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Quality of Life Matters®

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

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Hospice Delivers Optimized Quality of Care, Improves Survival for Patients with Lung Cancer

For patients with non-small cell lung cancer (NSCLC) — the most common form of lung cancer and one of the leading causes of cancer-related deaths in the U.S. — enrollment in hospice not only decreases the likelihood of receiving aggressive care at the end of life and of dying in the hospital, it may also have a survival benefit, according to findings reported in the *Journal of Palliative Medicine*.

“Hospice services are commonly perceived to hasten death,” write the authors. “Our study supports the find-

ings of those previous, which showed that stage IV NSCLC patients enrolled in hospice services had a significantly longer median survival than their non-hospice counterparts.”

The receipt of less aggressive care towards life’s end “is theorized to be one of the potential mechanisms of...longer survival,” the authors suggest. “It is also proposed that hospice services provide better monitoring, palliative treatment, and increased social support, factors which have individually been associated with improved survival.”

Investigators analyzed data on deceased patients (n = 197; mean age, 67 to 69 years) diagnosed with stage IV NSCLC between 2008 and 2010 at two tertiary medical centers within a single county. Nearly three-quarters of subjects were enrolled in hospice. Mean length of hospice stay was 48.9 days (range, 1 to 396 days), with 84.2% of enrollees receiving hospice services for > 7 days.

KEY FINDINGS

- Median survival was significantly longer for patients who were enrolled in hospice (145.5 days, hospice vs 87 days, nonhospice; $P = 0.02$).
- Hospice patients were significantly more likely to die at home (31%, hospice vs 16%, nonhospice).
- Those enrolled in hospice were significantly less likely to die in any of the following acute care settings: general hospital ward (1% vs 35%), an intensive

care unit (1% vs 19%), an emergency department (1% vs 6%), or hospital palliative care unit (3% vs 18%).

- Among hospice patients, 58% died in an inpatient hospice setting.

“A benefit of hospice services includes access to another inpatient alternative [i.e., inpatient hospice], which is able to provide a high level of supervision and skilled nursing care often required at the end of life, but in a less severe and intimidating environment for the patient, their family, and caregivers,” comment the authors.

IN THE LAST 30 DAYS OF LIFE, HOSPICE ENROLLEES:

- Had a lower mean number of hospitalizations per patient (0.44 hospice vs 0.84 nonhospice; $P = 0.0003$)
- Had fewer emergency department visits (0.36 vs 0.67; $P = 0.0062$)
- Had fewer intensive care unit admissions (0.0086 vs 0.16; $P = 0.0004$)
- Were less likely to receive a new chemotherapy agent in the last 30 days of life (3.47% hospice vs 11.76% nonhospice; $P = 0.038$)
- Were less likely to receive any chemotherapy in the last 14 days of life (1.39% hospice vs 13.73% nonhospice; $P = 0.0014$)

Source: “The Impact of Hospice Services in the Care of Patients with Advanced Stage Non-small Cell Lung Cancer,” *Journal of Palliative Medicine*; January 2017; 20(1):29–34. Duggan KT et al; Wake Forest Baptist Medical Center, Winston-Salem, North Carolina.

Inside:

NewsLine..... 1–3

- ✓ Hospice Delivers Optimized Quality of Care, Improves Survival for Patients with Lung Cancer
- ✓ ‘Would You Like to Talk about What This Means?’ Simple Intervention Can Prompt Discussion of Prognosis
- ✓ Palliative Care Consults Optimize End-of-Life Care for Nursing Home Residents, Study Finds

Research Monitor..... 4–6

- ✓ Heart Failure Patients Want to Discuss Advance Care Planning, Prognosis
- ✓ Regional Variation in End-of-Life Care Suggests Primary Care Physician Involvement May Influence Care Choices and Hospice Use
- ✓ Primary Palliative Care: A ‘Critical Addition’ to the Care of Patients with Heart Failure

Clinician Resources..... 7

- ✓ Patient Video May Aid Physician Interpretation of End-of-Life Care Documents

NEWSLINE

‘Would You Like to Talk about What This Means?’ Simple Intervention Can Prompt Discussion of Prognosis When Delivering Scan Results

Oncologists may not always know whether their patients with advanced cancer comprehend the incurable nature of their disease. Deciding when and how to discuss prognosis can be challenging. But an investigation into the pattern of patient-physician discussions pinpoints an opportunity for physicians to introduce the topic of prognosis in a meaningful way for patients, according to a report published in the *Journal of Oncology Practice*.

“There is an opportunity after scan-talk and before treatment recommendations for an intentional pause and a question: ‘Would you like to talk about what this means?’ By phrasing this as a question, the oncologist seeks permission to enter into a space where prognosis can be discussed while ceding control of the conversation to the patient,” write the authors.

“Crucially, the addition of this question does not alter the typical flow or organization of an oncologist-patient interaction, and thus has the potential to improve prognostic communication without breaking its intrinsic structure.”

Investigators analyzed the conversational content of audio recordings of patient-physician encounters that included the presentation of scan results (n = 64). Subjects were recruited between 2004 and 2007 as part of a large, multi-site clinical trial — including both academic and private clinics — for patients with stage IIIA, IIIB, or IV non-small cell lung cancer. Encounters were identified as good news (19%), stable news (45%), and bad news (36%).

The authors acknowledge that one limitation to their study is the recorded encounters were 10 years old. Although treatment options have evolved during that time, the authors note that they have not observed any strong evidence to suggest that outpatient communication strate-

Barriers to Prognostic Disclosure Include:

- “Bad news is bad.” It is difficult to disclose, and often shrouded to appear more optimistic and preserve hope.
- Even when prognosis is stated explicitly, patients may misinterpret the message or just not hear it.
- Patients and physicians can sometimes be tacitly complicit in avoiding or ignoring important prognostic information.
- The reporting of bad news is perceived as a “dis-preferred social action,” so that just as oncologists struggle with or avoid delivering bad news, patients struggle with or avoid receiving it.

— Adapted from Singh et al, *Journal of Oncology Practice*

gies have changed significantly among oncologists.

More than three-quarters (77%) of the encounters followed the typical structure of an oncologic visit, as identified in previous studies, report the authors. This phase structure consists of four major components, which occur frequently in oncologic visits in nearly unvarying sequential order.

COMPONENTS OF A TYPICAL ONCOLOGIC VISIT

- 1. Symptom-talk:** Patients report on physical and psychologic symptoms
- 2. Scan-talk:** Physicians present the most recent imaging and laboratory results
- 3. Treatment-talk:** Oncologists and patients discuss chemotherapy, radiation, surgical, or symptom management options
- 4. Logistic-talk:** Parties address coordination and organization of care

The amount of time spent in each phase of conversation varied by type of news. More time was spent discussing symptoms during good news and stable news delivery than during bad news talks. More than half (50.2%) of encounter time

with bad news delivery was devoted to treatment-talk.

“Together, these four observed communication patterns limit patient inquiries about ‘what this [scan result] means to the quality or duration my life,’ and run counter to the main principles of shared decision making and patient-centered care,” write the authors. “Scan-talk, which is indisputably news of a prognostic nature, was always less than 10% of the entire conversation, regardless of the news type delivered.”

PERCENTAGE OF ENCOUNTER TIME, BY TYPE OF NEWS DELIVERED

- Symptom-talk: Good news, 34.6%; stable news, 37.2%; bad news, 20.7%
- Scan-talk: Good news, 9.2%; stable news, 7.9%; bad news, 9.0%
- Treatment-talk: Good news, 31.1%; stable news, 19.8%; bad news, 50.2%
- Logistic-talk: Good news, 15.0%; stable news, 15.0%; bad news, 12.9%

There were only four instances of prognosis-talk (6.3% of all encounters). Of

Continued on Page 3

NEWSLINE

Palliative Care Consults Optimize End-of-Life Care for Nursing Home Residents, Study Finds

The first study of the effects of specialty palliative care (PC) consultations provided to seriously ill patients in nursing homes who are not yet eligible or ready for hospice care has found lower rates of hospitalization, emergency department (ED) use, and burdensome transitions near the end of life, according to a report published in the *Journal of the American Geriatrics Society*. Further, these rates were even lower when PC specialists were consulted earlier.

“These findings have never been shown in nursing homes,” says lead author Susan C. Miller, PhD, a Brown University gerontologist and professor at Brown’s School of Public Health. “It’s important that we document this because essentially when people are in the nursing home for a long stay, that’s their final residence. These are people in need of supportive care and expertise in palliative care.”

PC consults are most often provided from outside agencies by nurse practitioners with expertise in the field, note the authors. Consults can be requested by staff or family members who recognize a patient’s need for symptom management or aid in decision making, and must be ordered by an attending physician.

Investigators analyzed data on 653 nursing home residents who died between 2006 and 2010 in one of 46 facilities in two states. These residents had received initial PC consultations within 180 days of death. Burdensome transitions were defined as hospitalization or hospice enrollment ≤ 3 days before death, or ≥ 2 hospitalizations or ED visits within 30 days of death.

KEY FINDINGS

- When the consultation was held 8 to 30 days before death, the hospitaliza-

tion rate in the last 7 days of life was about half that of residents with no PC consult (11.1% vs 22.0%).

- For patients whose consult was held 61 to 180 days before death, the hospitalization rate was one-third that of non-consult residents (6.9% vs 22.9%).
- The rate of burdensome transitions also was significantly lower for those with consults 61 to 180 days before death (16.2% vs 28.2%).

Source: “Palliative Care Consultations in Nursing Homes and Reductions in Acute Care Use and Potentially Burdensome End-of-Life Transitions,” *Journal of the American Geriatrics Society*; November 2016; 64(11):2280–2287. Miller SC, Lima JC, Hanson LC, et al; Department of Health Services, Policy & Practice, Brown University; and Center for Gerontology and Health Care Research, Brown University School of Public Health, Providence, Rhode Island; Division of Geriatric Medicine; Center for Aging and Health; and Palliative Care Program, University of North Carolina, Chapel Hill.

‘Would You Like to Talk about What This Means?’ (from Page 2)

these, three-quarters (75%) were initiated by the patient or accompanying caregiver. Otherwise, prognostic information was “shrouded in scan-talk,” i.e., characterized by information describing tumor size.

“In all cases, the physicians spoke the vast majority of the time, and demonstrated control over the direction of the discussion, particularly with regard to transitioning between different phases of the conversation,” write the authors. Thus, they point out, although these discussions are “co-constructed” by the patient/caregiver and physician, there is asymmetry in the selection and timing of topic introduction.

BETWEEN SCAN-TALK AND TREATMENT-TALK, A SIMPLE MODIFICATION

“We propose the question, ‘Would you like to talk about what this means?’ as a communication device that can regularly incorporate occasions for prognosis-talk and shared decision making in the clinic encounters,” write the authors. “It has the benefit of keeping the sequential order of the phase structure intact and maintaining the oncologist’s role as the lead architect of the discussion.”

The space in between scan-talk and treatment-talk is an optimal opportunity

to ask the question. If patients say yes, oncologists are empowered to disclose prognostic implications and express empathy. “It is our hope that, as patients answer this question honestly, oncologists, too, can engage in discussion surrounding prognosis that leads to enhanced prognostic awareness and improved illness understanding,” the authors state.

Source: “Characterizing the Nature of Scan Results Discussions: Insights into Why Patients Misunderstand Their Prognosis,” *Journal of Oncology Practice*; Epub ahead of print, January 17, 2017. DOI: 10.1200/JOP.2016.014621. Singh S, Cortez D, Maynard D, Cleary JF, DuBenske, et al; University of Colorado Denver, Aurora, Colorado; University of Wisconsin, Madison.

RESEARCH MONITOR

Heart Failure Patients Want to Discuss Advance Care Planning, Prognosis

Patients with heart failure (HF), which is the nation's leading cause of adult hospitalizations and readmissions, overwhelmingly report that they wish to discuss their prognosis, what to expect from their disease, and advance care planning (ACP) with their physicians. Although many have had such discussions, there is more to be done to reach all who want these conversations, according to a report published in the *Journal of Palliative Medicine*.

"Conforming to national guidelines, most patients with HF have discussed ACP with clinicians and most of those who have not, want to," write the authors. "Findings should embolden clinicians to routinely discuss ACP," they add.

"Understanding preferences toward important issues such as prognosis, goals of care, ACP, surrogate decision making, and social and spiritual support among patients with HF, and the patient factors associated with discussing these issues, may help guide clinicians in initiating discussions with their patients and in ensuring that care aligns with patient preferences."

Investigators analyzed the survey responses of 104 adult HF patients (male, 66%; white/European, 66.3%) with New York Heart Association HF class II (57%) or III (43%) who were cared for in clinics affiliated with a large, urban, academic medical center between 2007 and 2009. Mean age of patients was 53 years (range, 21 to 84 years); respondents had been living with HF for a mean 7.0 years (range, < 1 year to 46 years).

OVERALL:

- 76.5% of patients reported having a discussion with their physician about what to expect from their condition.
- 68% reported discussing prognosis.
- 46.5% indicated that they had a discussion about ACP.

- 63.4% had a discussion about their healthcare surrogate choice.

Although 90.3% of patients indicated they had thought about choosing a surrogate decision maker, less than two-thirds of these (64.8%) reported having talked to their physician about a surrogate. And despite the more than three-quarters who had discussed expectations regarding their HF, 63.7% said they still had questions about their condition.

PATIENTS FAVOR DISCUSSIONS

Among patients who had not discussed these topics, but wished to:

- 87.5% wished to discuss expectations regarding their HF.
- 80.6% would have liked to discuss prognosis.
- 59.6% desired to discuss ACP.

While only 25.2% of patients reported having discussed their religion/spirituality with their clinician, the vast majority (85.7%) of those who had not discussed their faith or beliefs with their clinician indicated that they would not be interested in having such a discussion. This finding did not differ by either gender or race.

"These findings are in marked contrast to previous research that found that many patients wanted to discuss these issues and may be specific to our patient population," note the authors. They suggest that data showing that increased patient spirituality is associated with less risk of depression and improved quality of life might encourage physicians to consider raising this issue with their patients.

Having had or wishing to have discussions on these topics was not associated with such patient factors as assessed quality of life, number of years living with HF, or number of hospitalizations. There was, however, a significant gender association.

Men were found to be more likely than

women to have discussed:

- What to expect (83.6% vs 62.9%; $P = 0.02$)
- Prognosis (78.5% vs 48.6%; $P = 0.002$)
- ACP (56.1% vs 28.6%; $P = 0.01$)

'MORE WORK TO BE DONE'

"The fact that most patients reported having conversations with their clinicians about HF management, prognosis, and choice of surrogate shows that in this setting clinicians are not waiting until end of life to discuss them," comment the authors. "Still, there is more work to be done to make these important conversations universal, as most patients who did not have these discussions want to have them."

Patients who have not yet had these discussions may be waiting for their physician to broach the subject. The authors suggest that a "safe entrance" for physicians to initiate a discussion of ACP with HF patients could be the topic of selecting a surrogate decision maker. Their investigation found that most patients have thought about choosing a surrogate, but only about two-thirds have shared their thoughts with their clinician.

"Alternatively, clinicians who are not comfortable or who feel the discussion would be too difficult may consider referring their patient to palliative care specialists," they suggest. "Regardless, these conversations are critical to understanding patient and family expectations and to developing mutually agreed-upon goals of care, and not just focus on the diagnosis."

Source: "Let Us Talk about It: Heart Failure Patients' Preferences toward Discussions about Prognosis, Advance Care Planning, and Spiritual Support," *Journal of Palliative Medicine*; January 2017; 20(1):79-83. Gordon NA et al; Frank H. Netter MD School of Medicine, Quinnipiac University, North Haven, Connecticut; Palliative Care Program; School of Medicine; and School of Nursing, University of California, San Francisco.

RESEARCH MONITOR

Regional Variation in End-of-Life Care Suggests Primary Care Physician Involvement May Influence Care Choices and Hospice Use

Region by region, there is a vast difference in end-of-life care practices, including the amount of primary care, specialist, intensive care unit (ICU), and hospice usage. A study published in *Annals of Family Medicine* suggests that the involvement of the primary care physician during the last six months of life is associated with several end-of-life care quality indicators, including ICU visits, number of physicians involved with end-of-life care, and hospice use.

The role physicians may play in influencing patients' end-of-life care decisions is especially important today, the authors point out. "During the last decade, individuals dying in the United States have received an increasing volume and intensity of care without clear improvements in the quality of that care."

Investigators analyzed data from Medicare Part B claims organized by hospital referral regions from the Dartmouth Atlas. The population included over one million Medicare Part B patients with a chronic illness who died in 2010. The authors examined the ratio of primary care visits to specialist visits in the last six months of life among Medicare patients in each hospice referral region. The 306 regions were sorted into quartiles, from lowest to highest ratio of primary care to specialist visits.

FINDINGS

Patients in regions with a greater ratio of primary care to specialist visits had:

- Fewer ICU days in the last six months of life ($P < 0.001$; mean, 2.90 in quartile with greatest primary care involvement vs 4.29 in quartile with lowest primary care involvement)

- A lower chance of receiving ICU care in their final hospital admission ($P < 0.001$; 14.5% of patients vs 17.5% of patients)
- A lower chance of seeing 10 or more physicians during the last six months of life ($P < 0.001$; 37.0% of patients vs 42.4% of patients)
- Less Medicare spending during the last two years of life ($P = 0.003$; mean, \$65,160 vs \$69,030)
- A lower rate of hospice enrollment ($P = 0.004$; 44.5% of patients vs 50.4% of patients)

ICU usage rate and total number of physicians responsible for a patient's care, which were both negatively associated with a higher ratio of primary care, are commonly used indicators of end-of-life care, note the authors. Evidence has suggested that seeing many specialists at once can disrupt a patient's primary care coordination.

PRIMARY CARE INVOLVEMENT AND HOSPICE

The authors note it is unusual that fewer Medicare patients were enrolled in hospice in regions that had a greater ratio of primary care visits. They write that primary care has previously been shown to improve quality of care, but that little research has been conducted on primary care at the end of life. Previous studies on primary care associations with hospice use have produced conflicting results.

The authors point out several potential reasons for the association of greater primary care involvement with lower hospice use in their study. Hospice enrollment may be lower in areas with greater primary care involvement because:

- Physicians may view a hospice referral as terminating a long-standing relationship with a patient.
- Long-term primary care physicians may not realize that a patient's life expectancy is six months or less.
- Longtime physician-patient relationships reportedly decrease the accuracy of prognoses.
- Hospice care may be more prevalent in geographical areas with less emphasis on primary care.

IMPORTANCE OF FUTURE STUDY

Rates of hospice care have doubled over the last decade. However, as the authors report, the amount of "burdensome care" received by patients at the end of life has also risen. According to the authors, "Understanding the potential influence of the primary care physician in this shifting landscape is critical to explaining variations in care patterns and identifying opportunities for quality improvement."

The authors conclude that the results show promising evidence that primary care physician involvement may reduce the intensity and cost of end-of-life care. They write, "Given the size of the aging population and the magnitude of the primary care physician infrastructure, further work to understand and optimize the role of primary care physicians will be critical to improve care of the dying."

Source: "Regional Variation in Primary Care Involvement at the End of Life," *Annals of Family Medicine*; January/February 2017; 15(1):63-67. Ankuda CK, Petterson SM, Wingrove P, Bazemore AW; Robert Wood Johnson Clinical Scholars Program, Family Medicine, University of Michigan Health System, Ann Arbor, Michigan; and Robert Graham Center, Washington, DC.

RESEARCH MONITOR

Primary Palliative Care: A ‘Critical Addition’ to the Care of Patients with Heart Failure

Primary palliative care (PC) for patients diagnosed with serious illness focuses on treating symptoms, exploring goals and values, and helping patients make decisions that align with their desired care. But the bulk of the research on the benefits of PC and guidelines on how to incorporate it into primary patient care has focused on the cancer population, with very little attention paid to heart failure (HF), according to an article published in the international journal, *Heart Failure Reviews*.

“Palliative care is a critical addition to the care of patients with HF and their families,” write the authors. “The development of high-quality primary PC is particularly important for HF, given its rapidly increasing incidence, high morbidity and mortality, and the complex decision making in advanced stages involving consideration of ventricular assist device therapies, cardiac transplant, and hospice.”

The article describes domains of care in which primary PC can be incorporated into traditional HF management. Included is a table outlining and comparing the responsibilities appropriate for either primary or specialist PC, along with case examples of providing primary PC. In addition, the authors provide descriptions of and contact information for several existing models for primary PC training.

Specialist PC for HF patients is rare because of existing barriers to referral and the increasing shortage of PC specialists, note the authors. Specialist help may be needed when symptoms are complex or refractory to interventions or when support or communication needs exceed the expertise of the HF team. “[P]rimary palliative care in HF offers a key opportunity to ensure that this population receives high-quality palliative care in

spite of the growing numbers of patients with HF as well as the limited number of specialist palliative care providers,” write the authors.

The authors identify four major domains of primary palliative care in heart failure: symptom management, communication, psychosocial support, and care coordination.

SYMPTOM MANAGEMENT

Common symptoms of HF include shortness of breath, fatigue, pain, anxiety, and depression, each of which can be highly distressing for patients. Indeed, the symptom burdens of HF have been found to exceed those reported by cancer patients. However, these symptoms are frequently under-recognized and under-treated, note the authors.

“Because addressing symptoms is often the mainstay of HF management, with basic education, HF clinicians can also be alerted to identify and treat other symptoms [besides congestion], such as uncomplicated depression, anxiety, and pain,” they write.

COMMUNICATION

Patients with HF rarely complete advance directives. Even when they do, these documents seldom address goals of care specific to HF, note the authors. Because of the added layer of complexity in decision-making at the end of life for HF patients, physicians are urged to hold discussions that address not only prognosis and therapies, but also issues concerning device deactivation.

PSYCHOSOCIAL SUPPORT

Informal caregivers of patients with advanced HF can face a tremendous burden of care responsibilities. Clinicians are encouraged to learn to identify

those caregivers at risk for symptoms of anxiety, depression, poor quality of life, and complicated bereavement.

“By conducting earlier goals-of-care discussions and providing prognostic information,” clinicians can help caregivers and patients “prepare for the increasing care needed at home and thus mobilize the necessary resources,” the authors suggest.

CARE COORDINATION

Once clinicians understand the goals and values of HF patients and their caregivers, they can deliver primary PC by communicating with other providers and coordinating care in line with patients’ preferences. For those patients who have clearly stated a desire for comfort care at the end of life, referral to a hospice service should be arranged.

The following training opportunities for primary PC are suggested: Center to Advance Palliative Care (CAPC), a web-based clinical skills curriculum (www.capc.org); Education in Palliative and End-of-Life Care (EPEC) Program, which includes curricula in both fundamental and specialist PC skills (www.epec.net); End-of-Life Nursing Education Consortium (ELNEC), an initiative to train nursing faculty in PC (www.aacn.nche.edu/elneec); and CardioTalk (beckwithinstitute.org/cardiotalnk), a communication skills training program, based on VitalTalk (vital.org), which originated as Oncotalk.

Source: “Primary Palliative Care for Heart Failure: What Is It? How Do We Implement It?” Heart Failure Reviews; Epub ahead of print, March 9, 2017; DOI: 10.1007/s10741-9604-9. Gelfman LP et al; Brookdale Department of Geriatrics and Palliative Medicine; and Divisions of Cardiology and Population Health Science and Policy, Icahn School of Medicine at Mount Sinai, New York City; James J. Peters VA Medical Center, Bronx, New York; Division of General Internal Medicine, Section of Palliative Care and Medical Ethics, University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania.

CLINICIAN RESOURCES

Patient Video May Aid Physician Interpretation of End-of-Life Care Documents

The addition of a brief patient-generated video to a living will or POLST (Physician Orders for Life-Sustaining Treatment) document may help clarify patient preferences for physicians caring for acutely ill patients who have lost their decision-making capacity, according to a study published in *Journal of Patient Safety*.

“Both living wills and POLST are very much needed and effective,” says lead author Ferdinando L. Mirarchi, DO, University of Pittsburgh Medical Center Hamet in Erie, PA. “However, they are prone to medical errors related to provider misinterpretation of what is documented and appropriate patient selection.”

Video support tools have been shown to work successfully as patient decision aids, note the authors, “and they should also work as communication tools. Our study focuses on using videos to communicate patient wishes back to clinicians.”

Investigators conducted a nationwide survey of 741 resident and attending physicians (emergency medicine, family practice, and internal medicine) at 13 teaching hospitals across nine states who were presented with nine clinical scenarios involving critically ill patients who had completed either a living will or POLST document.

Participants were randomly assigned to interpret patient wishes based on either the living will or POLST documents alone, or with the addition of a brief, scripted video in which the patient talked about his or her choices. Respondents were asked to interpret code status and make resuscitation/treatment decisions for each scenario. Concordance of 95% or more among participants indicated consensus and by inference, clarity in the information provided about the patient’s preferences.

KEY FINDINGS INCLUDE:

- In decisions based on documents only, consensus ($\geq 95\%$ agreement) was reached in only two of nine scenarios for both code status and resuscitation/treatment decisions.
- Most respondents selected DNR (do not resuscitate) as the code status for a POLST document (68.3%) and for a living will (78.4%).
- Nearly half (46.1%) equated DNR with “comfort measures only” beyond an arrest event, with the remaining responses being equally split between “full care” and “uncertain.” Research has shown that clinicians frequently conflate DNR code status with “do not treat” in nonarrest situations, note the authors.
- With the addition of an explanatory patient video, responses changed significantly in seven of the nine scenarios (code status, by 9% to 62% [$P \leq 0.026$]; resuscitation, by 7% to 57% [$P \leq 0.005$]). In both interpretation categories, consensus was achieved in four of the nine scenarios.

Secondary factors, such as physician specialty, experience, and training in the use of POLST or living will documents were found to have little influence on physician interpretation, the authors report. “Overall, addition of a video message was the most consistent predictor of either code status determination or resuscitation choices achieving consensus.”

Source: “TRIAD VIII: Nationwide Multicenter Evaluation to Determine Whether Patient Video Testimonials Can Safely Help Ensure Appropriate Critical versus End-of-Life Care,” *Journal of Patient Safety*; Epub ahead of print, February 14, 2017; DOI: 10.1097/PTS.0000000000000357. Mirarchi FL et al; University of Pittsburgh Medical Center Hamot, Erie, Pennsylvania; and Allegheny General Hospital/Allegheny Health Network, Pittsburgh.

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.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

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

End-of-Life Caring through Communication, Law, & Ethics. June 29–July 7, 2017, 8-night Scandinavian Escape Cruise Conference, round-trip from Southampton, England. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 800-422-0711; Website: www.continuingeducation.net

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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