the treatment plan should be provided. Specific details should be included regarding what can be expected for disease control, effects on symptoms and quality of life, and length and frequency of treatment.

“The patient’s and family’s understanding of the patient’s illness, prognosis, and goals of care should be assessed at diagnosis, at disease progression, and with changes in the treatment plan,” write the authors. “Mistakes should be openly acknowledged and addressed as soon as they are noticed.”

ADVANCE CARE PLANNING (78%)

The process of advance care planning should be started at diagnosis of advanced cancer, beginning with the assessment of the patient’s and family’s readiness for the discussion and any concerns they may have.

“Panelists agreed that code status, living wills, advance directives, healthcare surrogate, and out-of-hospital do-not-resuscitate orders should be discussed, completed, and documented for all patients as soon as possible.”

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NEWSLINE

Oncology Practices Offered First Formal Guidance (from Page 2)

APPROPRIATE PALLIATIVE CARE AND HOSPICE REFERRAL (69%)

Routine patient assessments should be conducted to determine the need for PC or hospice referral. During discussion, panelists thought that practices should have protocols to facilitate these assessments. Oncology practices should explain to patients the differences between PC and hospice, and the benefits of each.

“There was strong consensus that patients with a prognosis of three months or less and/or an Eastern Cooperative Oncology Group performance status of 3 to 4 be referred for hospice,” write the authors. Ideally, practices would maintain rosters of patients receiving palliative/comfort care and hospice care “for purposes of improvement and outcomes tracking,” the authors write.

SYMPTOM ASSESSMENT AND MANAGEMENT (65%)

The panel also agreed that oncology practices should conduct a general symptom assessment at least monthly, educate patients about the cause and management of existing symptoms, and inform patients about how to contact the clinic for new or newly distressing symptoms.

“All symptoms should be assessed and managed at a basic level, with more comprehensive management for common symptoms such as nausea, vomiting, diarrhea, dyspnea, and pain,” write the authors. Any patients with uncontrolled or poorly controlled symptoms should be referred to palliative medicine specialists.

“Rather than devaluing the importance or need for specialist palliative medicine, our findings reiterate that primary palliative care skills — such as symptom assessment and management, with honest and compassionate communication about treatment options and their limits in advanced disease — have been and continue to be essential for all clinicians caring for seriously ill patients.”

CARER SUPPORT (56%)

The term “carer” encompasses both the patient’s family/friend caregivers and the oncology clinic staff. Panelists agreed that, after permission is obtained to talk with them, primary caregivers should be included in discussions of the patient’s care and assessed at least once for signs of distress.

Caregivers should be supplied with information on how to contact the clinic when they wish, and be directed to local and online caregiver resources. Bereaved caregivers should get a

phone call and/or condolence card from the clinic and receive information regarding local bereavement resources.

The oncology clinic staff, who are themselves also carers, should be cared for through the maintenance of a supportive environment and allowance for “open communication, respect, growth, and self-care,” write the authors.

COORDINATION AND CONTINUITY OF CARE (48%)

Care coordination with primary care, hospital, nursing home, and hospice services received strong endorsement by the panel. Panelists were less certain about oncology practices’ responsibility for establishing protocols for referring patients back to primary care or for tracking healthcare utilization.

PSYCHOSOCIAL ASSESSMENT AND MANAGEMENT (39%)

Practices should conduct basic psychosocial and distress assessments at initial clinical encounter, and after any clinical change. Distress should be managed “with supportive, empathetic statements and validation of the patient’s experience.”

SPIRITUAL AND CULTURAL ASSESSMENT AND MANAGEMENT (35%)

The panel endorsed only two assessment items in this domain: the documentation of a patient’s faith and the differentiation of a grief reaction from depression. However, several support elements were rated as “included,” such as providing patients with a framework in which to consider their goals and hopes — along with the likely medical outcomes of their illness — and supporting those goals.

The authors recognize the significant responsibility that medical oncology practices shoulder for delivering primary palliative care. They point out that their statement is not a clinical practice guideline, nor is it a set of standards, but that “with appropriate education, evaluation, and reimbursement models, this statement can guide the medical oncology community toward operationalizing and improving primary palliative care delivery.”

Source: “Defining High-Quality Palliative Care in Oncology Practice: An American Society of Clinical Oncology/American Academy of Hospice and Palliative Medicine Guidance Statement,” Journal of Oncology Practice; September 2016; 12(9):e828–838. Bickel KE, McNiff K, et al; White River Junction VA Medical Center, White River Junction, Vermont; Geisel School of Medicine at Dartmouth, Hanover, New Hampshire; Dana-Farber Cancer Institute; and Beth Israel Deaconess Medical Center, Boston; Duke University Medical Center, Durham, North Carolina; American Academy of Hospice and Palliative Medicine, Glenview, Illinois; and Partnership for Health Analytic Research, Beverly Hills, California.

RESEARCH MONITOR

Palliative Care Improves Quality of Life and Lessens Symptom Burden, Major Review Finds

The first meta-analysis of the effect of palliative care on patient outcomes has found that people living with serious illness who receive palliative care have better quality of life and lower symptom burden. Further, palliative care was linked consistently to improvements in advanced care planning (ACP), improved patient and caregiver satisfaction, and lower use of healthcare resources, according to a report published in the *Journal of the American Medical Association*.

“Taken all together, this is a very compelling message,” says lead author Dio Kavalieratos, PhD, assistant professor at the University of Pittsburgh School of Medicine’s Section of Palliative Care and Medical Ethics. “People’s quality of life and symptoms improved, their satisfaction with their healthcare improved — all during what is likely one of the most difficult periods of their lives.

“Historically, palliative care has overwhelmingly focused on individuals with cancer, but anyone with a serious illness, be it cancer, heart failure, multiple sclerosis, or cystic fibrosis, deserves high-quality individualized care that focuses on reducing their suffering and improving their quality of life,” adds Kavalieratos.

Investigators conducted a systematic review of 43 randomized clinical trials of palliative care interventions published through July 2016 that included 12,731 adults with life-threatening illness (mean age, 67 years) and 2479 of their family caregivers. The team also performed a meta-analysis to determine the overall association between palliative care and quality of life, symptom burden, and survival — three outcomes often linked to palliative care.

The majority (72.0%) of the trials were conducted in the U.S. Included were pa-

tients mostly with either cancer (69.7%) or heart failure (32.5%), which are two diseases most commonly requiring palliative care, the authors note. Because the inclusion criteria were broad and not limited to interventions delivered by palliative care specialists, 41.8% of the trials were home-based, 32.5% were in ambulatory settings, and 25.6% were hospital-based.

The Functional Assessment of Chronic Illness Therapy-Palliative Care scale (FACIT-Pal) instrument was used to evaluate quality of life (range, 0 to 184, worst to best), and the Edmonton Symptom Assessment Scale (ESAS) for symptom burden (range, 0 to 90, best to worst). Minimal clinically important difference was considered to be 9 points for FACIT-Pal, 5.7 points for ESAS.

STATISTICALLY AND CLINICALLY SIGNIFICANT IMPROVEMENTS WERE FOUND IN:

- Quality of life at the one-to-three-month follow-up (standardized mean difference [SMD], 0.46; 95% confidence interval [CI], 0.08 to 0.83; FACIT-Pal mean difference, 11.36)
- Symptom burden at the one-to-three-month follow-up (SMD, -0.66; 95% CI, -1.25 to -0.07; ESAS mean difference, -10.30)

OTHER KEY FINDINGS

- When analyses were limited to a subset consisting only of trials with low risk of bias, the impact of palliative care on quality of life was less pronounced. While this impact remained statistically significant, the effect on symptom burden was no longer statistically significant.
- Palliative care was consistently associated with improvements in ACP,

patient and caregiver satisfaction, and less use of healthcare resources.

- Palliative care was associated with significantly longer hospice stays among intervention patients (24 days vs 12 days; $P = 0.04$) in one of the few trials that assessed for hospice use, although no effect was found on the percentage of patients referred to hospice.
- There was no association between palliative care and survival (hazard ratio, 0.90; 95% CI, 0.69 to 1.17).

“Given that some clinicians and members of the lay public view palliative care negatively, due to an unfounded belief that it may shorten survival, it is important to note that no trial showed a decrease in survival from palliative care,” the authors write. Survival has been reported as an outcome in several recent trials, “although improving survival is not an aim of palliative care,” the authors explain.

A PHILOSOPHY OF CARE

“This review regards palliative care as a philosophy of care” and thus “includes a wide spectrum of palliative care delivery models,” point out the authors. Further, their review “did not distinguish between early palliative care interventions vs those at the end of life, reflecting the prevailing view that palliative care is appropriate at any point in the disease trajectory.” The authors urge future research that aims at identifying the effective components of palliative care and establishing optimal models for delivery of care that helps caregivers as well as patients.

“[I]f viewed as a philosophy of care rather than a specific model of care, palliative care can be delivered by a range of individuals, from primary care clinicians to a formally trained, interdisciplinary

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RESEARCH MONITOR

Rapid Screening Tool for Palliative/Hospice Care Accepted by Emergency Department Physicians

A structured tool for quickly assessing the palliative care needs of older adults presenting to the emergency department (ED) was deemed acceptable for use by a majority (70%) of emergency medicine physicians, who spent a mean of 1.8 minutes per patient to complete the checklist, according to a report published in the *Journal of Palliative Medicine*.

“The short administration time makes this tool attractive for wider dissemination and testing,” write the authors. “Furthermore, our study confirmed the feasibility and reliability of such screening on actual ED patients, instead of hypothetical case vignettes.”

More than three-quarters of older adults visit the ED in the last six months of life, point out the authors. For some patients, this will be their last stop and they will die in the hospital. For other patients, the ED visit is the first step on a path of increasingly aggressive care before death. Palliative/hospice services are often needed by these patients, but screening for palliative care needs is not yet an integral part of ED practice.

Barriers that physicians currently face in integrating palliative care into routine ED practice include time constraints and the lack of an evidence-based, practical

method for identifying seriously ill patients who might benefit from palliative care services, the authors observe.

Researchers asked 38 emergency medicine attending physicians (male, 67%; mean years in practice, 9.2) to apply the content-validated screening tool to all patients ≥ 65 years of age ($n = 207$; mean age, 75 years) they cared for throughout 55 shifts at an academic, urban ED in October 2015. Physicians were also asked to rate the tool’s acceptability and report the time taken to complete it.

The screening tool consists of a checklist with about one dozen items reflecting the clinician’s overall assessment, and includes the Surprise Question (“Would I be surprised if this patient died within 12 months?”). Medical records from the electronic health record (EHR) were then used to identify life-limiting illnesses for all screened patients, and this information was compared to the ED physicians’ clinical assessments for palliative care needs.

KEY FINDINGS

- 70% of physicians found the screening tool acceptable to use.
- The number of most of the life-limiting illnesses that were identified through chart abstractions were not statistically

different from the physicians’ report.

- 82% of physicians reported being confident about the clinical information they provided.
- Overall, 32% of patients screened positive for palliative care needs; of these, 77% were admitted.
- For 85% of patients who screened positive, the ED physicians stated they would “not be surprised” if the patient died in the next 12 months.

Further research is needed to determine the specific care pathways for patients who screen positive for palliative care needs, and to define other clinically useful means for identifying such patients in the ED, recommend the authors. They suggest that a two-tiered approach using both a brief, structured physician assessment and information automatically elicited from the EHR on the presence of life-limiting illness might also be useful, thus “further reducing physician burden.”

Source: “Feasibility Testing of an Emergency Department Screening Tool to Identify Older Adults Appropriate for Palliative Consultation,” *Journal of Palliative Medicine*; January 2017; 20(1):69–73. Ouchi K et al; Department of Emergency Medicine; Division of Palliative Medicine, Department of Medicine, Brigham and Women’s Hospital; Department of Emergency Medicine, Harvard Medical School, Boston.

Palliative Care Improves Quality of Life (from Page 4)

team of subspecialists,” write the authors of an editorial accompanying the report.

Along with expanding research and public awareness concerning palliative care, more clinicians should be trained so that “all clinicians who have interactions with seriously ill patients” can deliver high-quality interventions proven to be ef-

fective within this “dynamic and evolving field” of palliative care.

Source: “Association between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-Analysis,” *Journal of the American Medical Association*; November 22, 2016; 316(20):2104–2114. Kavalieratos D, Corbelli J, et al; Section of Palliative Care and Medical Ethics; and Center of Research

on Health Care, Division of General Internal Medicine, Department of Medicine, University of Pittsburgh, Pittsburgh; and Department of Health Policy and Management, Gillings School of Global Public Health, University of North Carolina at Chapel Hill. “The Promise of Palliative Care: Translating Clinical Trials to Clinical Care,” *ibid.*; pp. 2090–2091. Malani PN et al; Division of Infectious Diseases, Department of Internal Medicine, University of Michigan Health System, Ann Arbor.

RESEARCH MONITOR

Home-Based Palliative Care Programs May Improve Outcomes, Lower Cost

Benefits include earlier hospice referral and longer hospice length of stay

Numerous clinical studies in recent years show that many patients with advanced illness may benefit from palliative care. Home-based palliative care (HBPC) programs can be extremely beneficial for patients and families, as patients using an HBPC program tend to have fewer hospital visits, utilize hospice services for a greater period of time, and save money on care. They are also much more likely to die at home, according to a study published in the *Journal of Palliative Medicine*.

“People with advanced illness usually want their healthcare where they live — at home — not in the hospital,” the authors write. “Home-based care is especially important since hospitals may accelerate functional decline for those with advanced illness.” According to the authors, the objective of this study was “to evaluate the cost savings and outcomes associated with HBPC.”

In a retrospective analysis, investigators collected data from patients (n = 651) with the Medicare Shared Savings Program Accountable Care Organization in three New York City counties who died between October 2014 and March 2016. Patients studied were either enrolled in the HBPC program ProHEALTH Care Support (n = 82) or belonged to the control group and did not receive HBPC services (n = 569). The researchers compared rates of hospital admissions, hospice enrollment rates, length of stay (LOS), and the cost of care between the two groups.

USE OF AN HBPC PROGRAM:

- Reduced the number of hospital admissions in the final month of life (3073 admissions per 1000 patients for

HBPC vs 4634 admissions per 1000 patients for control; $P = 0.0221$)

- Increased the hospice enrollment rate (57%, HBPC vs 37%, control; $P = 0.0005$)
- Increased the mean hospice LOS (47 days, HBPC vs 23 days, control; $P = 0.0003$)
- Lowered the costs of care in the final month of life considerably (\$8432, HBPC vs \$15,391, control; $P = 0.0002$)

PHYSICIAN FACTORS, CARE PROGRAMS INFLUENCE HOSPICE USE AND HOME DEATH

Patients using the HBPC program were more likely to be enrolled in hospice, and had a longer average LOS. The authors stress the importance of availability of hospice for terminally ill patients, and say that a late referral to hospice, or the lack of a hospice referral, often results in care that is discordant with patient preferences. Physician factors, and not patient preferences, are most correlated with hospice referral rate, according to the authors. That means that the type of care program can have a large influence on decisions near the end of life.

In addition to spending more time in hospice, patients cared for with an HBPC program were very likely to die at home, investigators report. During the study period, 87% of the HBPC patients died at home, compared to the national average of 24% among Medicare patients with usual care. More HBPC patients were able to die at home, according to the authors, because of early hospice referrals and the application of palliative care for those patients who weren't eligible for or declined hospice care.

The HBPC program was associated with a significantly reduced cost of care near the end of life. HBPC patients had a 45% reduction in cost during the last month of life compared to patients without HBPC. This study suggests that patients and families can save money with an HBPC program, and the authors stress that even with the inclusion of hospice care these services still cost less than usual care. This decreased cost may be due to the fact that an HBPC program can help patients to avoid unwanted hospitalizations and to be able to die at home.

“Key elements of successful programs appear to be home-based care, in person interactions, geriatric assessment, caregiver support, palliative care skills, and round-the-clock clinical availability,” write the authors. Factors that may suggest a patient could benefit from palliative care such as HBPC include a prognosis of less than one year, frailty, functional decline, and social isolation.

The authors conclude that a home-based palliative care program can offer a high value of care; these types of programs can increase quality of care and result in good outcomes for patients, while reducing the cost of care at the end of life.

Source: “The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization,” Journal of Palliative Medicine; January 2017; 20(1):23–28. Lustbader D, Mudra M, Romano C, Lukoski E, Changa A, Mittelberger J, Scherr T, Cooper D; Department of Palliative Care, ProHEALTH Care, Lake Success, New York; Optum Center for Palliative and Supportive Care, Eden Prairie, Minnesota; ProHEALTH Medical Management, An Optum Company, Lake Success, New York; Healthcare Analytics, OptumCare, Eden Prairie, Minnesota; and ProHEALTH Care, Lake Success, New York.

CLINICIAN RESOURCES

FREE PATIENT AND PHYSICIAN RESOURCES

Stanford Letter Project: End-of-Life Care Planning Tool Helps Patients Start the Conversation

While most patients — and their physicians — agree that discussing plans for medical treatment at the end of life is important, many find it difficult to know when and how to broach the topic. Yet, without documentation of their end-of-life preferences, patients risk receiving unwanted and expensive care that does not improve their quality of life or death. With this in mind, the Stanford Letter Project has produced a simple tool that encourages patients to open the conversations with their families and physicians.

The letter, available at <http://med.stanford.edu/letter.html>, was developed based on findings from research conducted by V.J. Periyakoil, MD, and her team at Stanford University's School of Medicine, Palo Alto, CA, with input from patients and families of various cultural and racial backgrounds. It can be completed by anyone, of any age or health condition, and is available in English and seven other languages.

The questions and prompts of the three-page letter are designed to be non-intimidating. Patients can download the free PDF version, or complete it online, then print and/or email it to their loved ones and physicians. It can generate conversations, and can also help lead to the completion of more official documents, such as advance directives and Physician Orders for Life-Sustaining Treatment.

But, unlike more formal documents, the letter also addresses preferences that may vary from culture to culture: how the patient wishes to be told bad news, how information is shared within families, and who makes the serious medical decisions.

“In order for us to give the best quality care for everyone, we need to avoid burdening and overtreating people who will not be benefited,” says Periyakoil. “What are their hopes, wants, needs, and fears? Do they want to die at the hospital on a machine? Do they want to die at home? We can't know unless we have a conversation.”

Online AMA Module Helps Physicians Continue/Support the Conversation

The American Medical Association (AMA) has partnered with Stanford Medicine to develop a free online resource to aid physicians and their practices in planning for end-of-life conversations with patients, as part of its collection of interactive educational modules, the STEPS Forward™ Practice Improvement strategies. The end-of-life planning module offers CME credit upon completion and includes the Stanford letter, referenced above, plus various downloadable tools.

Guidance in the use of the Stanford end-of-life letters, which includes answers to questions about billing for these discussions, is organized into the following steps:

1. Prepare your practice to use the letter.
2. Share the letter with patients and their families.
3. Discuss the patient's completed letter and add it to the chart.
4. Periodically update the letter as appropriate.

The module can be found at <https://www.stepsforward.org/modules/end-of-life-planning>.

End-of-Life Care Websites

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

American Hospice Foundation
www.americanhospice.org

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

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

Center to Advance Palliative Care
www.capc.org

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

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.nhpco.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

Pain Management and Palliative Care. May 7–14, 2017. Seven-night Eastern Caribbean Cruise Conference, round-trip from Fort Lauderdale, FL. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 800-422-0711; Website: www.continuingeducation.net

36th Annual Scientific Meeting of the American Pain Society. May 17–20, 2017, David L. Lawrence Convention Center, Pittsburgh, PA. Email: info@americanpainsociety.org; Website: www.americanpainsociety.org

2017 Annual Scientific Meeting of the American Geriatrics Society. May 18–20, 2017, San Antonio, TX. Website: www.americangeriatrics.org

15th World Congress of the European Association for Palliative Care: Progressing Palliative Care. May 18–20, 2017, IFEMA Feria de Madrid, North Convention Center, Madrid, Spain. Website: www.eapc-2017.org

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



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