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Quality of Life Matters®

News & clinical findings about serious illness

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Skilled Communication with Seriously Ill Patients Is Both Crucial and Learnable, Experts Say

Clinicians who receive training report increased confidence in their care delivery

High-quality communication is a critical factor in the care of seriously ill patients, as it enables patients and their families to understand the illness and participate in care planning decisions aligned with their goals and values. Yet, because too few clinicians have been exposed to evidence-based training, serious illness conversations can often be suboptimal, according to a special article published in the *Journal of the American Geriatrics Society*.

“The good news is that communication skills training, if based on proven programs, is highly effective,” write the

authors, three specialists in palliative medicine. “Numerous studies show that communication skills training is judged by clinician learners to be valuable, to increase confidence in their preparedness to care for patients with serious illness, and to create commitment to continue to try new skills.”

Experts in palliative medicine have identified a set of skills critical for effective communication with seriously ill patients, according to the authors. These include learned techniques in:

- Discussing serious medical updates and prognosis
- Eliciting patient and family values and goals
- Engaging patients in advance care planning discussions in order to make patient-centered recommendations ensuring future treatments align with their preferences

“This set of communication skills during serious illness requires expertise and should be regarded as a procedure requiring special training and demonstration of competence,” state the authors.

In their article, the authors make a case for the importance of evidence-based communication training, identify barriers to its implementation and widespread use, offer recommendations for the expansion of communication skills training in the near future, and provide a list of established, effective training programs.

THE NEED FOR COMMUNICATION TRAINING

Nine out of ten older adults will live with at least one serious illness in the last year of life, note the authors. Studies published in recent years demonstrate that patient outcomes are improved when conversations with older adults with serious illness are conducted by clinicians trained in these communications. The lack of such training poses a significant barrier to high-quality care for these high-need patients and their families.

Observational studies have shown that, despite their best intentions, clinicians conducting serious illness conversations often routinely use medical jargon, miss cues that the patient is not following or is too emotional to absorb the presented information, and subtly prevent the patient from asking questions or expressing concerns, note the authors.

After evidence-based training, clinicians have been observed to adopt the following behaviors helpful to seriously ill patients:

- Assessing the patient’s knowledge of their illness before giving serious medical news
- Using plain, non-jargon language
- Allowing for silence immediately after imparting news
- Responding to patient emotions
- Affirming continuing commitment to the patient

Continued on Page 2

Inside:

NewsLine..... 1-3

- ✓ Skilled Communication with Seriously Ill Patients Is Both Crucial and Learnable, Experts Say
- ✓ Bereaved Families of Kidney Disease Patients Rate Care Higher When Palliative Care and Hospice Are Involved

Research Monitor..... 4-7

- ✓ Patients and Oncologists Agree Less Than Two-Thirds of the Time About Goals of Treatment and Adverse Effects
- ✓ New Risk Scores Predict Mortality, Need for Palliative Care in Pulmonary Patients
- ✓ Medicare Hospice Use Continues to Grow, But Short Stays Remain a Concern

NEWSLINE

Skilled Communication with Seriously Ill Patients Is Both Crucial and Learnable, Experts Say (from Page 1)

The majority of clinicians practicing today were trained before research on the need for and efficacy of communication skills training was published, and most educational programs for health professionals still do not offer such training, note the authors.

“Thus, the majority of clinicians now in practice learned to communicate on the job, without a curriculum, explicit role modeling, or learning techniques backed by evidence,” write the authors. “Clinicians were left to assume — unintentionally — that communication was something that a clinician was born knowing how to do or would acquire through passive exposure combined with trial and error.”

The authors estimate that roughly 50% of physicians (and 25% of all advance practice providers) involved in the care of patients with serious illness and their families could improve care with communication training. This works out to more than 219,000, or one trained clinician for every 54 patients with high needs.

Widespread implementation of communication skills training has been recommended by such national medical professional and policy-making organizations as the American Society of Clinical Oncology and the federal National Academy of Sciences.

BARRIERS TO ACQUIRING COMMUNICATION SKILLS

- Misconceptions concerning the value of communication skills training, e.g., the belief that “you have to be born with this skill”
- Inaccurate self-assessment of one’s own competence in skilled communication with seriously ill patients
- Lack of availability of training options
- Lack of role models or mentors to

provide feedback/coaching

- Lack of inclusion of communication skills in clinical competencies
- Lack of prospective identification of patients with a high need for serious illness conversations
- Lack of resources to record and easily access clinical conversations for review, to spur improvement
- Lack of financial or regulatory incentives for clinicians to seek training and/or for healthcare systems to address existing barriers to training

Because the incorporation of evidence-based communication training into the curricula of medical colleges is unlikely anytime soon, the authors suggest some “new,” alternative engagement strategies to quickly “scale up” communication skills training.

‘SCALE-UP’ STRATEGIES TO IMPROVE TRAINING

- Use social marketing, i.e., specific messaging and marketing techniques, to encourage practicing clinicians to seek training.
- Continue to build the research base on the efficacy of training in communication skills.
- Cultivate a community of skilled faculty.
- Develop a certification program for skilled clinicians.
- Encourage payers and healthcare systems to invest in training programs.

Recommendations for advancing progress in expanding communication skills training over the next several years include:

- Make evidence-based training — including specialty-specific training — widely available, with providers as the highest priority, and offering various

convenient entry points.

- Create a national corps of skilled communication faculty, capable of teaching in a variety of settings and formats.
- Embed communication teachers in health systems to serve as consultants and coaches.
- Combine communication training with system workflow redesign to support busy clinicians.
- Create incentives by payers that reward clinicians and healthcare systems for training participation and documentation of patient values and goals of care.
- Drive accountability through public reporting of measures of clinician uptake of training and patient-reported outcomes.

ESTABLISHED, EFFECTIVE TRAINING MODELS

- Center to Advance Palliative Care (CAPC) CME modules: www.capc.org/training/communication-skills/
- Respecting Choices: <https://respectingchoices.org/>
- Serious Illness Care Program at Ariadne Labs: www.ariadnelabs.org/areas-of-work/serious-illness-care/
- VitalTalk: www.vitaltalk.org/
- End-of-Life Nursing Education Consortium: www.aacnnursing.org/ELNEC
- Education on Palliative and End-of-Life Care (EPEC): www.bioethics.northwestern.edu/programs/epec/index.html

Source: “Training Clinicians with Communication Skills Needed to Match Medical Treatments to Patient Values,” Journal of the American Geriatrics Society; May 2019; 67(S2):S435–S431. Back AL, Fromme EK, Meier DE; VitalTalk, University of Washington, Seattle; Ariadne Labs, Dana-Farber Cancer Institute, Boston; Center to Advance Palliative Care, Mount Sinai School of Medicine, New York City.

NEWSLINE

Bereaved Families of Kidney Disease Patients Rate Care Higher When Palliative Care and Hospice Are Involved

Family members of patients with advanced chronic kidney disease (CKD) rate the quality of care lower when their loved ones receive high-intensity treatment focused on life extension in the last months of life, awarding the highest care ratings when palliative care consults and hospice services are provided, according to a report published in the *Clinical Journal of the American Society of Nephrology*.

“This study highlights concerns about the intensive patterns of end-of-life care among patients with advanced kidney disease, especially since patients with advanced kidney disease often report that they would prefer to focus on comfort and relief of suffering rather than life prolongation,” write the authors.

Investigators analyzed data on a national cohort of 9993 veterans with CKD (mean age at time of death, 76 years [range, 66 to 85 years]; male, 97%; African-American, 25%) who died in Department of Veterans Affairs (VA) facilities between 2009 and 2015. Family ratings of care quality, obtained via a survey conducted within ten weeks post-death, were dichotomized as the most favorable (“excellent”) vs all other responses.

More than half (55%) of patients received no dialysis; 12% underwent acute dialysis (i.e., having at least one diagnostic or procedure code for dialysis in the year before death); and 34% had maintenance or long-term dialysis (of these, 96% received hemodialysis). Patients treated with dialysis had more intensive patterns of end-of-life care than those with no dialysis.

OVERALL

- 52% of patients spent ≥ 2 weeks in the hospital in the last 90 days of life.
- 34% received an intensive procedure

(intubation/mechanical ventilation, cardiopulmonary resuscitation, feeding tube placement, enteral nutrition, or tracheostomy) in the last 30 days of life, and 47% were admitted to the ICU during that time period.

- 38% received a palliative care consultation in the last 90 days of life.
- 36% were receiving hospice services at the time of death.

SURVIVAL TIME

- Median time from cohort entry to death for those with no dialysis was 9.2 months (interquartile range [IQR], 0.9 to 32.6 months); for those who received acute dialysis, 7.7 months (IQR, 1.2 to 28.8 months); for maintenance dialysis patients, 51.7 months (IQR, 24.9 to 86.5 months).
- The median time between the first procedure code for dialysis during the last year of life and death for the acute dialysis group was 32 days (IQR, 13 to 122 days).
- For the maintenance dialysis group, median time from onset of end-stage kidney disease (ESKD) and death was 37.9 months (IQR, 15.6 to 72.5 months).

PLACE OF DEATH

- 31% died in the ICU.
- 27% died on an acute care ward.
- 16% died in a nursing home.
- 26% died in an inpatient hospice or palliative care unit

KEY FINDINGS

Patients who received acute or maintenance dialysis were more likely than those with no dialysis to:

- Spend ≥ 2 weeks in the hospital in the

last 90 days of life (predicted probability: acute dialysis, 68.4% vs maintenance dialysis, 53.6% vs no dialysis, 47.4%; $P < 0.001$)

- Be admitted to the ICU in the last 30 days of life (58.1% vs 48.9% vs 44.0%; $P < 0.001$)
- Receive an intensive procedure in the last 30 days of life (50.2% vs 35.5% vs 29.0%; $P < 0.001$)
- Die in the ICU (41.5% vs 32.9% vs 26.8%; $P < 0.001$)

Patients treated with acute or maintenance dialysis were less likely than those with no dialysis to use hospice services (acute dialysis, 30.3% vs maintenance dialysis, 32.7% vs no dialysis, 39.2%; $P < 0.001$), but no differences among the three groups were found in the receipt of a palliative care consultation in the last 90 days of life.

FAMILY RATINGS OF CARE QUALITY

Receipt of maintenance (but not acute) dialysis and more intensive patterns of care were associated with lower overall family ratings of the quality of end-of-life care. Receipt of palliative care and/or hospice services was associated with higher overall ratings.

55% of family members rated their loved one’s overall care as excellent. For individual items relating to communication and support, family ratings of excellent ranged from a high of 80% for “staff were always kind, caring, and respectful” to a low of 59% for “providers always provided spiritual support.”

Families were less likely to give an “excellent” rating when care included:

- Death in the ICU (49.4% vs 55.0%, no ICU death; $P < 0.001$)

Continued on Page 5

RESEARCH MONITOR

Patients and Oncologists Agree Less Than Two-Thirds of the Time About Goals of Treatment and Adverse Effects

A discrepancy often occurs between cancer patients' understanding of the intent of their therapy — along with their understanding and acceptance of its adverse effects—and the opinion of their physicians, researchers have found. Further, patients who misapprehend the intent and nature of treatment have higher rates of distress, according to a report published in the *Journal of Oncology Practice*.

“Adequate understanding of the goals and adverse effects of cancer treatment has important implications for patients' decision making, expectations, and mood,” write the authors. A high level of patient-physician agreement about the intent and nature of treatment — that is, high concordance — can “lead to treatment satisfaction, adherence, and improved psychosocial adjustment for the patient.”

“However, treatment decision making on the basis of an inaccurate understanding of prognosis or treatment-induced symptom burden may result in unrealistic expectations,” they add. “Fortunately, communication with both realism and hope is possible.”

Investigators analyzed questionnaire responses of patient-provider dyads consisting of 100 adult cancer patients (mean age, 59.3 years [\pm 13.7 years]; female, 51%; African-American, 16%) receiving treatment at a comprehensive cancer center in the southeastern U.S. and their 34 oncologists (24 medical, five radiation, and three surgical oncologists).

Overall, the most common cancer types were breast cancer, leukemia and myelodysplastic syndrome, and lung cancer. 24% of patients had Stage IV disease.

Directly before their clinic appointments, patients were asked in person to complete a packet of questionnaires that have been validated as reliable among patients with cancer and/or chronic illness. These instruments measure: patient satisfaction with treatment; spiritual well-being; emotional distress; and availability of social support.

Both the patient and oncologist were given a 12- to 13-item questionnaire to complete — as closely together as possible within the timeframe of the clinic visit — to assess aspects of the treatment process. Patients were queried about prognosis understanding, goals of treatment, understanding and acceptance of side effects, and expectations for treatment success and life expectancy.

The physician questionnaire mirrored that of the patients, but combined the oncologists' own medical opinions of the aspects of patients' illness and treatment with their perceptions of what

they believed the patients knew or understood. (Physician answers were not made available to patients.)

FINDINGS: TREATMENT GOALS

- Patients and their oncologists agreed 61% of the time on the intent of treatment (i.e., curative, extension of life for several years, extension of life for 6-12 months, or palliative).
- Of those patients in non-agreement about the goal of therapy, 36% were more optimistic than their physicians; only 3% were less optimistic.
- While 73% of patients believed that complete cure was the treatment goal, just 50% of physicians believed the goal was curative.
- 22% of patients vs 28% of physicians thought life extension of several years was the goal; 3% vs 19% thought life extension of 6-12 months was the goal.
- Only 1% and 3% of patients and physicians, respectively, considered the goal to be palliative.

No relationship was noted between patient-physician concordance on treatment goals and any patient or physician characteristic — including patient's stage of disease or clinician's years in practice — with the exception of patient spirituality, in which patients who believed treatment was curative scored significantly higher.

FINDINGS: ADVERSE EFFECTS

- Patient-provider dyads were in concordance 69% of the time regarding the patient's acknowledgment and understanding of the adverse effects of treatment.
- Patients who reported understanding of adverse effects scored significantly lower in measurements of distress than patients lacking understanding (2.5 vs 4.1 on a 10-point scale; $P = 0.008$).
- Of note, patients who scored higher than 4 on the 10-point distress scale also scored comparatively lower on the social-support measure.

“Screening on distress and social support indicators could alert clinicians to patients who may need additional supportive services and education,” write the authors. They suggest the use of a communication strategy such as Ask-Tell-Ask to “assess patient understanding (Ask), clarify misperceptions (Tell), and invite subsequent discussion (Ask).”

Continued on Page 5

RESEARCH MONITOR

Bereaved Families of Kidney Disease Patients Rate Care Higher When Palliative Care and Hospice Are Involved (from Page 3)

- A hospital stay of ≥ 2 weeks in the last 90 days (51.0% vs 55.8%; $P < 0.001$)
- Receipt of an intensive procedure in the final 30 days (50.6% vs 54.7%; $P < 0.01$)
- Maintenance dialysis vs no dialysis (50.8% vs 54.7%; $P < 0.03$)

Families were more likely to give an “excellent” rating when patients had:

- A palliative care consultation within the last 90 days of life (57.2% vs 50.9%, no consult; $P < 0.001$)
- Receipt of hospice services at the time of death (61.5% vs 48.6%)

The authors acknowledge that their findings may not be generalizable to the population of CKD patients cared for outside of a VA facility, although the intensive patterns of care near the end of life found in their study are largely consistent with previous reports among Medicare recipients and veterans with ESKD.

“Available evidence suggests that patients with advanced CKD often have uncertain and/or unrealistic expectations about the

future, may not be aware of conservative and comfort-oriented treatment options, and may not share the same priorities for care as the clinicians caring for them,” they write.

“More research is needed about what drives both patterns and quality of end-of-life care among patients with advanced CKD and to identify opportunities to improve care for members of this population.”

Source: “Family Perceptions of Quality of End-of-Life Care for Veterans with Advanced CKD,” Clinical Journal of the American Society of Nephrology; September 6, 2019; 14(9):1324–1335. Richards CA, Liu C-F, Hebert PL, Ersek M, Wachterman MW, Reinke LF, Taylor LL, O’Hare AM; Health Services Research and Development, Veterans Affairs Seattle-Denver Center of Innovation for Veteran-Centered and Value-Driven Care, Seattle; Department of Health Services, School of Public Health, Department of Biobehavioral Nursing and Health Informatics, School of Nursing, and School of Medicine, University of Washington, Seattle; Center for Health Equity Research and Promotion, Corporal Michael J. Crescenz Veterans Affairs Medical Center, Philadelphia; School of Nursing, and Perelman School of Medicine, University of Pennsylvania, Philadelphia; Section of General Medicine, Veterans Affairs Boston Healthcare System, Boston; Division of General Internal Medicine, Brigham and Women’s Hospital, Boston; and Department of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, Boston.

Patients and Oncologists (from Page 4)

HIGH SATISFACTION

- Treatment satisfaction was high, with 93% of patients reporting overall treatment as good, very good, or excellent.
- 81% reported that treatment was about what they expected, a little better, or a lot better.
- Scores for effectiveness of treatment were similarly high; only 1% of patients said they would not recommend this treatment.

The percentage of “good” or better ratings for satisfaction, despite the high level of discordance found between patient understanding and physician assessment, may reflect a high rate of comfort with their oncologists among these patients, note the authors. However, the importance of clear communication and patient education cannot be overstated.

Patient-physician discordance may be reduced through the “basic task of communicating clearly what patients often are not prepared to hear or understand,” write the authors. “Education on the fundamentals of active listening for both patients and

providers could result in improved information exchange and mindfulness of what is not heard.”

The authors acknowledge that their findings are limited by the small sample size from a single institution at one particular point in the treatment continuum, but are encouraged that their results show the feasibility of collecting data from both patients and clinicians in quick succession, in order to devise strategies for improving communication with seriously ill patients.

“In addition to continuing to teach providers-in-training about active listening and intentional responding, the implementation of clinic-based data monitoring systems to increase awareness of discrepancies in understanding and dissatisfactions could improve the quality of care,” they write.

Source: “Goals and Adverse Effects: Rate of Concordance Between Patients and Providers,” Journal of Oncology Practice; July 2019; 15(9):e798–e808. Duckworth KE, Morrell R, Russell GB, Powell B, Cansona M, Lichiello S, Riffle O, Tolbert A, McQuellon R; Wake Forest Baptist Medical Center; Wake Forest School of Medicine; and Wake Forest University, all in Winston-Salem, North Carolina; University of North Carolina at Charlotte, Charlotte.

RESEARCH MONITOR

New Risk Scores Predict Mortality, Need for Palliative Care in Pulmonary Patients

A laboratory-based prediction model for patients with chronic obstructive pulmonary disease (COPD), developed by identifying those patients at high risk for all-cause death or disease advancement, and correlating closely with palliative care use, may help guide clinicians' care decisions regarding therapy and referral to palliative care, say researchers.

Results of a study of the prediction model, entitled the Laboratory-based Intermountain Validated Exacerbation (LIVE) score, were presented at the American Thoracic Society's annual international conference in May 2019.

"We found the LIVE score helps personalize therapy to patients beyond the COPD diagnosis alone, and provides additional risk information to both patients and their doctors," says lead author Denitza Blagev, MD, of the Pulmonary and Critical Care Division, Intermountain Medical Center, Murray, UT.

"From a population health perspective," continues Blagev, "the LIVE score allows for designing pathways of care that identify and treat patients based on individual risk beyond a single diagnosis label alone."

Investigators retrospectively calculated the LIVE scores of 17,124 patients with COPD in 2013 from the Kaiser Health System Northwest Region, Portland, OR, and assessed the association of the scores with all-cause mortality and palliative care referral rates.

The LIVE score combines a patient's five simple laboratory values (levels of hemoglobin, albumin, creatinine, chloride, and potassium) to identify COPD patients at high mortality or morbidity risk, and thus assist clinicians in determining whether the patient may benefit from op-

"Our findings lend more insight into how we can use these laboratory-based scores at the bedside to ensure that patients are receiving the most appropriate care."

— Blagev et al, American Thoracic Society 2019 annual conference

timized COPD management, management of other diseases in addition to COPD, and referral to palliative care. The resultant scores range in category from highest risk (LIVE1) to lowest risk (LIVE5).

Unlike other COPD prediction scores, the LIVE score is based solely on blood tests, and incorporates assessments of other diseases COPD patients may have, such as heart and kidney disease, in determining overall mortality and morbidity risk.

The prediction model had been previously validated in more than 100,000 COPD patients, note the researchers, including cohorts of Intermountain patients as well as cohorts in several diverse health systems, such as University of Chicago hospitals and medical facilities of the U.S. Department of Veterans Affairs.

KEY FINDINGS

- Overall, increased-risk LIVE score was associated with increased palliative care referral rates and increased all-cause mortality ($P < 0.001$).
- COPD patients with the highest-risk LIVE scores (LIVE1) had the highest mortality rates (39.4% at one year; 63.3% at four years).
- COPD patients with the lowest-risk scores (LIVE5) had the lowest all-cause mortality rates (0.7% at one year;

4.3% at four years).

- Patients with the highest-risk LIVE score (LIVE1) had the highest rate of palliative care referrals (41.7% at one year; 75.8% at four years).
- Those with the lowest-risk scores (LIVE5) had the lowest palliative care referral rates (0.7% at one year; 18.8% at four years).

"By exploring the association of palliative care referrals and LIVE score risk, this study is a step forward in understanding how the LIVE score may be used to target appropriate patient care," says Blagev. "Our findings lend more insight into how we can use these laboratory-based scores at the bedside to ensure that patients are receiving the most appropriate care."

The researchers recommend future prospective research be conducted "to determine whether the LIVE score can help target appropriate advance care planning referrals and conversation" in this patient population.

The study abstract is available from the American Thoracic Society at: www.atsjournals.org/doi/abs/10.1164/ajrccm-conference.2019.199.1_MeetingAbstracts.A2435.

Source: "Laboratory-based Intermountain Validated Exacerbation (LIVE) Score and Palliative Care Referrals in Patients with Chronic Obstructive Pulmonary Disease," Abstract presented at the American Thoracic Society 2019 International Conference; May 19, 2019. Blagev DP, Collingridge DS, Rea S, Mularski RA, Zeng S, Arjomandi M, Press VG; Pulmonary and Critical Care Division, and Office of Research, Intermountain Healthcare, Murray, Utah; The Center for Health Research, Kaiser Permanente, Portland, Oregon; Division of Pulmonary, Critical Care & Allergy/Immunology, University of California, San Francisco; San Francisco VA Medical Center, San Francisco; Center for Healthcare Delivery Science and Innovation, University of Chicago Medicine, Chicago.

RESEARCH MONITOR

Medicare Hospice Use Continues to Grow, But Short Stays Remain a Concern

Nearly one-half (48.5%) of all Medicare beneficiaries who died in 2017 received hospice care in 2017, a 4.5% increase over the year before. However, more than one-quarter (27.8%) of these patients spent just one week or less in hospice, according to “NHPCO Facts and Figures,” an annual report released in a revised edition by the National Hospice and Palliative Care Organization in July 2019.

While cancer remains the leading hospice admitting diagnosis, the percentage of noncancer diagnoses continues to rise, accounting for nearly 70% of all admissions.

PRINCIPAL ADMITTING DIAGNOSES, 2017 VS 2016

- Cancer: 30.1% (vs 31.1% in 2016)
- Circulatory/heart disease: 17.6% in both years
- Dementia: 15.6% (vs 15.4%)
- Respiratory: 11.0% (vs 10.9%)
- Stroke: 9.4% (vs 9.2%)
- Chronic kidney disease: 2.3% (vs 2.4%)
- Other: 13.9% (vs 13.5%)

More people are receiving care at home or in nursing homes. Care in hospice inpatient facilities has declined since 2014, while care delivered at the place the patient calls home — a private residence, nursing home, or residential facility — has risen by 42%. Sites of care included: home or private residence (58.7%), nursing facility (42.2%), hospice inpatient facility (0.8%), and acute care hospital (0.3%).

Median length of hospice service in 2017 was 24.0 days (mean, 76.1 days). But the greater proportion of Medicare patients were enrolled for short periods of time, with more than half (54%) receiving care for ≤ 30 days and 40.5% enrolled for ≤ 14 days. 27.8% of hospice patients received care for ≤ 7 days.

The high rate of short hospice stays is “a significant concern,” says NHPCO president and CEO Edo Banach, JD. “We must do better to ensure that all those who will benefit from hospice care — or palliative care earlier in the course of a serious illness — have access to this compassionate, high-quality care.”

Medicare hospice patients identified as Hispanic and Asian increased by 21% and 32%, respectively, in the three years since 2014. While Caucasians remain the substantial majority at 82.5%, hospice beneficiaries include a representative proportion of African Americans (8.2%), Hispanics (6.4%), Asians (1.7%), and Native Americans (0.4%).

New to this annual report are the rankings of U.S. states and the District of Columbia by the percentage of their 2017 Medicare decedents enrolled in hospice at the time of death. Utah (59.4%), Arizona (59.2%) and Florida (57.9%) had the highest hospice care usage, while Alaska (22.5%), North Dakota (29.7%) and New York (30.6%) saw the smallest percentage of their resident Medicare beneficiaries using hospice.

The report is available at www.nhpc.org.

End-of-Life Care Websites

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

Information and Support for End-of-Life
Care from the National Hospice and
Palliative Care Organization
www.nhpc.org/patients-and-caregivers/

Center to Advance Palliative Care
www.capc.org

The EPEC Project (Education in Palliative
and End-of-Life Care)
[www.bioethics.northwestern.edu/
programs/epec/about/](http://www.bioethics.northwestern.edu/programs/epec/about/)

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.advancingexpertcare.org

Hospice Foundation of America
www.hospicefoundation.org

Medical College of Wisconsin
Palliative Care Program
www.mcw.edu/departments/palliative-care-program

National Hospice & Palliative
Care Organization
www.nhpc.org

Division of Palliative Care
Mount Sinai Health System
www.stoppain.org

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End-of-Life Care Meetings for Clinicians

National Hospice and Palliative Care Organization Interdisciplinary Conference 2019. November 4–6, 2019, Gaylord Palms Resort and Convention Center, Orlando, FL. Website: www.nhpco.org/education/nhpco-conferences

Center to Advance Palliative Care National Seminar 2019. November 14–16, 2019, Atlanta Marriott Marquis, Atlanta, GA. Areas of focus include: Palliative Care and the Opioid Crisis, Quality with Efficiency, and Telehealth. Website: www.capc.org/seminar

Palliative Medicine and End of Life Care, Including Related Topics in Neurology. December 14–21, 2019, seven-night southern Caribbean cruise conference, round-trip from San Juan, Puerto Rico. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 800-422-0711; Website: www.continuingeducation.net

1st State of the Science in Hospice and Palliative Care Symposium. March 20–22, 2020, Grand Hyatt San Diego, San Diego, CA. Hosted by the American Academy of Hospice and Palliative Medicine and accredited by the Accreditation Council for Continuing Medical Education. Website: <http://aahpm.org/meetings/state-of-the-science-meeting>

American Geriatrics Society 2020 Annual Scientific Meeting. May 7–9, 2020, Long Beach, CA. Website: www.americangeriatrics.org



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