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Most Bereaved Family Members Rate Hospice Highly, Especially for Care at Home Rather Than in a Nursing Home

Nearly 90% of family caregivers rate the hospice care their deceased loved ones received as very good or excellent, with relatives of those receiving care at home or in an assisted living facility (ALF) more likely to give an excellent rating than those whose loved ones were cared for in a nursing home (NH), according to a report published in the *Journal of the American Geriatrics Society*.

Although a large majority of respon-

dents overall (84%) believed that hospice referral had occurred at the right time, relatives of NH residents were also more likely than others to report that hospice referral occurred too late. “Lower perceived quality of hospice care in NHs may be related to general dissatisfaction with receiving care in this setting,” suggest the authors.

Investigators analyzed 7510 surveys completed by bereaved family members of patients in 18 states who had received routine hospice care provided by a large, national hospice service at home (49%), in a NH (29%), or in an ALF (22%). Fully 27,714 surveys were administered as part of the Family Evaluation of Hospice Care (FEHC), a federally mandated quality survey distributed to bereaved family members from 2009 to 2014.

In a logistic regression model, those whose loved ones received hospice care in a NH or ALF were significantly less likely to rate care as excellent (odds ratio [OR], 0.48; $P < 0.001$ and OR, 0.67; $P < 0.001$, respectively) compared with those whose loved one received care at home.

OVERALL

- Nearly 95% of all respondents rated hospice care as excellent, very good, or good.
- Median length of hospice service among all 27,714 participants was 17 days (range, 1-2 to 117 days).
- Although individuals of black race constituted 15.2% of the total sample, they were represented by only 9.3% of returned surveys.

“[T]his is the first study to directly compare perceptions of quality of routine hospice care for individuals in three settings of care — home, NHs, and ALFs,” write the authors. “These findings highlight considerations for policymakers, hospices, and individuals and their families.”

Source: “Quality of Hospice Care at Home Versus in an Assisted Living Facility or Nursing Home,” Journal of the American Geriatrics Society; Epub ahead of print, February 10, 2018; DOI: 10.1111/jgs.15260. Unroe KT et al; Center for Aging Research, Indiana University; Regenstrief Institute, Inc.; Department of Medicine, and Department of Biostatistics, School of Medicine, Indiana University, all in Indianapolis.

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PERCEIVED QUALITY OF CARE BY SETTING

- Care was rated as excellent: home, 67.8%; ALF, 64.3%; NH, 55.1% ($P < 0.001$).
- Referral occurred at the right time: home, 86.7%; ALF, 85.8%; NH, 79.1% ($P < 0.001$).
- Referral was too late: home, 8.3%; ALF, 8.2%; NH, 13.7% ($P < 0.001$).
- Death occurred in the patient’s preferred place: home, 98.8%; ALF, 93.5%; NH, 81.7% ($P < 0.001$).

NEWSLINE

Focus of Outpatient Palliative Care Visits Linked to Different Improvements in Patient Outcomes

Palliative care (PC) provided in the ambulatory setting improved patient outcomes among advanced cancer patients, with different elements of visit content associated with different outcomes. Identifying these aspects of care may help in the development and integration of PC into the outpatient oncologic care experience, according to a report published in the *Journal of Clinical Oncology*.

“To our knowledge, this is the first study to link the content of PC visits to patient-reported outcomes and end-of-life care,” write the authors. “This study defines the key elements of early PC for patients with advanced cancer and provides a roadmap for building outpatient PC practices to enable dissemination of this care model.”

Three key elements — support with coping with life-threatening illnesses, treatment decisions, and advance care planning — were found to be associated with improvement in patient quality of life, risk of hospitalization, and likelihood of entering hospice, respectively.

Investigators analyzed the content of 2921 outpatient PC visits by 171 adult patients newly diagnosed with advanced lung or non-colorectal gastrointestinal cancer (mean age, 65.4 years; white race, 88.9%) from 2011 to 2015. Participants were randomly assigned to visits with 40 PC clinicians (board-certified PC specialists and advanced practice nurses) at least monthly, with a minimum 18-month follow-up.

PC clinicians documented the visit content after each encounter, and patient-reported quality of life and mood were assessed at baseline and at 24 weeks. PC and oncology appointments were usually scheduled for the same day, with

oncologists participating in many of the PC visits.

OVERALL

- **Oncology clinicians were present for 23% of all visits.**

“Early, longitudinal involvement of PC can increase opportunities for oncology and PC to work collaboratively to enhance patients’ ability to understand and cope with their illness, which may help patients and caregivers to better tolerate future difficult discussions about discontinuing chemotherapy and advance care planning,” the authors point out.

- **Most visits emphasized symptom management (74.5%) and coping techniques (64.2%).**

“Notably, PC clinicians managed symptoms through patient education and counseling more often than medications,” write the authors. “Although oncology clinicians are often appropriately prescribing and adjusting medication for symptoms, these data suggest that patients may benefit from additional education and counseling regarding the use of such medicines and support for non-pharmacologic strategies.”

KEY FINDINGS

- **Coping.** Patients with more visits that focused on coping experienced improvement in quality of life ($P = 0.02$) and depression symptoms ($P = 0.002$). Support with coping was a consistent hallmark of PC across the illness trajectory.
- **Treatment decisions.** Patients with a higher proportion of visits addressing

treatment decisions were less likely in the last 60 days of life to start a new chemotherapy regimen (odds ratio [OR], 0.57; $P = 0.02$) or to be hospitalized (OR, 0.62; $P = 0.005$).

- **Advance care planning.** Patients with a higher percentage of visits focused on advance care planning were more likely to use hospice services (OR, 1.79; $P = 0.03$).

SUPPORTIVE COPING TECHNIQUES USED BY CLINICIANS INCLUDED:

- Redirecting hope throughout the illness trajectory
- Discussing behavioral coping strategies early on
- Providing supportive counseling along the illness trajectory, especially in later visits

“Interestingly, this [increased counseling later in the illness] parallels practices in psychotherapy in which cognitive strategies are increasingly used over behavioral strategies when patients have less control,” observe the authors.

FINDINGS AMONG DECEDENTS

Among the 125 study participants who had died:

- 81.6% received hospice services
- 57.6% died at home
- 64.8% were admitted to the hospital within 60 days of death
- 48.8% had an emergency department visit in the 60 days before death
- 19.2% began a new chemotherapy regime within 60 days of death

The 2017 updated clinical practice

Continued on Page 3

NEWSLINE

Re-examining Assumptions about 'The Good Death:' A Crucial Step for Meeting the Needs of an Aging, Diverse Society

With a rapidly aging society and current advances in medical treatments, most older adults will experience a prolonged dying process, often living with the burdens of multiple chronic illnesses, disability, and/or dementia for years before succumbing to them. Death for these older adults can no longer be viewed by the medical community as an event (whether "good" or "bad") that occurs to an individual at a single point in time, according to two experts in geriatrics and palliative medicine.

"We argue that the notion of a monolithic 'good death' should be abandoned," write the authors of an editorial published in the *Journal of the American Geriatrics Society*. "It does not exist. A good death is individual, and is highly influenced by social relationships and cultural, religious, and historical factors."

Abandoning the imposed values of a "good death" does not mean that clinicians should abrogate their moral responsibility to shepherd patients through the end-of-life experience in favor of unre-

strained patient choice, note the authors. Most people are too shielded from what is medically involved in the actual process of dying to navigate the journey unaided.

"Clinicians have an ethical duty to guide when they perceive that an individual is making a choice about his or her end-of-life care that (often unknowingly) conflicts with his or her values and life goals," they write.

"In an increasingly diverse society, we have a responsibility to respect diversity in goals of care, perspectives, and preferences," add the authors.

PHYSICIANS CAN RESPECT PATIENT DIVERSITY BY:

- Reflecting on their own assumptions and biases
- Being prepared to support patient preferences and choices that are radically different from ones they would make themselves
- Making a careful review of the available care options within the larger

context of the patient's preferences

- Discussing these care options honestly and compassionately, then helping the patient make realistic plans

It is time for "a larger vision of a society that meets the diverse priorities of older adults not only at the moment of death, but also during their last years and decades of life." What is needed is a fundamental shift of resources from the delivery of high-intensity care to a system that will "support the ability of older adults to live in their communities for as long as possible, including home-based primary and palliative care, support for caregivers, and home health aides," the authors conclude.

Source: "Should We Bury 'The Good Death'?" Journal of the American Geriatrics Society; Epub ahead of print, March 6, 2018; DOI: 10.1111/jgs.15321. Smith AK and Periyakoil VS; Division of Geriatrics, Department of Medicine, University of California, San Francisco; San Francisco Veterans Affairs Medical Center, San Francisco; Division of Primary Care and Population Health, Department of Medicine, School of Medicine, Stanford University, Palo Alto; and Veterans Affairs Palo Alto Health Care System, Palo Alto, California.

Focus of Outpatient Palliative Care Visits (from Page 2)

guidelines of the American Society of Clinical Oncology recommend early PC ("early" being defined in this study as occurring soon after diagnosis of advanced cancer) integrated with cancer treatment. While most large healthcare systems now offer inpatient PC, such care is less available in the outpatient setting, and its effects on patient outcomes have had little investigation, note the authors.

Further, hospital-based PC focuses largely on symptom management and end-of-life decision making, while "care in the ambulatory setting enables PC clinicians to establish lon-

gitudinal relationships with patients and their families, to help patients understand their prognosis and make decisions about their cancer care over time."

Source: "Defining the Elements of Early Palliative Care That Are Associated with Patient-Reported Outcomes and the Delivery of End-of-Life Care," Journal of Clinical Oncology; Epub ahead of print, February 23, 2018; DOI: 10.1200/JCO.2017.75.6676. Hoerger M, Greer JA, Jackson VA, Park ER, Pirl WF, El-Jawahri A, et al; Tulane Cancer Center, New Orleans; Massachusetts General Hospital Cancer Center, Boston; Harvard Medical School, Boston; Sylvester Comprehensive Cancer Center/University of Miami, Miami; and University of Pittsburgh, Pittsburgh.

RESEARCH MONITOR

Collaborative Palliative Care Intervention for Heart Failure Patients Improves Depression, Fatigue, Anxiety

A palliative intervention using a collaborative delivery model to address symptoms and psychosocial needs of patients with chronic heart failure (HF) and high symptom burden has been found to significantly improve common and difficult-to-treat symptoms such as depression and fatigue, although it did not show significant change in disease-specific health status.

“To our knowledge, the CASA (Collaborative Care to Alleviate Symptoms and Adjust to Illness) trial is the first clinical trial of a palliative and psychosocial collaborative care intervention for patients with heart failure,” write the authors of a report published in *JAMA Internal Medicine*.

“Many of the 5.8 million Americans with heart failure live with bothersome symptoms, reduced function, and poor quality of life,” says lead author David B. Bekelman, MD, MPH. “Improving their care is important because many people with heart failure live with these challenges for years.”

Researchers studied Colorado outpatients with chronic HF and poor health status and/or bothersome symptoms ($n = 314$; mean age, 65.5 years), half of whom were randomly assigned to receive the CASA intervention from 2012 to 2015. The remaining half of patients received usual care.

Patient-reported symptoms and health status were recorded at baseline and in a series of follow-ups at 3 months, 6 months, and 12 months. Questionnaires were administered to assess patients' HF-specific health status and depression, as well as overall symptom distress, pain, shortness of breath, fatigue, and anxiety.

Intervention patients met with a registered nurse who addressed burdensome symptoms and followed up with six

phone meetings made once or twice per month. More than two-thirds (67.5%) of intervention patients chose fatigue or breathlessness as the initial symptom of focus. A social worker addressed patients' psychosocial needs, including the topics of grief, coping with change, and managing depression symptoms, through approximately six phone-based counseling sessions.

The nurse and social worker, who were specifically trained for the CASA intervention, discussed the patients' needs at weekly meetings with a primary care clinician, a cardiologist, and a palliative care physician. Care recommendations from these meetings were relayed to patients' usual care clinicians. Patients in the control group were given information about self-care and were notified if they displayed significant depression symptoms, but were otherwise cared for at the discretion of their clinicians, with no additional instructions or referrals.

The intervention group was relatively diverse, point out the authors, regarding race (nonwhite, 28.0%), education (high school or lower as highest level of education, 30.2%), and income (less than or equal to \$40,000 household income, 64%), but the majority of participants were men (78.7%).

KEY FINDINGS

- Depressive symptoms were significantly improved in the CASA intervention group compared with the control group at 3 months (score change difference on a scale of 0-27, -1.6; $P = 0.01$), and 6 months (score change difference, -1.4; $P = 0.02$). This effect continued at 12 months ($P = 0.006$).
- Fatigue improved with CASA at 6 months (score change difference on a scale of 0-32, -2.0; $P = 0.02$), although

the change wasn't significant at 12 months ($P = 0.16$).

- Anxiety improved with CASA at 3 months (score change difference on a scale of 0-21, -1.1; $P < 0.001$), but the change did not reach statistical significance at 6 months (score change difference, -0.9; $P = 0.09$).
- Change in HF-specific health status did not differ significantly between the groups (score change difference on a scale of 0-100, 2.6; $P = 0.19$).
- Mortality did not differ significantly between the groups: 10 of 157 CASA patients died within 12 months, as did 13 of 157 control patients ($P = 0.52$).
- No significant changes were observed in overall symptom distress, pain, or shortness of breath.

The improvements in the secondary outcomes of depression and fatigue are important results, notes Bekelman, because both these symptoms are common, burdensome, and difficult to treat in HF. As for why CASA had no significant effect on the primary outcome of HF-specific health status, the authors speculate that the intervention may need to be more intense or to target a more specific group.

Meanwhile, the authors call for further research into interventions similar to CASA, i.e., “a structured, scalable intervention that could be integrated into outpatient care and could be provided earlier in the course of the illness prior to the end of life.”

Source: “Effect of a Collaborative Care Intervention vs Usual Care on Health Status of Patients with Chronic Heart Failure: The CASA Randomized Clinical Trial,” JAMA Internal Medicine; Epub ahead of print, February 26, 2018; DOI: 10.1001/jamainternmed.2017.8667. Bekelman DB, Allen LA, Meek PM, et al; Department of Medicine, Department of Veterans Affairs, Eastern Colorado Health Care System, Denver.

RESEARCH MONITOR

Non-Cancer Hospice Admitting Diagnoses Continue to Rise While Concerns about Late Referrals Remain

Continuing an upward trend, nearly three-quarters (72.8%) of Medicare hospice patients were enrolled in 2016 with a non-cancer primary diagnosis. Yet the increasing trend for late referrals has also continued, according to “Facts and Figures: Hospice Care in America,” the most recently updated overview of hospice care delivery in the U.S. from the National Hospice and Palliative Care Organization (NHPCO).

“When hospice first became available as a covered benefit under Medicare in 1983, the overwhelming majority of patients had cancer,” says Edo Banach, JD, NHPCO president and CEO. “That has changed in recent years as we’ve seen hospices caring for more people with a cardiac or circulatory diagnosis, a respiratory illness, and the fastest growing diagnosis of dementia.”

OVERALL

- 1.43 million Medicare beneficiaries (up from 1.38 million in 2015) received hospice services for one day or more in one of the nation’s 4382 Medicare-certified facilities.
- 48% of all Medicare decedents in 2016 were enrolled in hospice at the time of death.
- 64.2% of enrollees were aged \geq 80 years; 86.5% were Caucasian.

PRINCIPAL ADMITTING DIAGNOSES IN 2016 INCLUDED:

- Cancer: 27.2% (vs 27.7% in 2015)
- Cardiac and Circulatory: 18.7% (vs 19.3% in 2015)
- Dementia: 18.0% (vs 16.5% in 2015)
- Respiratory: 11.0% (vs 10.9% in 2015)
- Stroke: 9.5% (vs 8.8% in 2015)

SHORT DURATION OF STAY CAUSE FOR CONCERN

“Hospice professionals continue to be concerned about the number of people who receive hospice care for a short period of time,” states the NHPCO. The report indicates that just over 40% of Medicare beneficiaries accessing hospice received care for 14 days or less in 2016, “which is considered too short a period for patients to fully benefit from the person-centered care available from hospice.”

- Median length of service for all patients in 2016 was 24 days (mean, 71 days).
- 27.9% were enrolled for 1 to 7 days; 40.5% were enrolled for less than 14 days.
- 54.2% were under hospice care for one month or less.
- The median number of days of care by diagnosis was lowest for patients with cancer (19 days) and highest for those with dementia (54 days).

“The hospice interdisciplinary team is ideally suited to provide care and support to patients and family caregivers throughout the last months of life, not just the last days,” says Banach. “We need to continue reaching out to patients, family caregivers, and other healthcare professionals to help them understand all the benefits that hospice care brings, particularly when provided in a timely fashion as part of a continuum of care.”

The multidisciplinary hospice team provides person-centered care by:

- Managing pain and other symptoms
- Providing medications and medical equipment
- Instructing the family on how to care for the patient
- Assisting both the patient and family with the emotional, psychosocial, and

spiritual aspects of dying

- Making short-term inpatient care available when pain or symptoms become too difficult to manage at home or when the caregiver needs respite time
- Delivering speech and physical therapy and other special services when needed
- Providing counseling and grief support

TYPES AND LOCATIONS OF HOSPICE CARE

The majority of hospice care in 2016 was provided in the place the patient calls home, which can be a private residence (55.6%) or nursing facility (41.9%). Nursing facilities can include nursing homes, skilled nursing facilities, and assisted living facilities. Only 0.5% of patients received hospice services in an acute care hospital.

In 2016, nearly all patients (98%) received the most common type of Medicare hospice care, Routine Hospice Care, which is delivered at the patient’s residence. In addition, 1.5% received General Inpatient Care, which is provided for pain or other acute symptoms that cannot be managed in a residential setting; 0.3% received Inpatient Respite Care to grant temporary relief for the primary caregiver; and 0.2% received Continuous Home Care, which is intended to maintain the patient at home through a pain or symptom crisis.

LOCATION OF DEATH IN 2016

- Home: 44.6%
- Nursing facility: 32.8%
- Hospice inpatient facility: 14.6%
- Acute care hospital: 7.4%

The full report, which was released in March 2018, is available at www.nhpc.org.

CLINICIAN RESOURCES

Emergency Physicians Offered Practical Palliative Care Tips for Immediate Use

As the population continues to age and an increasing number of older Americans live longer, often with complex chronic conditions, physicians in the emergency department (ED) face more and more patients requiring palliative and hospice care. Yet the training in palliative care skills has not yet caught up to the need, according to two experts.

“We sought to increase the emergency physician’s knowledge of and comfort with symptom control in palliative and hospice patients,” write the authors of an article published in the *Journal of Emergency Medicine*, the official journal of the American Academy of Emergency Medicine. Palliative/hospice care initiated in the ED has been shown to reduce the duration of inpatient stays and improve patient satisfaction and quality of life, they note.

Following a review of palliative care concepts, the authors address basic symptom management for chronic and terminally ill patients presenting in the ED, illustrated by three clinical case studies. Their discussion of symptoms covers the causes and management of pain, nausea, dyspnea, agitation, and oral secretions.

The article also includes tables listing narcotic equivalence, the World Health Organization analgesic ladder, and pharmacological therapies for treatment of pain, nausea, and vomiting. “This paper addresses these issues and offers skills that can be readily put to use,” write the authors. “While [hospice and palliative medicine is] a new subspecialty, palliative skills can be readily learned and applied on a daily basis, even in a busy ED.”

Hospice care is usually delivered to patients expected to live for six months or less, while palliative care is appropriate earlier in the disease and has no limiting time frame, the authors note. The clinician

“In general, patients with early hospice enrollment live longer than those without hospice.”

— Siegel and Bigelow,
Journal of Emergency Medicine

can use the following version of the Surprise Question: “Would I be surprised if this patient died in the next two years?” If the answer is no, palliative care is appropriate and should be considered.

In 2006, the American Board of Emergency Medicine (ABEM) recognized hospice and palliative medicine as a subspecialty of emergency medicine and, in 2012, added palliative care principles to its Model of the Clinical Practice for Emergency Physicians.

The ABEM expects all emergency physicians to be proficient as generalists (rather than as specialists) in palliative medicine. However, because there is yet no unified set of guidelines for teaching palliative care skills to emergency physicians, the authors chose to share some of their knowledge and experience to help with this education gap.

EMERGENCY PHYSICIAN PALLIATIVE CARE SKILLS

Generalist palliative care skills expected of all emergency physicians include:

- Assessment of illness severity, trajectory, and decline
- Prognosis formulation
- Advance care planning
- Allowing the family to be present during resuscitation
- Management of pain and non-pain symptoms
- Withdrawal/withholding of non-beneficial treatments

- Initiating difficult communications, such as breaking bad news and making death disclosures
- Management of the imminently dying
- Familiarity with hospice and palliative care systems; management of referrals
- Knowledge of ethical and legal issues
- Competency in spiritual and cultural considerations
- Management of the dying child

EARLY HOSPICE REFERRAL RECOMMENDED

The authors advocate for appropriately timely referrals to hospice. “In general, patients with early hospice enrollment live longer than those without hospice,” they write. “Although the use of hospice and other palliative care services at the end of life has increased in recent years, many patients are enrolled in hospice less than three weeks before their death, which limits the benefit they may gain from these services.”

Although they include a narcotic equivalence table in their paper, the authors suggest obtaining an opioid equivalency chart as a smartphone app, such as “Opioids” by Norris Vivatrat and Chris Marcellino, or as the two-page (single sheet), printable guide “Calculating Total Daily Dose of Opioids for Safer Dosage” from the Centers for Disease Control. The guide is available at: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf.

Source: “Palliative Care Symptom Management in the Emergency Department: The ABC’s of Symptom Management for the Emergency Physician,” *Journal of Emergency Medicine*; January 2018; 54(1):25–32. Siegel M and Bigelow S; Department of Emergency Medicine, Lewis Katz School of Medicine, Temple University Hospital, Philadelphia; and North Sound Emergency Medicine, Everett, Washington.

CLINICIAN RESOURCES

Online Curriculum Offers Courses in Palliative Care for Primary Care Clinicians

<https://csupalliativecare.org>

A newly launched educational resource from the California State University (CSU) system marks the addition of a comprehensive online curriculum for primary care clinicians to its growing collection of evidence-based learning courses in palliative care.

“Essential Palliative Care Skills for Every Clinician: Tools to Support Seriously Ill Patients in a Primary Care Practice,” from CSU’s Institute for Palliative Care, is designed for busy physicians, physician assistants, nurse practitioners, and other healthcare professionals in primary care “anywhere in the world” who are interested in learning or improving palliative care skills and integrating palliative care into their primary care practice.

“This curriculum allows all physicians caring for patients with serious illness to expand their level of comfort and efficiency with some of the most important parts of care: symptom management and communication around difficult topics,” says Institute task force member Michael Rabow, MD, professor of clinical medicine at the University of California, San Francisco. “All of us need to be able to do the basics, and without wasting any time or effort.”

The curriculum of nine courses can be purchased as a full series or as one or more of five bundles, arranged thematically and covering specific aspects of care, such as: pain and symptom management in primary palliative care; operationalizing primary palliative care; psychosocial, spiritual, and cultural dimensions of care; and care near the end of life.

COURSES INCLUDE:

- Introduction to Primary Palliative Care
- Communication and Advance Care Planning
- Physical Aspects of Care
- Psychosocial Aspects of Care
- Spiritual Aspects of Care
- Cultural Aspects of Care
- Care of the Patient at the End of Life
- Integrating Palliative Care into Practice
- Self-Care and Resilience

The pressing need for more primary care clinicians with palliative care skills is highlighted in a 2014 report from the Center to Advance Palliative Care and cited by the CSU Institute. This report noted the existence of only one palliative medicine specialist for every 1200 of the estimated 90 million seriously ill persons in the U.S., a patient population expected to double over the next 25 years.

The program was developed by an interdisciplinary team of experts in primary and palliative care “to give primary care providers and non-palliative specialists a core set of effective palliative care skills.” The program “is presented in an online, self-paced format designed with busy providers in mind.”

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/fast-facts

Hospice and Palliative Nurses Association
www.hpna.org

Hospice Foundation of America
www.hospicefoundation.org

Medical College of Wisconsin Palliative Care Program
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

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