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</table>
| Desbiens, 1998¹ | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (non ICU)  
Funding: Robert Wood Johnson Foundation | Sample size: 9105  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Hospitalization  
Outcomes: Pain, preferences of care  
Duration: 10 days  
Withdrawals: 6437 | Results: Preference of care does not affect patients’ overall pain experience in later stages of disease. |
| Gagnon, 2000² | Design: Prospective Cohort  
Quality: Fair  
Setting: Hospital (non ICU)  
Funding: NCI of Canada | Sample size: 94  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Delirium  
Outcomes: Delirium  
Duration: Not reported  
Withdrawals: 5 | Results: Delirium as an outcome may not be as poor as previously considered in cancer. |
| Goodwin, 2003³ | Design: Prospective Cohort  
Quality: Good  
Setting: Ambulatory/outpatient medical care  
Funding: London Region NHS Research and Development Program | Sample size: 173  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Palliative Day Care  
Outcomes: Pain, symptom control, palliative day care, QOL  
Duration: 18 weeks  
Withdrawals: 56 | Results: Palliative day care was not found to improve health related quality of life relative to usual care. |

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| Lammi, 2001<sup>4</sup> | Design: Prospective Cohort  
Quality: Fair  
Setting: Hospice  
Funding: Europe Against Cancer Program of the European Union | Sample size: 100  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Palliative care  
Outcomes: Anxiety, depression  
Duration: >180 days  
Withdrawals: 28 | Results: Awareness of the multidimensional needs of hospice patients in primary health care centers is needed. |
| van der Steen, 2002<sup>5</sup> | Design: Prospective Cohort  
Quality: Fair  
Setting: Nursing home  
Funding: Dutch Ministry of Public Health | Sample size: 706  
Disease: Unclear  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Antibiotic treatment for pneumonia  
Outcomes: Discomfort associated with pneumonia  
Duration: 3 months  
Withdrawals: 44 | Results: Level of comfort is generally higher in demented patients who are not receiving antibiotics. |
| de Wit, 1999<sup>6</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (non ICU)  
Funding: Dutch Cancer Society | Sample size: 383  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Pain treatment  
Outcomes: Pain management  
Duration: 20 months  
Withdrawals: 77 | Results: Structural resources were not the major cause of suboptimal pain management rather, the major cause was the process component. |

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| Friedman, 2001<sup>7</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (non ICU)  
Funding: American Heart Association | Sample size: 212  
Disease: Single disease: CHF  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Depression  
Outcomes: Physical symptoms, functioning, depression  
Duration: 6 weeks  
Withdrawals: 142 | Results: High levels of physical symptoms and poor functioning patients reported higher levels of depression. |
| Fulop, 2003<sup>8</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (non ICU)  
Funding: NIMH Grant | Sample size: 263  
Disease: Single disease: CHF  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Depression  
Outcomes: Hospitalization, health services utilization  
Duration: 6 months  
Withdrawals: 42 | Results: High prevalence of depression in CHF patients at discharge depressed patients utilized more medical services. |
| Goldberg, 1997<sup>9</sup> | Design: Prospective Cohort  
Quality: Fair  
Setting: Nursing home  
Funding: Not reported | Sample size: 109  
Disease: Single disease: Dementia  
Severity: Unclear  
Race: Not reported  
Gender: Not reported | Exposure: Risperidone  
Outcomes: Dementia-related bahavioral disturbances  
Duration: 6 months  
Withdrawals: 46 | Results: Risperidone was well tolerated overall among nursing home residents and deemed helpful in 38% of sample, moderately helpful in 26% of sample, slightly helpful in 17% of sample and not helpful in 19% of sample. |

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| Payne, 2002<sup>10</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Nursing home  
Funding: R-01 The depression in Alzheimer Disease Study | Sample size: 201  
Disease: Single disease: Dementia  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Depression  
Outcomes: Depression  
Duration: One year  
Withdrawals: Not reported | Results: Incidence and prevalence of dementia is high in long term care facility residents incidence of depression seems to decrease within a year of admission is appropriate diagnosis and treatment were initiated. |
| Rumsfeld, 2003<sup>11</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (non ICU)  
Funding: Pharmacia Corporation | Sample size: 460  
Disease: Single disease: CHF  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Depression  
Outcomes: Heart failure health status  
Duration: 6 weeks  
Withdrawals: Not reported | Results: Depressive symptoms are strong predictors of short term worsening HF specific health status. |
| Keene, 2002<sup>12</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Home health care  
Funding: Medical Research Council, Eli Lilly | Sample size: 100  
Disease: Single disease: Dementia  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Behavioral symptoms  
Outcomes: Symptom experience, behavior, causes of death  
Duration: 11 years  
Withdrawals: 9 | Results: Family members might benefit from prognostic information in terms of caregiving concerns. |

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| Jiang, 2002<sup>13</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (non ICU)  
Funding: National Institute of Aging | Sample size: 374  
Disease: Single disease: CHF  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Depression  
Outcomes: Depression, mortality, re-hospitalization  
Duration: One year  
Withdrawals: 43 | Results: Major depression common in hospitalized patients and is associated with poor prognosis. |
| Breitbart, 2002<sup>14</sup> | Design: Prospective Cohort  
Quality: Fair  
Setting: Hospital (non ICU)  
Funding: Not reported | Sample size: 83  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Olanzapine  
Outcomes: Delirium  
Duration: 7 days  
Withdrawals: 4 | Results: Olanzapine effective and safe for treatment of delirium in cancer patients. |

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### Evtab4.OS Symptoms Evidence Table

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<tr>
<td>Bradley, 2001¹</td>
<td>Design: Cross sectional Quality: N/A Setting: Hospital (ICU and non-ICU) Funding: Not reported</td>
<td>Sample size: 223 Disease: Single disease: Cancer Severity: Advanced Race: White, Hispanic, Black Gender: Males and females</td>
<td>Exposure: Demographic, clinical factors, hospice enrollment Outcomes: Chart documentation of a discussion about prognosis Duration: N/A Withdrawals: 232 / 325 approached agreed to medical record review</td>
<td>Results: Only 38% of charts included a documented discussion about prognosis, 29-45% of charts included discussions related to advance care planning. Non-physicians directed such discussion in 20/89 cases. Only emergency admission and length of stay, and hospital death were associated with increased odds of prognostic discussion in adjusted models.</td>
</tr>
<tr>
<td>Burge, 2003²</td>
<td>Design: Retrospective cohort secondary data analysis Quality: N/A Setting: Unclear Funding: Cancer Research and Education Nova Scotia (CaRE)</td>
<td>Sample size: 8702 Disease: Single disease: Cancer Severity: Advanced Race: Not reported Gender: Males and females</td>
<td>Exposure: MMCI as measured by family physician care - number of visits adjusted by number of physicians involved Outcomes: Emergency department use Duration: 6 months Withdrawals: N/A</td>
<td>Results: Patients with low continuity, MMCI &lt; 0.5, made more emergency department visits (rate ratio 3.93) and those with intermediate continuity, MMCI 0.5-0.8 made more emergency visits (rate ratio 2.28) compared with those experiencing high continuity (MMCI &gt; 0.8). Absolute number of visits approximately 2 in the lowest continuity group. Women and older patients less likely, and rural lower income, not enrolled in palliative care, receiving specialty treatment patients more likely to have emergency visits.</td>
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</table>
| Burge, 2003<sup>3</sup> | Design: Retrospective cohort secondary data analysis  
Quality: N/A  
Setting: Unclear  
Funding: Cancer Research and Education Nova Scotia (CaRE) | Sample size: 8702  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: Not reported  
Gender: Males and females | Exposure: MMCI as measured by family physician care - number of visits adjusted by number of physicians involved  
Outcomes: Emergency department use  
Duration: 6 months  
Withdrawals: N/A | Results: Patients with low continuity, MMCI < 0.5, made more emergency department visits (rate ratio 3.93) and those with intermediate continuity, MMCI 0.5-0.8 made more emergency visits (rate ratio 2.28) compared with those experiencing high continuity (MMCI > 0.8). Absolute number of visits approximately 2 in the lowest continuity group. Women and older patients less likely, and rural lower income, not enrolled in palliative care, receiving specialty treatment patients more likely to have emergency visits. |
| Tang, 2003<sup>4</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Home health care  
Funding: Roxane Laboratories | Sample size: 127  
Disease: Single disease: mixed cancer  
Severity: Advanced  
Race: Not reported  
Gender: Males and females | Exposure: Not reported  
Outcomes: hospice home care use  
Duration: 2-293 days  
Withdrawals: Not reported | Results: 50% used hospice home care. Use of home care predicted use of hospice. Number and length of re-hospitalizations were higher for hospice home care group. |

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| Tang, 2003<sup>5</sup> | Design: Prospective Cohort  
Quality: Fair  
Setting: Unclear  
Funding: Not reported | Sample size: 180  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: Non-hispanic white, other  
Gender: Males and females | Exposure: Demographic and clinical characteristics, social support, health system factors  
Outcomes: Site of death  
Duration: median of 36 days  
Withdrawals: 127 / 180 enrollees (207 approached) were eligible for analysis of site of death | Results: Only 30% of patients died at the site they preferred to die. In a limited model developed using variables selected for significance, re-hospitalization was significantly associated with a lower likelihood, hospice and perceived family support associated with a higher likelihood of achieving death in preferred site. |
| Wennberg, 2004<sup>6</sup> | Design: Retrospective cohort secondary data analysis  
Quality: N/A  
Setting: Hospice and Hospital (ICU & non ICU)  
Funding: RWJF, NIA 1PO1AG19783-01 | Sample size: 115089  
Disease: Mixed Disease  
Severity: Advanced  
Race: Black, non-black  
Gender: Males and females | Exposure: High quality geriatric, cardiovascular, cancer, or pulmonary disease as indicated by US News and World Report rankings.  
Outcomes: Healthcare resource use, number of days spent in hospital or ICU, % of patients seeing 10 or more physicians, % enrolled in hospice - in last 6 months of life.  
Duration: 6 months  
Withdrawals: N/A | Results: On average, 37% of the cohort saw more than 10 physicians in the last 6 months of life, 40% died in hospital and 27% were admitted to hospice. There was widespread variation in the use of resources and intensity of care over the last 6 months of life in hospitals with high quality perceived care. |

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| Townsend, 1990<sup>7</sup> | Design: Prospective Cohort  
Quality: Poor  
Setting: Home health care  
Funding: Harrow Health Authority, Rehabilitation Research Fund | Sample size: 84  
Disease: Single disease: mixed cancer  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Not reported  
Outcomes: congruence between preference for location of death and actual site of death  
Duration: 5-18 mos (or until death)  
Withdrawals: 6 | Results: Preference for site of death on initial interview: 58% at home, 20% in hospital, 20% in hospice, 2% other. Preference at final interview: 49% at home, 24% hospital, 25% in hospice. Of 32 who died in hospital, 63% had stated preference to die elsewhere. |
| Hutt, 2002<sup>8</sup> | Design: Retrospective cohort secondary data analysis  
Quality: N/A  
Setting: Nursing home  
Funding: CMS Contract No. 94-058 | Sample size: 636  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Males and females | Exposure: Demographic, clinical factors, advance directives  
Outcomes: Hospitalization vs. no hospitalization during acute illness in the nursing home  
Duration: N/A  
Withdrawals: N/A | Results: For three tracer conditions (UTI, CHF, and pneumonia), hospitalization varied greatly during acute illness in the nursing home (UTI 11%, pneumonia 46%, CHF 58%). Older age decreased and male gender increased odds of hospitalization for CHF, male gender increased and DNR decreased odds of hospitalization for pneumonia. Weekend and night / evening shifts increased odds of hospitalization for UTI. |
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<td>Burns, 2003&lt;sup&gt;9&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Poor Setting: Ambulatory/outpatient medical care Funding: Australian Commonwealth Department of Health and Community Services</td>
<td>Sample size: 136 caregivers Disease: Single disease: mixed cancer Severity: Mixed Race: Not reported Gender: Males and females</td>
<td>Exposure: time Outcomes: Caregiver's knowledge of treatment intent Duration: 12 weeks Withdrawals: 51 (unclear)</td>
<td>Results: There was little change over time in caregiver's knowledge of treatment intent. 40% at week 1 vs 48% at week 12 understood that treatment would not cure. However, patient prognosis was associated with knowledge: only 10% of caregivers of patients with less than six months to live believed that the treatment intent was curative. In bivariate analyses at baseline, multiple factors were statistically significantly associated with the view that treatment intent was curative, including male caregiver gender, older caregiver age, those who were still working, retired or unemployed (compared to those who had stopped work to care for the patient). Patient clinical characteristics associated with lack of caregiver understanding included breast or ovarian cancer and recruitment through radiation oncology.</td>
</tr>
<tr>
<td>Chin, 1997&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Ambulatory/outpatient medical care Funding: Not reported</td>
<td>Sample size: 257 Disease: Single disease: CHF Severity: Moderate Race: Not reported Gender: Not reported</td>
<td>Exposure: Not reported Outcomes: hospitalization Duration: 60 days Withdrawals: None</td>
<td>Results: 31% were re-hospitalized within 60 days. In multivariate analysis, neither race nor gender predicted re-hospitalization.</td>
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| Chin, 1997<sup>10</sup> | Design: Prospective Cohort  
Quality: Fair  
Setting: Ambulatory/outpt medical care and Hospital (non ICU)  
Funding: NIA K12-AG-00488 award | Sample size: 257  
Disease: Single disease: CHF  
Severity: Moderate  
Race: White, non-white  
Gender: Males and females | Exposure: Demographic, clinical, and social characteristics  
Outcomes: Readmission  
Duration: 60 days  
Withdrawals: Not reported | Results: Single marital status, comorbidity, and other clinical variables were independently associated with risk of readmission. Risk of re-admission was 31% at 60 days. |
| Fried, 1997<sup>11</sup> | Design: Retrospective cohort secondary data analysis  
Quality: N/A  
Setting: Nursing home  
Funding: Not reported | Sample size: 3782  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Males and females | Exposure: Demographic, clinical, functional factors, advance directives.  
Outcomes: Hospitalization vs. no hospitalization during a six month period  
Duration: N/A  
Withdrawals: N/A | Results: Older, female residents hospitalized less frequently. Stage 2 or greater pressure ulcer, feeding tube, recent medication prescription associated with higher risk of hospitalization. Advance directives not associated with hospitalization. Moderate to severe cognitive impairment associated with lower risk and severe functional impairment a higher risk of hospitalization. |

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### Evtab1. OS Continuity and Coordination Evidence Table

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| Kane, 2003<sup>12</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Nursing home  
Funding: CMS | Sample size: ~4800  
Disease: Mixed Disease  
Severity: Moderate  
Race: Not reported  
Gender: Not reported | Exposure: Evercare  
Outcomes: resource utilization: hospital, ER, physician, and psychotherapy use  
Duration: 15 months  
Withdrawals: 3% disenrollment in Evercare per month, "almost all due to death" | Results: Evercare is a capitated HMO for long-stay nursing home residents. The model seeks to increase primary care intensity by employing nurse practitioners in contracted nursing homes to supplement the care of the primary care physicians and train nursing home staff. They enrolled 44 Evercare and control facilities and compared 3 groups: Evercare patients, patients in Evercare-contracted nursing homes not receiving Evercare, and patients in non-Evercare-contracted nursing homes. Patients were matched by admission date. Multivariate analyses controlling for multiple patient variables (but not accounting for clustering by facility) found fewer hospitalizations and less hospital use in the Evercare group, mainly by substituting nursing home care for hospital care. Preventable hospitalizations were also reduced. Patient attention was more than twice as high. No information is given on the terminally ill or those who died. |

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<td>Knol, 2003</td>
<td>Design: Prospective Cohort Quality: Good Setting: Home health care Funding: Dutch government, University of Groningen, Faculty of Medical Sciences, Dutch Cancer Foundation, Netherlands Organization for Scientific Research</td>
<td>Sample size: 555 Disease: Mixed Disease Severity: Moderate Race: Not reported Gender: Not reported</td>
<td>Exposure: time Outcomes: utilization of professional home care Duration: 2 years Withdrawals: 555 are of an original sample of 753.</td>
<td>Results: Patients who died or couldn't participate in interviews due to illness were excluded. 25% were receiving home care initially, compared to 35% 2 years later. The best predictors of new home care use were high chronic morbidity, older age, and a high level of mastery. Lower income and less self-efficacy had borderline statistical significance. Disability and the amount of informal help did not play a role in prospectively determining home care use.</td>
</tr>
<tr>
<td>Heller, 2000</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (ICU and non-ICU) Funding: Not reported</td>
<td>Sample size: 4981 Disease: Predominately one disease: Cardiovascular disease Severity: Moderate Race: Not reported Gender: Males and females</td>
<td>Exposure: Disease group (post-MI, other heart disease, CHF, or stroke), Demographic and clinical characteristics Outcomes: Death and readmission to a hospital the year after discharge for an index condition Duration: 1 year post-index discharge Withdrawals: None</td>
<td>Results: Patients with CHF had the highest risk for re-admission or death (49%) the year after index hospitalization. Stroke had a low re-admission rate of about 11%. Age was the most important consistent prognostic indicators.</td>
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## OS Continuity and Coordination Evidence Table

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<thead>
<tr>
<th>First Author Year</th>
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<th>Exposure, Outcomes Duration, Dropouts</th>
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</thead>
</table>
| Holtzman, 1998    | Design: Prospective Cohort  
Quality: Good  
Setting: Home health care  
Funding: HCFA, Assistant Secretary for Planning and Evaluation | Sample size: 970  
Disease: Mixed Disease  
Severity: Moderate  
Race: Not reported  
Gender: Not reported | Exposure: HMO care  
Outcomes: ADL function, hospital readmission  
Duration: 6 months  
Withdrawals: None in 6 weeks | Results: This study compared Medicare patients discharged after a CVA, COPD, CHF, hip replacement, or hip fracture repair. Information on end-of-life issues (such as mortality rate) is not reported. In multivariate analyses, there were no significant differences in hospital readmissions or ADL status by HMO or fee-for-service status. |
| Nourhashemi, 2001 | Design: Cross sectional  
Quality: N/A  
Setting: Hospital (non ICU)  
Funding: Not reported | Sample size: 118  
Disease: Single disease: Dementia  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Not reported  
Outcomes: Emergency hospital admission  
Duration: N/A  
Withdrawals: 118 / 118 cases described | Results: Behavioral problems followed by falls. |

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</table>
| Stewart, 2002<sup>17</sup> | Design: Prospective Cohort  
Quality: Fair  
Setting: Home health care  
Funding: National Heart Foundation of Australia | Sample size: 90  
Disease: Single disease: CHF  
Severity: Moderate  
Race: Not reported  
Gender: Not reported | Exposure: Not reported  
Outcomes: Early Clinical Deterioration hospital utilization  
Duration: 6 months  
Withdrawals: None | Results: Among 90 patients with chronic heart failure assigned to a multidisciplinary, home-based intervention and followed for 14 days, 2 died, 5 had an unplanned readmission, and 28 were clinically unstable at a planned home visit. The outcome of Early Clinical Deterioration (ECD) was defined as the combination of these 3 outcomes. In multivariate analysis, greater age and greater comorbidity were associated with ECD. ECD was associated with greatly reduced event-free survival (death or hospitalization) in the next six months. |
| Zweig, 2004<sup>18</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Nursing home  
Funding: AHRQ, HRSA, RWJ | Sample size: 1031  
Disease: Mixed Disease  
Severity: Unclear  
Race: White, Black  
Gender: Males and females | Exposure: Evaluation for a lower respiratory tract infection  
Outcomes: Hospitalization  
Duration: 30 days  
Withdrawals: 21 | Results: In logistic regression model, there was no significant difference in the adjusted odds of hospitalization within 30 days of evaluation for a lower respiratory infection for African-Americans. The adjusted odds ratio for males was borderline significant (1.42 (0.99-2.03). DNR orders decreased the odds of hospitalization (0.69 (0.49-0.97)). |

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<tr>
<td>Collins, 1994</td>
<td>Design: Prospective Cohort Quality: Good Setting: Nursing home and home Funding: NIMH</td>
<td>Sample size: N=142 (46 residential CGs vs. 49 CGs of institutionalized vs. 47 bereaved CGs) Disease: Single disease: Dementia Severity: Unclear Race: Caucasian (98%), African-American (2%) Gender: Males and females</td>
<td>Exposure: Three 60-90 minute interviews and complete a self-administered booklet (Intake, 22 months, 37 months) Outcomes: Depression Duration: 3 years Withdrawals: Not reported</td>
<td>Results: No statistically significant differences were found among residential, institution, and bereaved caregivers on demographic characteristics. No statistically significant differences were found between the three groups on depression. Female bereaved caregivers experienced a pattern of decreasing depression following their relative's death while male bereaved caregivers experienced an increase.</td>
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<tr>
<td>Emanuel, 1999\textsuperscript{2}</td>
<td>Design: Survey Quality: Good Setting: Home, nursing home, hospital (ICU) and hospice Funding: Commonwealth Fund &amp; Nathan Cummings Foundation</td>
<td>Sample size: 988 terminally ill patients and 893 caregivers in 6 randomly selected areas of the US. 59% were over the age of 65 years and 51.5% were women (cancer 52%, heart disease-18%, and chronic obstructive pulmonary disease-11%). 4% were in a nursing home, hosp</td>
<td>Exposure: Once Outcomes: Type of assistance needed. Duration: None Withdrawals: Not reported</td>
<td>Results: A need for assistance was reported by 87% of the patients, including help with transportation (reported by 62%), homemaking services (55%), nursing care (29%), and personal care (26%). Seventy-two percent of caregivers were women and 96% of caregivers were family members. Most patients relied completely on family members and friends for assistance. Only 15.5% of patients relied totally on paid assistance for more than half of the care they needed. Volunteers (unpaid helpers who were not family members) provided less than 3% of all care. In addition to medical care, dying patients often need many types of assistance. Family members, primarily women, provided the majority of assistance with non-medical care.</td>
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| Grant, 2002³          | Design: Prospective Cohort  
Quality: Good  
Setting: Nursing home and home  
Funding: NIA | Sample size: N=167 (119 CG and 48 non-caregiving comparison CG)  
Disease: Single disease: Alzheimer's Disease  
Severity: Mixed  
Race: Not reported  
Gender: Females | Exposure: baseline, 6 months, 12 months, 18 months  
Outcomes: CG physical and mental health.  
Duration: 18 months  
Withdrawals: Not reported | Results: CG who placed the care recipient in a NH or whose care recipient died showed improvement in depressive and physical symptoms compared to CG who continued to provide care and non-caregiving comparisons. Both placement and death of pt associated with higher blood pressure during transitions. However, there were continued symptoms long term after transitions. |
| Hays, 1994⁴          | Design: Prospective Cohort  
Quality: Good  
Setting: Not reported  
Funding: NIMH & NIA | Sample size: N=1,112 caregivers  
Disease: Mixed Disease  
Severity: Advanced and moderate  
Race: White (91%), African American (8.5%), Hispanic (.5%)  
Gender: Females | Exposure: Baseline, 2 mo., 6 mo., 13 mo., and 25 mo. After enrollment  
Outcomes: Depression, General Anxiety, Feelings of Helplessness and Hopelessness.  
Duration: 2 years  
Withdrawals: 371 (25% of eligible respondents) | Results: Distress was related to the severity of the patient's illness, the actuality and timing of the bereavement, as well as the gender and age of the respondent. |

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# Evtab2.OS Family/Caregiver Concerns Evidence Table

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</table>
| Hodgson, 1997⁵       | Design: Prospective Cohort  
Quality: Good  
Setting: Home health care  
Funding: Cancer Society, Europe Against Cancer | Sample size: N=757 pts (508 died while in HH) and 747 caregivers  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: White (100%)  
Gender: Females | Exposure: Baseline, 2 weeks, week of death  
Outcomes: Cg function and ability to self-care, patient and family physical symptoms, psychological functioning, and communication.  
Duration: 6 months  
Withdrawals: Not reported | Results: 75% of patients died at home. 32% of families had severe or overwhelming anxiety. During the last week of care, anxiety remained severe for 26% of CGs. Patient and family well-being were inter-related and there were significant interactions between family anxiety and patient physical and psychological symptoms and communication. Family anxiety at referral strongly predicts family anxiety at last week of life. Excluding family anxiety at referral, other predictors for family anxiety were patient symptom control, sex of patient, diagnosis, and patient age. |
| Martikainen, 1998⁶    | Design: Prospective Cohort  
Quality: Good  
Setting: Not reported  
Funding: Social Science Research Council, Academy of Finland | Sample size: N=5,500 widowed decedents  
Disease: Mixed Disease  
Severity: Advanced  
Race: Caucasian (100%)  
Gender: Not reported | Exposure: Baseline, 5 years later  
Outcomes: Mortality.  
Duration: 5 year  
Withdrawals: Not reported | Results: Results indicated that both men and women experience excess mortality after the death of a spouse and that the relative excess mortality among the bereaved is broadly similar in all education and income subgroups analyzed. The absolute mortality difference between widowed and married persons, however, tends to be larger among less educated and, especially, low-income persons. |

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<tr>
<td>Schulz, 2001†</td>
<td>Design: Prospective Cohort</td>
<td>Sample size: N=129 caregivers</td>
<td>Exposure: Baseline, 3 annual in-person interviews, 2 years after</td>
<td>Results: CES-D scores remained high but did not change among strained caregivers (p=.76) while CES-D scores increased for both non-caregivers (p=&lt;.001) and non-strained caregivers (p=.04). Non-caregivers significantly more likely to be using antidepressant medications following the death than non-strained group (p=.05). The strained CG group experienced significant improvement in health risk behaviors following the death of their spouse (P&lt;.001) while the non-caregiver and non-strained CG groups showed little change. Non-caregivers experienced significant weight loss following the death while the strained and non-strained CG groups did not. The impact of losing one's spouse among older persons varies as a function of the caregiving experiences that precede the death. Among individuals who are already strained prior to the death, the death itself does not increase their level of distress.</td>
</tr>
<tr>
<td></td>
<td>Quality: Good</td>
<td>Disease: Single disease: Cardiovascular Disease</td>
<td>Outcomes: Depressive symptoms, antidepressant medication use, 6 health risk behaviors, weight.</td>
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<tr>
<td></td>
<td>Setting: Unclear</td>
<td>Severity: Advanced and moderate</td>
<td>Duration: 4 years</td>
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<tr>
<td></td>
<td>Funding: NIMH</td>
<td>Race: White (90%)</td>
<td>Withdrawals: 103</td>
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<td></td>
<td></td>
<td>Gender: Males and females</td>
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<td>Schulz, 2003&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Design: Prospective Cohort</td>
<td>Sample size: N=217 caregivers</td>
<td>Exposure: Baseline, 6 months, 12 months, 18 months</td>
<td>Results: Overall, caregivers exhibited high levels of depressive symptoms while providing care to the relative with dementia (mean CES-D score: 15.8±11.7; median, 13). Forty-three percent of caregivers had scores above 15. At the death of the relative, depressive symptom scores spike to 22. However, within three months of the death of the relative, caregivers had clinically significant declines in the level of depressive symptoms, declining to a level similar to pre-bereavement levels 9(mean, 16.2±12.3; median, 14). Within one year the levels of symptoms were substantially lower than at baseline (mean 11.5±9.4; median, 9) (P=0.03). Caregivers who cared for and then placed their relative in a nursing home had mean scores for depression of 17.1±11.9 (median, 15) before placement and mean depression scores of 18.1±13.0 (median, 15) after placement. One year after placement, depression scores remained high among and were significantly higher among caregivers of patients who had been institutionalized than among those caregivers of patients who had died (mean, 16.2 vs. 11.5; median, 14 vs. 9; P=0.02). Use of antidepressant medication and anxiolytic drugs increased after the death of the relative (16.6% and 19.4% before the death, 21% and 18% after the death). While the death of a close relative is generally viewed as a powerful source of psychological stress, the caregivers in this study showed remarkable resilience in adapting to the death of their relatives.</td>
</tr>
<tr>
<td></td>
<td>Quality: Good</td>
<td>Disease: Single disease: Alzheimer's Disease</td>
<td>Outcomes: Number of hours/wk spent helping pt, type of assistance provided patient, CG burden and depression, medication use, impact of caregiving on employment, formal health service use, CG response to death of patient.</td>
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### Evtab2.OS Family/Caregiver Concerns Evidence Table

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</table>
| Teno, 2004<sup>a</sup> | Design: Telephone Survey  
Quality: Good  
Setting: Home, hospice, nursing home, and hospital (ICU and non-ICU)  
Funding: RWJ | Sample size: N=1578 respondents  
Disease: Mixed Disease  
Severity: Advanced  
Race: White (83%), Black (12%), Hispanic (3%)  
Gender: Males and females | Exposure: Survey  
Outcomes: Patient and family centered end of life care.  
Duration: None  
Withdrawals: 1697 | Results: Sixty-seven percent of decedents died in an institutional setting while 33% died at home. Of those dying at home, 38% did not receive nursing services, 13% used home nursing services, and 49% had home hospice services. About 25% of all patients with pain or dyspnea at the end of life did not receive adequate treatment and one quarter reported concerns with physician communication. More than one-third of respondents cared for by a home health agency, nursing home, or hospital reported insufficient emotional support for the patient and/or 1 or more concerns with family emotional support, compared with about 1/5 of those receiving home hospice services. Nursing home residents were less likely than those care for in a hospital or by home hospice services to always have been treated with respect at the end of life (68% vs. 77% and 96% respectively). Family members of patients receiving hospice services were more satisfied with overall quality of care: 71% rated care as "excellent" compared with less than 50% of those dying in an institutional setting or with home health services. These data suggest that those dying in institutions have unmet needs for symptom management, physician communication, emotional support and being treated with respect. Family members of decedents who died with home hospice services were more likely to report a favorable dying experience. |

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<td>Tilden, 2004&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Design: Telephone Survey Quality: Good Setting: Home, nursing home, hospice and other Funding: NINR and RWJ</td>
<td>Sample size: N=1,089 widowed caregivers Disease: Mixed Disease Severity: Advanced Race: White (83%), Black (4.4%), Hispanic (3.9%), Asian-Pacific Islander (4.3%), American Indian (4.1%) Gender: Males and females</td>
<td>Exposure: Once Outcomes: Advance directives, hospice enrollment, use of life-sustaining treatments, perceived decedent symptom distress, financial hardship, out-of-pocket costs, family caregiver strain. Duration: None Withdrawals: 471</td>
<td>Results: Results showed that most decedents had an advance directive (78.3%) and were enrolled in hospice (62.4%). Although perceived decedent symptom distress was low overall, certain symptoms (e.g., pain, dyspnea, constipation) were distressing for approximately half of decedents experiencing them. Financial hardship, out-of-pocket expenses, and caregiver strain were frequently reported. American Indian race and younger age were associated with decedent symptom distress. Greater perceived decedent symptom distress, hospice enrollment, more caregiver involvement, and more financial burden were associated with greater caregiver strain. Thus, despite high rates of advance directives and hospice enrollment, perceived symptom distress was high for a subset of decedents, and caregiver strain was common.</td>
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<tr>
<td>Volicer, 2003</td>
<td>Design: Mail Survey</td>
<td>Sample size: n=156 Caregivers</td>
<td>Exposure: Once</td>
<td>Results: 22% of pts died at home. Results suggest that end of life experiences of individuals with dementia differ according to setting of care. Patients cared for at home and receiving hospice care during last 90 days had fewer symptoms vs. other groups and fewer signs of physical distress during the dying process. Hospice use did not affect caregiver burden but these patients stayed at home 23 days longer and were twice as likely to die at home than in an institution. Caregivers of patients dying at home had increased time dependence burden but other burden scores were similar among all groups. Caregivers with patients dying both at home and in an institution were less satisfied with care than those cared for in only one setting. No effect on burden was found for use of formal or informal assistance. Psychiatric symptoms in the patient increased caregiver burden and were the most common cause of institutionalization. Receipt of psychiatric care was associated with longer stay at home. Presence of advance directive decreased hospital stays and increased the likelihood of dying in a nursing home. These results indicate that quality end of life dementia care can be provided at home by hospice and psychiatric care.</td>
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<td>Quality: Good</td>
<td>Disease: Single disease: Alzheimer's Disease</td>
<td>Outcomes: Severity of dementia, Place of death, CG burden, CG satisfaction with care, enrollment in hospice, amount and type of help received by CG.</td>
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<td>Severity: Advanced</td>
<td>Duration: None</td>
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<tr>
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<td>Funding: Alzheimer's Association and Dept. of Veterans Affairs</td>
<td>Race: Caucasian (97%)</td>
<td>Withdrawals: Not reported</td>
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<td>McCarthy, 1997&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Design: Telephone Survey&lt;br&gt;Quality: Good&lt;br&gt;Setting: Hospital (ICU and non-ICU), home and other&lt;br&gt;Funding: North East Thames Regional Health Authority, East Anglia Regional Health Authority, South East Thames Regional Health Authority, The Care Foundation, Tunbridge Wells, the Stanley Luff Bequest Fund</td>
<td>Sample size: 600 Caregivers&lt;br&gt;Disease: Single disease: Cardiovascular Disease&lt;br&gt;Severity: Advanced&lt;br&gt;Race: Not reported&lt;br&gt;Gender: Not reported</td>
<td>Exposure: Once&lt;br&gt;Outcomes: Information about illness, Knowledge of prognosis, Learning about dying, Support in dying, Place of death, Time to death.&lt;br&gt;Duration: None&lt;br&gt;Withdrawals: 75</td>
<td>Results: Just under half (47%) of caregivers felt they had not been able to get all the information regarding the deceased’s illness that they had wanted or when they had wanted it. Thirty-seven percent of caregivers said they had known the deceased was likely to die and 26% said they had “half-known,” whereas 26% of deceased patients were reported to have known and 25% were reported to have “probably” known that they were likely to die. Of those deceased patients who were reported to have known or probably known they were likely to die, most were reported to have had to work this out for themselves: only 8% were said to have been told by a GP or hospital doctor. Moreover, only 44% of caregivers were told of the terminal prognosis. Half of the patients (54%) died in hospitals, 30% at home, and 4% in other places. Patients under age 75 were less likely to die in an institution and more likely to die at home than patients 75 or older. Women aged 75 or older more frequently died in residential or nursing homes than males. A quarter of the deceased were reported to have expressed a wish to die sooner; more women than men were said to have expressed such a wish (30% vs. 17%, &lt;i&gt;P&lt;/i&gt; &lt; 0.01). Moreover, decedents who were aged 75 or older were 2.6 times more likely to have expressed a wish to die sooner; those with four or more symptoms perceived as “very distressing” were 2.3 times more likely; and those who had a poor quality of life were 1.9 times more likely to expressed such a wish.</td>
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<td>Evangelista, 2002¹³</td>
<td>Design: Prospective Cohort Quality: Good Setting: Home Funding: American Heart Association Western Division and the UCSF School of Nursing</td>
<td>Sample size: 103 CG/PT dyads Disease: Single disease: Cardiovascular Disease Severity: Advanced Race: White (77%), Black (6%), Other (17%) Gender: Males and females</td>
<td>Exposure: Once Outcomes: Emotional well-being. Duration: None Withdrawals: Not reported</td>
<td>Results: Caregivers were predominantly female (71%) and spouses of patients with HF (83%). Patients had significantly lower (poorer) emotional well-being scores than caregivers. Both gender and age were associated with patients' emotional well-being; male and younger respondents had higher (better) scores than female and older patients (P&lt;.05). Patient's age, gender, and caregivers' emotional well-being accounted for 54% of the variance in patients' emotional well-being. Findings suggest that caregiver emotional well-being is associated with HF patient well-being. A focus on supporting caregivers and providing them with methods to support their loved ones would be beneficial to patients.</td>
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<td>Covinsky, 1994(^14)</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (ICU &amp; non ICU) Funding: RWJ</td>
<td>Sample size: N=2,129 caregivers Disease: Mixed Disease Severity: Advanced Race: White (81%), Black (16%), Other (3%) Gender: Males and females</td>
<td>Exposure: Baseline, 2 months, 6 months Outcomes: Frequency of adverse caregiving and economic burdens, patient functional status Duration: 6 months Withdrawals: Not reported</td>
<td>Results: One third (34%) of patients required considerable caregiving assistance from a family member. In 20% of cases, a family member had to quit work or make another major life change to provide care for the patient. Loss of most or all of the family savings was reported by 31% of families, whereas 29% reported the loss of the major source of income. Patient factors independently associated with loss of the family's savings included poor functional status (OR 1.40; 95% CI 1.10 to 1.78), lower family income (OR 1.74; 95% CI 1.37 to 2.21 for those with annual incomes below $25,000_, and young age (OR, 2.85; 95% CI 2.13 to 3.82 for those younger than 45 years of age compared to those 65 or older). Families of younger, poorer, and more functionally dependent patients are the most likely to report loss of most or all of the family's savings to a serious or fatal illness.</td>
</tr>
<tr>
<td>Brazil, 2003(^15)</td>
<td>Design: Interview Survey Quality: Fair Setting: Home, nursing home, hospital (ICU) and nursing home Funding: N/R</td>
<td>Sample size: N=151 caregivers Disease: Predominately one disease: Cancer Severity: Advanced Race: Not reported Gender: Males and females</td>
<td>Exposure: Once Outcomes: Physical restrictions, need for assistance, CG burden Duration: None Withdrawals: Not reported</td>
<td>Results: The majority of respondents were the female spouses (79%) of the patient. The numbers of caregivers providing assistance in specific functional activities were: bathing (88%); mobility 81%; dressing and undressing (76%); TOILETING (67%); and assistance at night (64%). 41% reported that they had been providing some form of care for over 1 year. CGs reported that physical demands in caregiving increased substantially during the last three months of the care recipient's life. As family caregivers provided more assistance in ADLs, they were at greater risk of reporting high caregiver burden.</td>
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<td>Emanuel, 2000&lt;sup&gt;16&lt;/sup&gt;</td>
<td>Design: Interview Survey Quality: Good Setting: Home, nursing home, hospital (ICU) and hospice Funding: Commonwealth Fund &amp; Nathan Cummings Foundation</td>
<td>Sample size: 988 terminally ill patients and 893 caregivers in 6 randomly selected areas of the US. 59% were over the age of 65 years and 51.5% were women (cancer 52%, heart disease-18%, and chronic obstructive pulmonary disease-11%). 4% were in a nursing home, hosp</td>
<td>Exposure: Once Outcomes: Economic and non-economic burdens of caregiving. Duration: None Withdrawals: Not reported</td>
<td>Results: 35% of the sample had substantial care needs and that those with substantial care needs were more likely to report that they had a subjective sense of economic burden (44.9% vs. 35.3%; difference 9.6 percentage points [95% CI, 3.1 to 16.1]; P=0.005). In addition, 10% of these families household income was spent on health care (28% vs. 17%; difference, 11 percentage points [CI 4.8 to 17.1]; P&lt;0.001) and that they or their families had to take out a loan or mortgage spend their savings, or obtain an additional job (16.3% vs. 10.2%; difference, 6.1 percentage points [CI 1.4 to 10.6]; P=0.004). Patients with substantial care needs were more likely to consider euthanasia or physician-assisted suicide (P=0.001). Caregivers of thee patients were more likely to have depressive symptoms (P=0.01) and to report that caring for the patients interfered with their lives (P=0.001). Caregivers of patients whose physicians listened to patients’ and caregivers’ needs had fewer burdens.</td>
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<td>Markowitz, 2003&lt;sup&gt;17&lt;/sup&gt;</td>
<td>Design: Interview Survey Quality: Good Setting: Nursing home and home Funding: Janssen Pharmaceutica Products, L.P.</td>
<td>Sample size: 2,477 dementia caregivers Disease: Single disease: Alzheimer's Disease Severity: Advanced and moderate Race: Not reported Gender: Males and females</td>
<td>Exposure: Once Outcomes: Health related quality of life, difficulty of caregiving, patient functioning level, IADLs, health care use. Duration: None Withdrawals: Not reported</td>
<td>Results: Compared with a normative, age-adjusted sample, the dementia caregivers had lower mental and physical scores (for the latter, only those 54 years of age or older). Increased caregiver mental functioning was associated with caregiver support and perceived quality of patient medical care, fewer hus of caregiving, and fewer patient behavioral symptoms.</td>
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</table>
| Steinhauser, 2000 | Design: Telephone Survey  
Quality: Good  
Setting: Hospital (ICU and non-ICU)  
Funding: VA Health Services Research and Development award | Sample size: N=1,462 (340 seriously ill patients, 332 recently bereaved family members, 361 physicians and 429 other health care providers = nurses, social workers, chaplains, and hospice volunteers)  
Disease: Other:  
Severity: Other  
Race: White (82%), African American (7.4%), Asian American (3.6%), Latino (2.2%), Native American (3.4%), Other (1.9%)  
Gender: Males and females | Exposure: Once  
Outcomes: End of Life factors considered important by patients, families, physicians and other health care providers.  
Duration: None  
Withdrawals: Not reported | Results: Twenty-six items consistently were rated as being important by greater than 70% of respondents, including pain and symptom management, preparation for death, achieving a sense of completion, decisions about treatment preferences, and being treated as a “whole person.” Additionally, respondents expressed a strong preference for human development at the end of life. Results also highlighted differences among the respondent groups. Eight items received strong endorsement from patients but less from physicians (P<.001), including being mentally aware, having funeral arrangements planned, not being a burden, helping others, and coming to peace with God. Ten items had broad variation within as well as among the 4 groups, including decisions about life-sustaining treatments, dying at home, and talking about the meaning of death. Participants ranked freedom from pain most important and dying at home least important among 9 major attributes. Thus, although pain and symptom management, communication with one’s physician, preparation for death, and the opportunity to achieve a sense of completion are important to most, other factors important to quality at the end of life differ by role and by individual. |
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## Evtab2.OS Family/Caregiver Concerns Evidence Table


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</table>
| Baker, 2000³      | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (ICU and non-ICU)  
Funding: RWJF | Sample size: 726  
Disease: Mixed Disease  
Severity: Advanced  
Race: White, non-white  
Gender: Males and females | Exposure: pain, disease category, functional status, use of life sustaining treatment, circumstances of death  
Outcomes: Satisfaction with communication and comfort pain, disease category, functional status, use of life sustaining treatment, circumstances of death.  
Duration: up to 6 months  
Withdrawals: 216 / 983 deaths | Results: Gender of surrogate (male) associated with lower and death and intervention status associated with higher satisfaction with comfort. Not following preferences, and great and moderate impact on family finances associated with lower satisfaction with communication. |
| Correa-Velez, 2003³ | Design: Prospective Cohort  
Quality: Good  
Setting: Ambulatory/outpt medical care  
Funding: National Health and Medical Research Council #991215 | Sample size: 111  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: physical symptoms, psychological symptoms, satisfaction with conventional medical care,  
Outcomes: Physical symptoms, psychological symptoms, satisfaction with conventional medical care, complementary and alternative medicine (CAM) use.  
Duration: 12 months  
Withdrawals: 11/111 too ill to participate in longitudinal phase | Results: Complementary and alternative medicine (CAM) use was associated with lower satisfaction with conventional medical (e.g. oncology) care, non-users of CAM were even more dissatisfied in last 3 months of life. |

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| Curtisa, 1999³    | Design: Prospective Cohort  
|                   | Quality: Good  
|                   | Setting: Ambulatory/outpt medical care  
|                   | Funding: University of Washington Intramural funds | Sample size: 57  
|                   | Disease: Single disease: AIDS  
|                   | Severity: Advanced  
|                   | Race: Not reported  
|                   | Gender: Not reported | Exposure: degree of MD-patient communication about end of life care  
|                   | Duration: 6 months  
|                   | Withdrawals: 5 / 57 (baseline only) | Results: Lower income patients noted lower quality of communication, higher quality of communication associated with higher overall satisfaction with care. |
| Fakhoury, 1996⁴   | Design: Retrospective cohort  
|                   | Quality: N/A  
|                   | Setting: Unclear  
|                   | Funding: Hariri Foundation, ORS award, UK regional health authorities, Care Foundation Tunbridge Wells | Sample size: 1858  
|                   | Disease: Single disease: Cancer  
|                   | Severity: Advanced  
|                   | Race: White, non-white  
|                   | Gender: Males and females | Exposure: service characteristics of end of life care  
|                   | Outcomes: satisfaction with district nurse, general practitioner, and hospital physician care multiple sociodemographic, informal caregiver, and service characteristics.  
|                   | Duration: N/A  
|                   | Withdrawals: N/A | Results: High level of satisfaction for nurses, GP's, and hospital MDs noted. Stepwise procedures used to select from expansive regressor set. |

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| Fakhoury, 1997⁵      | Design: Retrospective cohort  
Quality: N/A  
Setting: Unclear  
Funding: Hariri Foundation, ORS award, UK regional health authorities, Care Foundation Tunbridge Wells | Sample size: 1858  
Disease: Single disease: Cancer  
Severity: Advanced  
Race: White, non-white  
Gender: Males and females | Exposure: service characteristics of end of life care  
Outcomes: Satisfaction with district nurse, general practitioner, and hospital physician care  
multiple sociodemographic, informal caregiver, and service characteristics.  
Duration: N/A  
Withdrawals: N/A | Results: Owner-occupiers, older patients, spouses vs non spouses, those with short duration of several symptoms somewhat higher satisfaction measures. Multiple comparisons. |
| Fisher, 2003⁶        | Design: Retrospective cohort secondary data analysis  
Quality: N/A  
Setting: Unclear  
Funding: RWJF, NIH CA52192, NIA 1PO1 AG19783-01 | Sample size: ~1,000,000  
Disease: Predominately one disease: 3 cohorts (hip fracture, colorectal cancer, acute myocardial infarction)  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Clinical and demographic characteristics, End of Life Exposure Index (EOL-EI)  
Outcomes: Mortality, functional status change, and satisfaction with care.  
Duration: N/A  
Withdrawals: N/A | Results: Higher spending at the end of life not associated with reduced mortality, improved functional status, or greater satisfaction with care in any cohort. |

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| Heyland, 2003^7    | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (ICU)  
Funding: Canadian ICU Foundation, Queen Elizabeth II Health Sciences Center Research Foundation | Sample size: 256  
Disease: Mixed Disease  
Severity: Advanced  
Race: N/A  
Gender: Not reported | Exposure: overall experience related to death of a loved one, communication  
Outcomes: Overall death experience, communication, overall satisfaction.  
Duration: 4 weeks  
Withdrawals: 256 / 413 responded | Results: Higher perceived courtesy and compassion, satisfaction with overall level of care, completeness of information provided were all associated with higher overall satisfaction with ICU care. |
| Higginson, 2002^8  | Design: Prospective Cohort  
Quality: Good  
Setting: Hospice  
Funding: European Commission, International Union Against Cancer for the International Cancer Fellowship | Sample size: 1326  
Disease: Mixed Disease  
Severity: Advanced  
Race: N/A  
Gender: Males and females | Exposure: enrollment in palliative care service  
Outcomes: Quality of life including communication.  
Duration: median, approximately 30 days  
Withdrawals: Not reported | Results: No gender differences in communication (trend toward lower difficulties in professional / pt / family communication among women, but not significant (p=0.09)), nor differences in interprofessional or professional / pt / family communication by site of death were observed. |
| Kristjanson, 1997^9 | Design: Cross sectional cohort  
Quality: N/A  
Setting: Home health care and hospice  
Funding: NCI Canada, Manitoba Health Research Council | Sample size: 72  
Disease: Mixed Disease  
Severity: Advanced  
Race: N/A  
Gender: Not reported | Exposure: family expectations and functioning  
Outcomes: Family care expectations, family functioning satisfaction.  
Duration: N/A  
Withdrawals: 72 / 82 responded | Results: Satisfaction differed by geographic province, higher among younger families, discrepancy score between expectations and perception of care was significantly related to satisfaction, site of care unrelated. |

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| Larsson, 2004<sup>10</sup> | Design: Cross sectional cohort  
Quality: N/A  
Setting: Home health care  
Funding: Not reported | Sample size: 67  
Disease: Unclear  
Severity: Advanced  
Race: N/A  
Gender: Not reported | Exposure: gender, age, and status (spouse, child, other) of family member, frequency of contact  
Outcomes: Patient and family perceptions of care.  
Duration: N/A  
Withdrawals: 67 / 100 responded | Results: Family members with more frequent contact both perceived better care and rated the perceived importance of those aspects of care to the patient's wellbeing higher than family members with less frequent contact. |
| Malacrida, 1998<sup>11</sup> | Design: Retrospective cohort  
Quality: N/A  
Setting: Hospital (ICU)  
Funding: 125th Jubileum Basle Insurance Company | Sample size: 123  
Disease: Mixed Disease  
Severity: Advanced  
Race: N/A  
Gender: Males and females | Exposure: quality of the ICU experience  
Outcomes: Family members perceptions of care delivered in the ICU.  
Duration: N/A  
Withdrawals: 123 / 390 respondents | Results: Multiple bivariate comparisons up to eight years after death. |

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| Sulmasy, 2002^12 | Design: Cross sectional cohort  
Quality: N/A  
Setting: Hospital (non ICU)  
Funding: Altman Foundation | Sample size: 84  
Disease: Mixed Disease  
Severity: Advanced  
Race: White, non-white  
Gender: Males and females | Exposure: pain, depression, nature of nursing and physician care  
Outcomes: Symptoms severity, anxiety and depression, perceptions and satisfaction with physicians and nurses.  
Duration: N/A  
Withdrawals: 110 /367 refused 84 / 88 remaining eligibles for current survey | Results: Only +DNR status, house-staff vs. private physician service status, and depression significant in multivariate models. All were associated with lower satisfaction with physician and nursing care. |
| Teno, 2004^13 | Design: Retrospective cohort  
Quality: N/A  
Setting: Hospice, nursing home and Hospital  
Funding: RWJF | Sample size: 1578  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: services and setting of care at the end of life  
Outcomes: Family perceptions of end of life care.  
Duration: N/A  
Withdrawals: 1578 / 3275 deaths | Results: Death in home hospice associated with improved satisfaction by all unadjusted measures, and improved emotional support, family emotional support, perceptions of treating patient respectfully, and overall quality compared to home care, nursing home, and hospital dying. Inadequate physician involvement, coordination noted in hospital and nursing home settings in particular. |

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| Tierney, 1998<sup>14</sup> | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (non ICU)  
Funding: AHRQ (RO1 - HS07632, 07763, 09083) | Sample size: 42 (26 with 2 measurements)  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: inpatient hospice treatment  
Outcomes: Satisfaction, quality of life, symptoms.  
Duration: 3-4 days  
Withdrawals: 16/42 (baseline only) | Results: Higher satisfaction highly correlated with better quality of life on admission, and also with better symptom control at follow-up. |
| Tolle, 2000<sup>15</sup> | Design: Retrospective cohort  
Quality: N/A  
Setting: Hospice, nursing home and Hospital  
Funding: Project on Death in American, Meyer Memorial Trust, RWJF, Nathan Cummings Foundation | Sample size: 475  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: services and setting of care at the end of life  
Outcomes: Family perceptions of end of life care.  
Duration: N/A  
Withdrawals: 475 / 1,458 deaths | Results: Transfers in care settings associated with respecting treatment preferences, pain management. Neither advance care planning and respect for treatment preferences, nor satisfaction with support from clinicians differed by setting of care. Report of pain comparable to Teno et.al., worse in hospital. Most difficulties in management of pain associated with home death. Difficulties with respect for treatment preferences and support from clinicians associated with worse pain management. |
| Volicer, 2001<sup>16</sup> | Design: Retrospective cohort  
Quality: N/A  
Setting: Unclear  
Funding: Alzheimer's Association, USPHS P30 AG13846 | Sample size: 156  
Disease: Single disease: Dementia  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: services and setting of care at the end of life  
Outcomes: Family perceptions of end of life care.  
Duration: N/A  
Withdrawals: 156 / 572 surveys returned | Results: Unclear sampling frame. Symptom scale and comfort scales modestly (~0.30) correlated with scale assessing aspects of health care and decision making. |

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| Zhukovsky, 1995¹⁷ | Design: Cross sectional cohort  
Quality: N/A  
Setting: Hospital (non ICU)  
Funding: Not reported | Sample size: 101  
Disease: Single disease: Cancer  
Severity: Unclear  
Race: Not reported  
Gender: Not reported | Exposure: pain and physician management of pain  
Outcomes: Pain, satisfaction with pain control.  
Duration: N/A  
Withdrawals: 101 / 171 approached | Results: Worse pain, belief that physician not adequately concerned about pain, and desire for more control in pain regimen associated with dissatisfaction with pain management. |
| Dawson, 1991¹⁸   | Design: Retrospective cohort  
Quality: N/A  
Setting: Home health care, hospice and hospital  
Funding: Not reported | Sample size: 100  
Disease: Unclear  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: site of care and death  
Outcomes: Emotional needs of patient and family, satisfaction with psycho-social support of nurse caregivers, overall satisfaction with medical care.  
Duration: N/A  
Withdrawals: 100 / 179 surveys returned | Results: Hospice users who died at home more satisfied by all measures than hospice users who died in other settings or non-hospice users who died in hospital. |
| Jacoby, 1999¹⁹   | Design: Retrospective cohort  
Quality: N/A  
Setting: Hospice, nursing home and Hospital  
Funding: Not reported | Sample size: 156  
Disease: Unclear  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: service quality and site of care  
Outcomes: Family perceptions of end of life care.  
Duration: N/A  
Withdrawals: 156 / 355 surveys returned | Results: Satisfaction with different practitioners and settings of care correlated with perceived efforts to relieve symptoms and communication. |

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| Kane, 2002<sup>20</sup> | Design: Cross sectional cohort  
Quality: N/A  
Setting: Ambulatory/outpatient medical care  
Funding: HCFA #500-96-0008 | Sample size: 1161  
Disease: Mixed Disease  
Severity: Moderate  
Race: Not reported  
Gender: Not reported | Exposure: Wisconsin Partnership Program participation  
Outcomes: Functional status, caregiver burden, advance directives, service attributes and satisfaction.  
Duration: N/A  
Withdrawals: 1161 / 1372 | Results: WPP participants demonstrated much higher levels of advance care planning and preference for limiting care compared with in-area controls. Satisfaction with care was largely no different, although in-area and out-of-area controls were more likely to report that their doctor treats them with respect, and that their care is well coordinated. Few to no differences in care-giving burden. |
| Steinhauser, 2000<sup>21</sup> | Design: Cross sectional cohort  
Quality: N/A  
Setting: Unclear  
Funding: VA HSR&D IIR 96-066 | Sample size: 1462  
Disease: Mixed Disease  
Severity: Advanced  
Race: White, African-American, Asian-American, Latino, Native American, Other  
Gender: Males and females | Exposure: N/A  
Outcomes: Ratings of attributes of experiences at the end of life.  
Duration: N/A  
Withdrawals: 1462 / 2000 | Results: Areas of concordance and discordance identified in the relative importance of 44 items related to symptoms or personal care, preparation for end of life, achieving a sense of completion, care planning, being treated as a 'whole person', and relationships with health professionals as noted by patients, physicians, family, and other providers. Race / gender, religiousness / spirituality, and relationship to deceased all related to various items or groups of items. |
Reference List


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Evtab3.OS Satisfaction Evidence Table


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<tr>
<td>Golin, 2000</td>
<td>Design: Prospective Cohort</td>
<td>Sample size: 1288</td>
<td>Exposure: Pts enrolled in SUPPORT.</td>
<td>Results: 30% of pts communicated resuscitation preferences to physicians. Pts wanting to forgo CPR and whose preferences changed from desiring to forgo CPR were more likely to communicate their preference than pts who continued to prefer to receive CPR. 50% of pts maintain preference to forgo CPR communicated their preferences over the study period. Having an AD and remaining in hospital associated with communication.</td>
</tr>
<tr>
<td></td>
<td>Quality: Good</td>
<td>Disease: Mixed disease: Cancer, Chronic disease</td>
<td>Outcomes: Communication of pts resuscitation preferences with their physicians.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting: Hospital (ICU &amp; non ICU)</td>
<td>Severity: Advanced</td>
<td>Duration: 2 month follow up</td>
<td></td>
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<tr>
<td></td>
<td>Funding: RWJ (SUPPORT)</td>
<td>Race: Black, Other</td>
<td>Withdrawals: Not reported</td>
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<tr>
<td></td>
<td></td>
<td>Gender: Males</td>
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<tr>
<td>Higginson, 2002</td>
<td>Design: Prospective Cohort</td>
<td>Sample size: 1326</td>
<td>Exposure: Time between first visit and death.</td>
<td>Results: 40% of EOL patients had severe communication. Communication problems associated with respiratory &amp; breast cancers, shorter time in care, and hospice death.</td>
</tr>
<tr>
<td></td>
<td>Quality: Good</td>
<td>Disease: Single disease: Cancer (Digestive, Respiratory, Breast, Genitourinary, Other)</td>
<td>Outcomes: Responsiveness to clinically important changes, correlation with other measures, correlation between patient self-assessment, family assessment, and team assessment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting: Hospice and Home</td>
<td>Severity: Advanced</td>
<td>Duration: Data collected over a 6-month period</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Funding: 1) European Commission &amp; 2) International Union Against Cancer for the International Cancer Fellowship</td>
<td>Race: Not reported</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Gender: Males and females</td>
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<tr>
<td>Lockhart, 2001⁵</td>
<td>Design: Prospective Cohort Quality: Fair Setting: Community Funding: AHRQ-HS08180</td>
<td>Sample size: 50 Disease: 8: Severity: Unclear Race: Not reported Gender: Not reported</td>
<td>Exposure: Initial interview - pts asked to imagine 7 different states. Outcomes: Participant rating of 7 states better/worse than death. Duration: Sub sample of 50 participants re-contacted, 5-16 months, asked same questions Withdrawals: 0</td>
<td>Results: Moderate stability in ratings of state that were better or worse than death.</td>
</tr>
<tr>
<td>Rose, 2000⁶</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (ICU &amp; non ICU) Funding: RWJF (SUPPORT)</td>
<td>Sample size: 642 Disease: Single disease: Cancer Severity: Advanced Race: Not reported Gender: Not reported</td>
<td>Exposure: Beginning of SUPPORT. Outcomes: Compare 844 oncologist pts. to 449 generalist pts. Duration: 6 months or pt. death Withdrawals: Not reported</td>
<td>Results: Generalists more pessimistic than specialists in prognostication. Similar LOS, discharge with supportive care, and hosp. readmission. Proportionally, more hospital deaths with generalists.</td>
</tr>
<tr>
<td>Tierney, 2001⁷</td>
<td>Design: Prospective Cohort Quality: Good Setting: Ambulatory/outpt medical care Funding: AHRQ Grant-Ro1-HS07632</td>
<td>Sample size: 686 Disease: Mixed Disease Severity: Unclear Race: African American Gender: Males</td>
<td>Exposure: Pt. visit when physician received computer reminder - part of the Dexter RCT. Outcomes: Level of patient satisfaction. Duration: Interview in waiting room following visit Withdrawals: 74</td>
<td>Results: Discussing advance directives associated with greater satisfaction with primary care physician. Elderly, chronically ill patients are more satisfied when they discuss ADs with their primary care physician.</td>
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<td>Weeks, 1998&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (non ICU) Funding: 1) RWJF (SUPPORT) &amp; 2) American Society of Clinical Oncology</td>
<td>Sample size: 917 Disease: Predominately one disease: Lung cancer or colon cancer metastatic to liver Severity: Advanced Race: Not reported Gender: Not reported</td>
<td>Exposure: Pts enrolled in SUPPORT. Outcomes: Relationship between pts prognostic estimates and their treatment preferences. Duration: After enrollment in SUPPORT Withdrawals: Not reported</td>
<td>Results: Pts estimating at least 6-month survival favored life-extending therapy over comfort care. Pts overestimated survival time.</td>
</tr>
<tr>
<td>Wenger, 2000&lt;sup&gt;9&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (ICU &amp; non ICU) Funding: RWJF (SUPPORT)+C191</td>
<td>Sample size: 5055 Disease: Not reported Severity: Advanced Race: White Gender: Males</td>
<td>Exposure: Pts enrolled in SUPPORT. Outcomes: Physician understanding of pts CPR preferences. Duration: Between second to sixth day after study enrollment Withdrawals: Not reported</td>
<td>Results: Physicians did not know of pts CPR preferences.</td>
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<td>McCarthy, 1997&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Unclear Funding: 1) North East Thames, South East Thames, and East Anglia Regional Health Authorities, 2) South East Thames Regional Health Authority, 3) Care Foundation Tunbridge Wells, 4) Stanley Luff Bequest Found, 5) Other participating districts</td>
<td>Sample size: 600 Disease: Single disease: Heart disease Severity: Advanced Race: Not reported Gender: Males and females</td>
<td>Exposure: Pt Death. Outcomes: Information about illness, knowledge of prognosis, learning about dying, support in dying, place of death, and timing of death. Duration: Follow-up with spouse, another relative, friend or neighbor, or formal carers. Withdrawals: Not reported</td>
<td>Results: Despite recognizing they were going to die, clinical staff rarely discussed the pts. Likelihood of death. Lack of discussion with pt on preferred place of death.</td>
</tr>
<tr>
<td>Townsend, 1990&lt;sup&gt;11&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (non-ICU) and community Funding: 1) Harrow Health Authority &amp; 2) Rehabilitation Research Fund</td>
<td>Sample size: 100 Disease: Single disease: Cancer Severity: Advanced Race: Not reported Gender: Not reported</td>
<td>Exposure: Cancer pts expected to live less than 1 year. Outcomes: Place of death, care before death. Duration: Pts interviewed at 2 week intervals if expected to live less than 2 months Withdrawals: 34</td>
<td>Results: Pts knew diagnosis and prognosis. Most pts admitted for investigation or treatment, but often stayed for respite and symptom control. 63% of pts who died in hospital, would prefer to die at home.</td>
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<td>Danis, 1991&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (non ICU) Funding: AHRQ - HS06655</td>
<td>Sample size: 244 Disease: Mixed Disease Severity: Advanced Race: White, Black Gender: Males and females</td>
<td>Exposure: Pts. With short life expectancy due to end-stage heart, lung, or liver disease, metastatic cancer, or lymphoma. Outcomes: Life-sustaining treatment utilization &amp; cost of hospital care. Duration: Followed for 6 months Withdrawals: 258</td>
<td>Results: Majority of pts wanted to receive life-sustaining treatment to prolong life. Chemotherapy and intensive care were the most frequent treatments. CPR and mechanical ventilation were the most frequently withheld. Pts deciding life-sustaining treatment to prolong life were no more likely to receive treatments than pts who desired limited treatment.</td>
</tr>
<tr>
<td>Hakim, 1996&lt;sup&gt;13&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (ICU &amp; non ICU) Funding: RWJF (SUPPORT)+C210</td>
<td>Sample size: 8836 Disease: Mixed Disease Severity: Advanced Race: Not reported Gender: Not reported</td>
<td>Exposure: Pts enrolled in SUPPORT. Outcomes: Association between pts resuscitation preferences and frequency and timing of DNR orders. Duration: Third day after study enrollment Withdrawals: Not reported</td>
<td>Results: DNR orders written earlier for pts older than 75 years of age, regardless of prognosis. Pt preferences associated with timing of DNR orders.</td>
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<tr>
<td>Junod Perron, 2002</td>
<td>Design: Prospective Cohort</td>
<td>Sample size: 255</td>
<td>Exposure: Pts who stayed more than 24 hours in hospital, and were provided with a DNR order.</td>
<td>Results: Quality of life was considered in more than 70% of DNR decisions. Physicians underrate their DNR pts. quality of life. Severe depression, social isolation and physical dependence negatively influenced patient’s perception of their quality of life.</td>
</tr>
<tr>
<td></td>
<td>Quality: Good</td>
<td>Disease: Predominately one disease: Cancer (Metastatic) Cardiac disease, Other</td>
<td>Outcomes: Agreement between physicians and DNR pts. Perception of quality of life.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting: Hospital (non ICU)</td>
<td>Severity: Advanced</td>
<td>Duration: 5 days following DNR order implementation</td>
<td></td>
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<tr>
<td></td>
<td>Funding: Not reported</td>
<td>Race: Not reported</td>
<td>Withdrawals: Not reported</td>
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<tr>
<td></td>
<td></td>
<td>Gender: Not reported</td>
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<tr>
<td>McParland, 2003</td>
<td>Design: Prospective Cohort</td>
<td>Sample size: 65</td>
<td>Exposure: Nursing home residents.</td>
<td>Results: Change in cognitive status related to changes in decision. Preferences changed at 12 and 24 months.</td>
</tr>
<tr>
<td></td>
<td>Quality: Good</td>
<td>Disease: Unclear</td>
<td>Outcomes: CPR and hydration and nutrition preferences.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Setting: Nursing home</td>
<td>Severity: Unclear</td>
<td>Duration: 12 and 24 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Funding: American Federation for Aging Research/John A. Harford Foundation Fellowship</td>
<td>Race: Not reported</td>
<td>Withdrawals: 21</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Gender: Not reported</td>
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<td>Azoulay, 2000(^{16})</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (ICU) Funding: Not reported</td>
<td>Sample size: 102 Disease: Unclear Severity: Advanced Race: Not reported Gender: Not reported</td>
<td>Exposure: Representatives of pts visited by at least one person during their ICU stay. Outcomes: Representatives' comprehension of the diagnosis, prognosis, and treatment of the pt. Duration: 2 days after ICU admission. Withdrawals: 124</td>
<td>Results: Families poor comprehension related to the age, unemployment, and referral from hematology or oncology ward, admission for acute respiratory failure or coma, and favorable prognosis. Family-related factors were foreign descent, not French speaking, not the spouse, and no healthcare professional in family.</td>
</tr>
<tr>
<td>Butow, 1997(^{17})</td>
<td>Design: Prospective Cohort Quality: Good Setting: Ambulatory/outpt medical care Funding: Not reported</td>
<td>Sample size: 80 Disease: Predominately one disease: Cancer (Breast, Genitourinary, Colon, Lung, Other) Severity: Advanced Race: Not reported Gender: Not reported</td>
<td>Exposure: Pts seeing oncologists in outpatient clinic, completed a questionnaire before a directly after one consultation. Outcomes: Differences in general information and involvement preferences before and after consultation. Duration: Pts complete questionnaire before their next consultation. Withdrawals: 38</td>
<td>Results: Females wanted more detailed information than males. Those whose follow-up visit encompassed a significant change in their condition were more likely to prefer having the doctor make decisions. General information and involvement preferences were relatively stable in the short term despite medical intervention. By the time of their next consultation, pts preferences had shifted considerably.</td>
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</table>
| Phillips, 2000\(^{18}\) | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (ICU & non ICU)  
Funding: RWJF (SUPPORT) | Sample size: 9105  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Females | Exposure: Pts enrolled in SUPPORT.  
Outcomes: Timing of decisions to withhold or withdraw ventilator support and dialysis, and decisions to withhold surgery.  
Duration: Between hospital days 3 and 6 after enrollment  
Withdrawals: Not reported | Results: Decisions to withhold or withdraw ventilatory support or dialysis, or withhold surgery, varied by race. African American pts more likely to prefer life-extending treatments. |
| Teno, 1997\(^{19}\) | Design: Prospective Cohort  
Quality: Good  
Setting: Hospital (ICU & non ICU)  
Funding: RWJF (SUPPORT) | Sample size: 4804  
Disease: Mixed Disease  
Severity: Advanced  
Race: Not reported  
Gender: Not reported | Exposure: Time of study enrollment in SUPPORT.  
Outcomes: Relationship between AD in record and hospital utilization.  
Duration: 6 months follow up or death  
Withdrawals: Not reported | Results: ADs in medical records did not guide medical decision-making. Despite specific instructions, care was inconsistent in half of the cases. |

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<td>Teno, 1998&lt;sup&gt;20&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (ICU &amp; non ICU) Funding: RWJF (SUPPORT)</td>
<td>Sample size: 14 Disease: Mixed Disease Severity: Advanced Race: Not reported Gender: Not reported</td>
<td>Exposure: Patient receives patient-specific information on prognosis and specially trained nurse to facilitate decision-making. Pt has AD. Outcomes: Role of AD in decision-making. Duration: Timeline of communication and decision-making. Withdrawals: Not reported</td>
<td>Results: Pt had a period of diminished capacity when AD should have been invoked. AD used in 5 of 14 cases. Complex interaction of several factors associated with AD having a limited role.</td>
</tr>
<tr>
<td>Wenger, 2000&lt;sup&gt;21&lt;/sup&gt;</td>
<td>Design: Prospective Cohort Quality: Good Setting: Hospital (non ICU) Funding: Not reported (SUPPORT)</td>
<td>Sample size: 565 Disease: Single disease: Kidney Disease Severity: Advanced Race: White Gender: Males</td>
<td>Exposure: Pts enrolled in SUPPORT. Outcomes: Predictors of decisions to withhold or withdraw dialysis. Duration: Between 2 and 7 days after study enrollment Withdrawals: Not reported</td>
<td>Results: Dialysis withheld associated with older men with a cancer diagnosis.</td>
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Evtab5. OS Advance Care Planning


