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Quality of Life Matters®

News & clinical findings about serious illness

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Nearly 60% of Older Adults with Probable Dementia Are Unaware of Their Condition

A majority of U.S. adults aged 65 years or older who have probable dementia are either undiagnosed or unaware of their diagnosis, Johns Hopkins researchers have found. Lack of diagnosis was most strongly linked to Hispanic ethnicity, while unawareness of diagnosis was linked to lower educational attainment. Both situations were associated with patients making medical visits by themselves, according to a report published in the *Journal of General Internal Medicine*.

“There is a huge population out there living with dementia who don’t know

about it,” says lead author Halima Amjad, MD, MPH, assistant professor of medicine, Johns Hopkins University School of Medicine, Baltimore. “The implications are potentially profound for healthcare planning and delivery, patient-physician communication, and much more.”

An estimated 5.7 million people in the U.S. are living with dementia, 5.5 million of whom are aged 65 years or older, according to a 2018 report from the Alzheimer’s Association. However, only about one-half have a documented, official diagnosis by a physician.

Documentation of a professional dementia diagnosis alone does not necessarily translate into awareness by the patient/family, point out the authors. Nor does reported lack of a diagnosis by a patient or proxy necessarily indicate the patient is undiagnosed, they add. “[B]oth elements are necessary for patients and families to understand patient cognitive and functional limitations and prognosis.”

Investigators analyzed data from fee-for-service Medicare claims before 2011 linked to data from the National Health and Aging Trends Study (NHATS), an ongoing, nationally representative study that conducts annual research interviews, including cognitive testing. Awareness of a clinical diagnosis of dementia was based on reports by participants or their proxies.

Using both the NHATS interviews and Medicare claims, 585 community-dwelling older adults with probable dementia were identified, yielding a weighted sam-

ple of an estimated 1,972,534 individuals.

OVERALL FINDINGS

- 58.7% of participants were either undiagnosed or unaware of their dementia diagnosis. Of these, 39.5% were undiagnosed, and 19.2% had been diagnosed but were unaware.
- 41.3% were both diagnosed and aware.
- Mean age for all three groups was > 80 years.

UNDIAGNOSED OLDER ADULTS WITH PROBABLE DEMENTIA:

- Were more likely to be Hispanic (odds ratio [OR], 2.48; 95% confidence interval [CI], 1.19 to 5.14) or black (OR, 1.26; 95% CI, 0.82 to 1.95) compared with those with a dementia diagnosis
- Were almost twice as likely to attend medical visits alone (OR, 1.98; 95% CI, 1.11 to 3.51)
- Were less likely to have seen a primary care provider in the previous year (OR, 0.52; 95% CI, 0.25 to 1.08)
- Were less likely to have more than a high school education (OR, 0.54; 95% CI, 0.32 to 0.91)
- Were less likely to have been hospitalized or evaluated in the ER in the past year (OR, 0.76; 95% CI, 0.44 to 1.31)
- Had fewer instrumental activity of daily living (IADL) impairments (OR, 0.79; 95% CI, 0.69 to 0.90)

When IADL impairments were exam-

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NEWSLINE

Advanced Heart Failure Patients Referred Rarely, and Very Late, from Hospital to Hospice

Only 3.8% of older adults hospitalized with advanced heart failure (HF) are discharged to hospice care, and nearly one-quarter of these die within three days of enrollment. Further, median survival time in hospice is just 11 days, according to a report on a 10-year retrospective analysis published in *JAMA Cardiology*.

“Median survival times in hospice did not change between 2005 and 2014,” write the authors. “While the number of patients with HF dying in hospice is increasing, patients with cardiovascular disease have been identified as having the greatest unmet need for palliative care.”

Investigators analyzed data from the national, multicenter Get With The Guidelines–Heart Failure (GWTG–HF) registry linked to Medicare claims for older adult patients hospitalized with HF who were discharged alive from 438 sites between 2005 and 2014. Patterns in hospice use and outcomes for hospice-referred patients (n = 4588) were compared with those for patients with advanced HF not discharged to hospice (n = 4537).

OVERALL

- Hospice enrollment at discharge accounted for 3.8% of 121,990 index HF hospitalizations.
- Of these, 52.8% were discharged to home hospice and 47.2% to a medical hospice facility.
- Median survival time for hospice-referred patients was 11 days (range, 3 to 63 days) as compared with 318 days (range, 78 to 1105 days) for those with advanced HF not discharged to hospice.
- For home hospice patients, median survival was 25 days (range 6 to 132 days), while for those admitted to a hospice facility, median survival was 5 days (range, 2 to 20 days).

- 22.5% of patients discharged to hospice died in < 3 days, with 12.2% of those discharged home with hospice dying in < 3 days and 34.1% of patients discharged to an inpatient hospice facility dying in < 3 days.

The shorter survival time for patients discharged to hospice facilities compared with those discharged home with hospice suggests that the facility patients may be sicker, the authors note.

KEY FINDINGS

- The hospice discharge rate increased only gradually over the study period, from 2.0% in 2005 to 4.9% in 2014 ($P = 0.001$).
- HF patients discharged to hospice were more likely to be older, white, and better educated, and to have worse HF severity than were patients in the non-hospice group.
- All-cause hospital readmission within 30 days was just 4.1% among hospice enrollees, compared with 27.2% among patients with advanced HF not enrolled in hospice.
- At six months, all-cause readmission rates were 8.7% among hospice patients and 57.3% among non-hospice patients with advanced HF.
- The strongest predictors of hospital readmission from hospice were nonwhite race (adjusted hazard ratio [HR], 1.59; 95% confidence interval [CI], 1.18 to 2.17) and younger age (adjusted HR per 5 years, 1.18; 95% CI, 1.10 to 1.27).
- 5.2% of hospitalized patients received comfort care only at any time during the hospitalization. Of these, 50.3% were discharged to hospice.
- HF patients discharged to hospice were more likely to have been cared for in

hospitals in the western and southern U.S. regions and less likely to have been cared for in hospitals in the north-east region.

“[A] downtrend in survival in hospice has been noted nationally,” observe the authors, “driven by the increase in patients with non-cancer diagnoses enrolling in hospice,” many of whom have diseases that are difficult to prognosticate.

“This might be one important reason why patients with heart disease continue to be grossly underrepresented in the hospice-enrolled population in the United States compared with patients with other diseases, such as cancer,” they continue. “Therefore, early recognition of poor prognosis and palliative consultation could facilitate timely hospice referral.”

‘NEVER TOO EARLY’ FOR ADVANCE CARE PLANNING

“This study confirmed that referral to hospice occurs very late and hospice remains underused in patients with HF,” write the authors of a commentary accompanying the report. HF is the leading cause of death in the U.S., but accounts for just 18.7% of hospice admitting diagnoses, they point out, as compared with 27.2% for a diagnosis of cancer.

“It is true that early recognition of poor prognosis and palliative care consultation could facilitate timely hospice referral” as the study authors have suggested, they observe. However, they point out several barriers to implementing these recommendations regarding HF patients.

For instance, prognostication for HF patients — already challenging — is likely to become further complicated by the rapid evolution of HF treatment and technology.

Continued on Page 3

NEWSLINE

Nearly 60% of Older Adults with Probable Dementia Are Unaware of Their Condition (from Page 1)

ined individually, persons were less likely to be undiagnosed if they had impairments in managing finances (OR, 0.14; 95% CI, 0.07 to 0.26) and in managing medications (OR, 0.31; 95% CI, 0.18 to 0.53).

FACTORS ASSOCIATED WITH UNAWARENESS OF DEMENTIA DIAGNOSIS

- Having a high school education only (OR, 0.42; 95% CI, 0.19 to 0.94)
- Attending medical visits alone (OR, 1.97; 95% CI, 0.77 to 5.02)
- Having fewer IADL impairments (OR, 0.72; 95% CI, 0.59 to 0.88)
- Self-responding to interview questions rather than relying on a proxy (OR, 8.77; 95% CI, 3.10 to 24.79)

A large minority of participants responded independently, without a proxy or assistant, suggesting that their families may also be unaware of a diagnosis of dementia, note the authors. Because “going to physician appointments alone — a

novel risk factor — was associated with greater likelihood of being undiagnosed and unaware of a dementia diagnosis,” their findings underscore the importance of having a knowledgeable informant for older adults at risk for dementia.

TIMELY DEMENTIA DIAGNOSIS

The authors stress the importance of early diagnosis of dementia. “Timely diagnosis of dementia may be important in improving patient outcomes, both now and when effective treatments become available,” they write. “Even in the absence of disease-modifying treatment, early diagnosis of dementia may have implications for mitigating safety risks, prevention of complications, and [providing opportunities for] patient/family planning for the future.”

CLINICAL IMPLICATIONS OF FINDINGS

- Be aware that non-white patients and

those with lower education levels may particularly benefit from screening.

- Carefully assess for difficulty in any IADLs.
- Observe for subtle signs of dementia among patients who attend medical visits alone.
- Ensure clear communication.

“[C]ommunication, counseling, and awareness are necessary to achieve any potential benefits of early diagnosis,” the authors conclude.

Source: “Underdiagnosis of Dementia: An Observational Study of Patterns in Diagnosis and Awareness in U.S. Older Adults,” Journal of General Internal Medicine; July 2018; 33(7):1131–1138. Amjad H, Roth DL, Sheehan OC, Lyketsos CG, Wolff JL, Samus QM; Division of Geriatric Medicine and Gerontology; and Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine; Johns Hopkins University Center on Aging and Health; and Department of Health Policy and Management, Johns Hopkins University Bloomberg School of Public Health, all in Baltimore, Maryland.

Advanced Heart Failure Patients (from Page 2)

And although models for prognostication in HF do exist, they are “not well applied in acute situations at the bedside.”

As to unmet needs in palliative care, the number of formally trained specialists in the field is relatively small, note the authors, making the argument for increasing palliative care skills among cardiologists and primary care physicians a more compelling one. Yet even clinicians with training in communication skills may find knowing when to discuss timely palliative/hospice care unclear.

One solution to addressing these barriers, urge the authors, is holding early and ongoing advance care planning conversations with patients. These can begin at diagnosis, with discussion of treatment benefits and burdens as well as what the patient would consider an acceptable or unacceptable health status. Then, as the disease progresses, discussions should address specific and evolving treatment preferences, including hospice.

“Some physicians worry about bringing up possible future negative events, but patients generally prefer to have these conversations earlier than physicians think,” write the authors. “While we never say never in medicine, it is never too early to start the conversation.”

*Source: “Trends in Hospice Discharge and Relative Outcomes Among Medicare Patients in the Get With The Guidelines–Heart Failure Registry,” JAMA Cardiology; Epub ahead of print, August 29, 2018; DOI: 10.1001/jamacardio.2018.2678. Warraich HJ, Xu H, Allen LA; Division of Cardiology, Department of Medicine, Duke University Medical Center; and Duke Clinical Research Institute, both in Durham, North Carolina; Department of Medicine, University of Colorado, Aurora. “Hospice Use and Palliative Care for Patients with Heart Failure: Never Say Never in Medicine, But It Is Never Too Early to Start the Conversation,” *ibid.*; DOI: 10.1001/jamacardio.2018.2750. Nakagawa S and Garan AR; Department of Medicine, Adult Palliative Care Services and Division of Cardiology, Columbia University Medical Center, New York City.*

RESEARCH MONITOR

Better Communication and Earlier Palliative Care May Help Avoid Unnecessary Hospitalizations Among Nursing Home Patients

Better communication among staff, clinicians, and patients, more inhouse resources, and earlier palliative care may be key to reducing the number of avoidable hospitalizations among long-stay nursing home (NH) residents, according to a report on an intervention study published in *Innovation in Aging*, a journal of the Gerontological Society of America.

“Our data show that preventing avoidable hospitalization is less about clinical diagnosis and more about having coordinated systems in place,” says lead author Kathleen Unroe, MD, MHA, of the Regenstrief Institute in Indianapolis. “These systems can prevent potentially harmful events that result from unnecessary transfers to the hospital.”

Investigators analyzed data on 1,931 acute care transfers (involving 1,158 long-stay residents) collected by specially trained registered nurses (RNs) embedded full-time in 19 participating nursing homes from 2014 to 2016. The RNs rated the avoidability of transfers and identified opportunities for quality improvement, as part of an ongoing intervention project to reduce hospital transfers, entitled OPTIMISTIC (Optimizing Patient Transfers, Impacting Medical quality, and Improving Symptoms: Transforming Institutional Care).

The intervention used six diagnoses identified in previous research as being associated with potentially preventable hospitalizations (i.e., hospitalizations for conditions that could reasonably be safely managed in a nursing home and would be amenable to quality improvement interventions and educational initiatives).

Because the embedded nurses worked alongside the staff but were not employed by the facility, they were well positioned to make objective assessments, note the authors. In addition, the RNs were trained

to respond to acute changes in conditions, facilitate advance care planning (ACP), and support the nursing staff through education and mentoring.

OVERALL FINDINGS

Among long-stay residents who experienced at least one acute transfer during the study period:

- 34% were aged 85 years or older.
- 44% had moderate to severe cognitive impairment.
- Nearly 90% were extensively or totally dependent in all reviewed activities of daily living but one (eating, 57%).
- 64% experienced one care transfer during the study period; 22% had two transfers, 7% had three, and 7% had four or more transfers.
- 92% were transferred back to the NH; 8% died in the hospital.

Overall, 44% of acute transfers included one of the following “potentially avoidable hospitalization” (PAH) diagnoses:

- Urinary tract infection (18%)
- Pneumonia (14%)
- Heart failure (12%)
- COPD/asthma (11%)
- Pressure ulcers/cellulitis (5%)
- Dehydration (3%)

MANY TRANSFERS RATED AVOIDABLE

The percentages of hospital transfers rated by embedded RNs as definitely or probably avoidable were calculated by diagnosis, using both primary hospital discharge diagnosis codes only and all diagnosis codes.

Avoidable transfers included those for patients with:

- Urinary tract infection (primary diag-

nosis code, 35%; all diagnosis codes, 30%)

- Pneumonia (22%; 24%)
- Heart failure (24%; 21%)
- COPD (15%; 24%)
- Pressure ulcers (37%; 31%)
- Dehydration (40%; 26%)

“These six conditions, which include exacerbations of chronic disease and common infections, can further be targeted through structured care pathways,” comment the authors.

QUALITY IMPROVEMENT OPPORTUNITIES

“When considering all transfers, regardless of avoidability, the most common quality improvement opportunities were associated with lack of NH resources [27%],” write the authors. In relation to the lack of available resources, the most frequently reported aspects were the lack of access to primary care physicians and to timely laboratory testing.

In contrast, among hospital transfers of residents with PAH diagnoses, the most commonly reported improvement opportunity was the lack of use of resources already available in the NH facility that could have been used to safely manage the resident’s condition (45%).

Avoidable transfers that exhibited opportunities for improvement include:

- Resources were not available in the NH at the time of transfer (all transfers, 27%; PAH transfers, 20%).
- The condition might have been managed safely in the NH with available resources (all transfers, 15%; PAH transfers, 45%).
- Changes in the resident’s condition

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RESEARCH MONITOR

Early Inpatient Palliative Care Shortens Hospital Stays, Improves Clinical Outcomes

Patients hospitalized with advanced illness whose attending physicians requested a palliative care (PC) consult within three days of admission had shorter lengths of stay (LOS) and a higher likelihood of discharge to home hospice, with no negative effect on mortality compared with patients who received later PC consults, according to a report published in the *Journal of Palliative Medicine*.

“This analysis demonstrated that when patients are involved with early palliative care, the positive effects of this intervention are amplified,” write the authors. “With late referral, the transition to end-of-life care or acute hospice was often delayed until the very end of the hospitalization.”

The benefits of PC programs in hospitals has been well established, point out the authors, but the effect of timing of PC intervention has received little examination, particularly among non-cancer patients. “Patients in the current study included

those of all ages with multiple diagnoses,” they note.

Investigators analyzed outcomes for early PC (≤ 3 days after admission) and late PC (≥ 4 days after admission) among all 449 inpatients with advanced disease referred for a PC consult in 2015 and 2016 at a medium-sized community hospital in Buffalo, NY.

KEY FINDINGS

- Patients in the early PC group were slightly older than those in the late group (mean age, 83.4 years vs 78.5 years).
- Disease categories in the early PC group were predominantly cancer (37.7%), dementia (20.2%), and cardiovascular disease (14.9%).
- Among those in the late PC group, COPD exacerbation (17.2%) and sepsis (17.2%) were prominent, as were also cancer (25.3%) and dementia (14.0%).

- Mean hospital LOS was shorter for early PC patients (6.09 days vs 16.5 days; $P = 0.001$).
- A higher percentage of early PC patients (25.9%) than late PC patients (14.9%) were discharged to outpatient hospice.
- 9% of patients in each group were transferred to a nursing home without hospice.
- Fewer early PC patients died in acute PC care (8.8% vs 15.8%).
- The timing of PC intervention was not influenced by functional status.
- Early PC intervention had no statistically significant adverse effect on inpatient mortality.

Source: “Economic Impact of Early Inpatient Palliative Care Intervention in a Community Hospital Setting,” *Journal of Palliative Medicine*; July 2018; 21(7):933–939. Fitzpatrick J, Mavisakalian M, Luciani T, Xu Y, Mazurek A; Kenmore Mercy Hospital and Catholic Health of Buffalo, both in Buffalo, New York.

Nursing Home Patients (from Page 4)

might have been communicated better among the NH staff (all transfers, 16%; PAH transfers, 43%).

- The new sign, symptom, or other change in status might have been detected earlier (all transfers, 13%; PAH transfers, 32%).
- Advance directives, palliative care, or hospice could have been put into place sooner (all transfers, 9%; PAH transfers, 15%).
- Patient and family preferences regarding hospitalization might have been discussed earlier (all transfers, 6%; PAH transfers, 15%).

“When considering only the primary hospital diagnoses, transfers not associated with PAH hospitalization diagnoses

were more likely to have quality improvement opportunities related to communication about resident change in status (48% vs 39%; $P < 0.05$,” note the authors. “A long-stay nursing home resident shouldn’t be sent to the hospital just because of miscommunication between doctors and nursing facility staff — we can do better than that,” says Unroe.

“Keeping complex patients in the nursing facility is often the right choice. A nursing facility setting — a familiar place with staff and clinicians who know the patient — may be the patient’s best option in many circumstances,” Unroe adds.

Although earlier advance care planning and palliative care were not among the most commonly noted opportunities

for improvement, note the authors, “OPTIMISTIC RNs are extensively trained in advance care planning, and nursing homes participating in this project have more access than most nursing homes to this expertise. Thus, it is notable that even in these facilities, there is room for improvement that may continue to impact hospital transfers.”

Source: “Investigating the Avoidability of Hospitalizations of Long-Stay Nursing Home Residents: Opportunities for Improvement,” *Innovation in Aging*; Epub ahead of print, July 5, 2018; DOI: 10.1093/geroni/igy017. Unroe KT et al; Indiana University School of Medicine, Division of General Internal Medicine and Geriatrics; Regenstrief Institute, IU Center for Aging Research; and Indiana University School of Nursing, all in Indianapolis, Indiana; and Purdue University, West Lafayette, Indiana.

CLINICIAN RESOURCES

Patient Navigators Help Latino Adults in the Community Deal with Advanced Cancer

Home visits from trained patient navigators (PNs) to community-dwelling Latino adults with advanced cancer yielded increased documentation of advance directives and improved physical symptoms. Further, the intervention was highly valued by the patients, according to a report published in *JAMA Oncology*.

“To our knowledge, Apoyo con Cariño (Support with Caring) is the first randomized clinical trial of a culturally tailored PN intervention addressing palliative care (PC) disparities for Latinos with advanced cancer,” write the authors.

“What distinguishes this culturally tailored PN intervention from other PC interventions is that the PNs are not directly providing care,” they continue. “Instead, they are trained laypersons empowering and activating patients to seek improved primary PC from their oncologists.”

Investigators conducted a randomized clinical trial from 2012 to 2016. Participants were 223 adults self-identified as Latino who had been diagnosed with stage III or IV cancer (mean age, 58.1 years; female, 55.6%). Patients were recruited from both urban and rural care settings (n = 10) across the state of Colorado, including community cancer clinics, an academic National Cancer Institute-designated center, and a safety-net cancer center. All participants were surveyed at baseline and three months following enrollment.

A CULTURALLY SENSITIVE INTERVENTION

All patients in both the intervention group and control group were given a culturally tailored educational packet of written information about advance care planning (ACP), pain management, and hospice care, along with a study-specific advance directive (AD). All materials were prepared at a fifth-grade reading

level in both Spanish and English.

Intervention patients received at least five home visits from a specially trained PN, who reviewed the information packet with the patient and addressed any identified barriers to PC. The PN was also available via phone contact to make additional visits at patient/family request. If the patient completed the study AD or one of his/her choice, the PN ensured that it was entered into the medical record at the oncology clinic. All PNs were bilingual and bicultural, and had backgrounds in healthcare-related work.

Patient characteristics were similar in both groups, clinically and demographically: for 47.5%, Spanish was their primary language; 68.2% had stage IV cancer; 50.2% had less than a high school education; and 53.6% had an annual income of less than \$15,000. For patients in both groups at baseline, pain intensity was rated as mild (mean, 3.1 on a scale of 1-10).

KEY FINDINGS

- Patients in the intervention group were more likely than controls to have any form of AD documented in the electronic health record at the patient's oncology clinic (65.2% vs 36.0%; $P < 0.001$).
- Intervention patients were more likely to have talked with their family members about the kind of care desired at the end of life (83.5% vs 55.2%; $P < 0.001$).
- Intervention patients were also more likely to have discussed their future care preferences with their healthcare provider (60.0% vs 35.2%; $P = 0.001$).
- Both groups reported a high degree of comfort in talking to their healthcare providers about uncontrolled pain (96.5% and 92.1%).

- A higher percentage of intervention patients than control patients indicated they would recommend hospice for a loved one (88.2% vs 65.5%; $P = 0.004$) and would consider hospice care for themselves (88.2% vs 65.9%; $P = 0.005$).

Both groups had a relatively high rate of hospice enrollment (81.7% overall), “well above previously reported national averages of a 40% Hispanic enrollment,” note the authors. This was most likely a reflection of the high rate of hospice use statewide in Colorado, they point out. In addition, ratings of pain did not change significantly in either group, suggesting that pain was already well controlled by the patients' oncological teams at baseline and throughout the intervention period.

Quality of life (QOL) measurements were also high in both groups, with little change from baseline. However, intervention patients had a larger mean change from baseline in the physical subscale of the QOL questionnaire than did controls (1.4 vs 0.1 on a 1-10 scale; $P = 0.004$).

Intervention patients reported high satisfaction with PNs, with nearly 100% agreeing the PN visits improved their lives as patients. More than 90% felt that the PNs listened and responded to their concerns, provided information that was understandable and helpful, provided emotional support, and helped them to make important care decisions.

Source: “Effect of Apoyo con Cariño (Support with Caring) Trial of a Patient Navigator Intervention to Improve Palliative Care Outcomes for Latino Adults with Advanced Cancer: A Randomized Clinical Trial, JAMA Oncology; Epub ahead of print, September 20, 2018. DOI: 10.1001/jamaoncol.2018.4014. Fischer SM, Kline DM, Min S-J, et al; Division of General Internal Medicine; Division of Health Care Policy and Research; and Division of Medical Oncology, University of Colorado School of Medicine, Aurora.

CLINICIAN RESOURCES

Clinical Checklist for Supportive Care Viewed as Productive, Easy to Use

A consensus-based checklist documenting best supportive care (BSC) for patients with advanced cancer was viewed favorably by treating clinicians, who found it had a positive impact on palliative care delivery while posing little workflow interruption, according to a report on a multisite study published in the *Journal of Palliative Medicine*.

“This line of inquiry is the first of its kind,” write the authors. “Our study provides an initial framework upon which to build a standardized assessment for BSC in clinical practice.”

Investigators analyzed survey responses of a sample of 15 clinicians (representing the specialties of medical oncology, gynecologic oncology, and palliative care) treating advanced cancer patients at four participating academic centers in three states. Over a four-month period, participants completed the checklist components at each eligible patient encounter, then entered their survey responses online.

SUPPORTIVE CARE CHECKLIST COMPONENTS

Symptom management. Includes: pain; pulmonary symptoms; fatigue; mood (anxiety, depression); gastrointestinal symptoms; financial, legal, and spiritual concerns.

Decision making. Does the patient have a preferred mode of decision making? Does he/she need assistance in making treatment decisions?

Illness comprehension. Has the patient received education concerning the goals of anti-cancer therapy? Does the patient understand their illness and prognosis? Are there coping concerns for the patient? For the caregivers?

Care plan. Future appointments were planned; appropriate referrals to other care providers were made.

KEY FINDINGS

- 40% of participants reported the checklist had an improved impact on delivery of supportive/palliative care.
- 46% noted improvement in documentation of supportive/palliative care.
- 33% reported increased frequency of comprehensive symptom assessment.
- 26% noted increased frequency of assessment for referral to support services.
- None reported a worsened impact or decreased frequency on any measure.
- 73% agreed that the checklist could be easily integrated into the regular workflow.
- 73% saw value in integrating the checklist.
- 80% found the checklist easy to use.

Source: “Feasibility and Acceptability of a Best Supportive Care Checklist Among Clinicians,” *Journal of Palliative Medicine*; August 2018; 21(8):1074–1077. Boucher NA, Nicolla J, Ogunseitan A, Kessler ER, Ritchie CS, Zafar YY, Durham VA GRECC (Geriatric Research Education and Clinical Center), Duke Center for the Study of Aging and Human Development, Sanford School of Public Policy and Duke Cancer Institute, Duke University Medical Center, all in Durham, North Carolina; Northwestern University Feinberg School of Medicine, Chicago; University of Colorado School of Medicine, Aurora; and University of California-San Francisco.

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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End-of-Life Care Meetings for Clinicians

Palliative and Supportive Care in Oncology Symposium. November 16–17, 2018, Hilton San Diego Bayfront, 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

Current Topics in Primary Care and Palliative Care. March 16–21, 2019, 5-Night Havana and Cozumel 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

American Pain Society Scientific Meeting. April 3–6, 2019, Milwaukee, WI. Theme: Combating the Opioid Epidemic Through Innovations in the Treatment of Pain. Website: americanpainsociety.org

National Hospice and Palliative Care Organization 2019 Hospice and Palliative Care Leadership and Advocacy Conference. (Formerly Known as Management and Leadership Conference.) April 15–17, 2019, Marriott Wardman Park Hotel, Washington, DC. Website: www.nhpco.org

American Geriatrics Society 2019 Annual Scientific Meeting, May 2–4, 2019, Portland, Oregon. Website: www.americangeriatrics.org



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