



Advance Care Planning Talking Points

The Advance Care Planning provision (section 1233) in the House's health care reform bill is about making YOUR choices known, and having the necessary tools to share those wishes. A great deal of misinformation has been voiced causing confusion among the public. Here are some talking points based on analysis of section 1233 from NHPCO.

The consultation provision gives patients information that will help them make their own informed decisions about their care:

- ◆ It covers the broad spectrum of care and options when facing a life-limiting illness;
- ◆ The consultation is with a physician, physician assistant or nurse practitioner—and in many cases may be the same health care professional the Medicare beneficiary has been seeing for years.
- ◆ Research has shown that patient discussions with their physicians results in a higher quality of life for patients and family caregivers.

This consultation would be voluntary, it is not required:

- ◆ It would be reimbursable under Medicare, just like other Medicare consultations.
- ◆ Beneficiaries could elect to have the consultation once every 5 years or when they face an important health situation.

Discussing advance care planning before a Medicare beneficiary finds him or herself in a medical crisis will help ensure the patient gets the care that he or she wants.

- ◆ One of the most frequent comments from family caregivers that hospice providers hear is "Why didn't we know about this sooner?" Hospice is just one option that would be discussed in an advance care planning consultation but this would ensure patients and family caregivers knew about it earlier.

The provision has bi-partisan support in Congress.

- ◆ Additionally, the 1991 Patient Self-determination Act already allows for advance care planning and stresses the importance of the patient's wishes—so this isn't necessarily new, it would now be more readily available to Medicare beneficiaries.

What the advance care planning consultation is NOT about...

- ◆ It's not about limiting care;
- ◆ It's not about hastening death;
- ◆ It's not about having choices made for the patient; and
- ◆ It's not about saving money.

This provision exists to ensure American have the tools to make their wishes known and to assist health care providers in honoring these wishes.

What is Advance Care Planning: Here is some helpful background information.

Advance care planning does involve...

- ◆ Understanding your possible future healthcare choices.
- ◆ Thinking about your choices in light of what is important to you and your values.
- ◆ Talking about your decisions with loved ones and your doctors.
- ◆ Writing down your plans in Advance Directives so they will be ready if needed.

It's important to remember that...

- ◆ Your plans and advance directives can be changed as your situation or wishes change.
- ◆ Advance care planning is done over time and not a single conversation.
- ◆ Decisions like these are best considered before there is a health crisis – and changes to your plans can be made at any time.
- ◆ Planning ahead for your healthcare – now, while you are able to – is a gift you can give to yourself and to those you love.

ADVANCE CARE PLANNING CONSULTATIONS

Section 1233 (pages 424-434) of the House Ways and Means Committee version of health care reform contains a new Medicare provision to allow coverage for an "Advance Care Planning Consultation". This provision is intended to offer Medicare beneficiaries an opportunity to engage in an informed and focused conversation with their health care practitioner about advance care planning options.

This consultation would be in addition to the "Welcome to Medicare" physician consultation.

This consultation, like other consultations within the Medicare system, would be voluntary and would be reimbursable under Medicare when provided no more than once every five years, or whenever a patient undergoes a qualifying event, such as a life threatening or terminal diagnosis, chronic disease diagnosis; or admission to a long-term care facility, a skilled nursing facility, or a hospice program.

Topics that are covered, during the consultation, include:

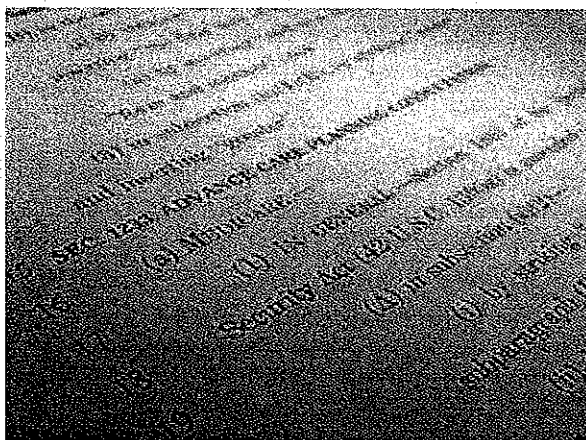
- An explanation by a physician, nurse practitioner or physician's assistant of advance care planning, including key questions and considerations, important steps and suggested people to talk to.
- An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses.
- An explanation by the practitioner of the role and responsibilities of a health care proxy.
- The provision, by the practitioner, of a list of national and state-specific resources to assist consumers and their families with advance care planning, including the national toll-free hotline, the advance care planning clearinghouses, and State legal services organization.
- An explanation of the end-of-life services and supports available, including palliative care and hospice.

The consultation is not mandatory. No one is required to undergo the consultation.

Doctors Providing End of Life Counseling See Benefit in Current Controversy

TOPICS: AGING, MEDICARE, HEALTH REFORM, DELIVERY OF CARE

By Jessica Marcy
AUG 14, 2009



The paragraphs, buried deep in the 1,000-page House health reform bill, appear innocuous, but they have ignited a firestorm among critics predicting government-sponsored euthanasia.

The controversy, over proposed Medicare funding of end-of-life counseling, has come to epitomize some of people's deepest fears about the government's role in health care.

Yet physicians who work with patients on end-of-life planning say that while they are surprised and upset about criticism of the proposal, it has brought needed attention to what they view as a long under-funded and overlooked service. Jon Radulovic, vice president for communications at the National Hospice and Palliative Care Organization, says the dispute "is providing the end-of-life care community with an opportunity to talk about what good care is and the services that are available."

Section 1233 of the House bill would reimburse physicians for advance care planning consultations with any Medicare beneficiary, but it does not mandate the completion of any advance care directive or living will. The provision, advocates say, would pay for doctors to have those conversations while a patient is healthy and communicative rather than in the middle of a health crisis.

Much of the furor has centered on claims that the provision would give rise to 'death panels' and euthanasia, which experts have dismissed. But critics also have raised concerns about the vagueness and complexity of the language in the bill, asserting that it could be open to a wide interpretation and encourage government to play an excessive role in end-of-life issues.

Sen. Chuck Grassley, R-Iowa, the top Republican on the Finance Committee, vowed the panel would not

include such a provision in its much anticipated health care reform package. "I don't have any problem with things like living wills," he said. "But they ought to be done within the family. We should not have a government program that determines if you're going to pull the plug on grandma."

Dr. Ted Epperly, president of the American Academy of Family Physicians, often has advance end-of-life conversations in his work as a family physician and geriatrician in Boise, Idaho. He says the discussions can protect patients from having costly procedures done against their will.

He describes such conversations as sensitive and time-consuming since they delve into the "nitty gritty" details: whether patients want to use ventilators to breathe, defibrillation to restart their hearts or feeding tubes for nourishment. He says the discussions are best done with a trusted physician who has developed a relationship with the patients. Family members are also sometimes involved, he says.

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To start such a conversation, Dr. Diane E. Meier, an internist and director of the Center to Advance Palliative Care in New York City, says she asks her patients what they would want if they were hit by truck and in a coma or a situation where they were not expected to recover sufficiently to be aware of their surroundings. Some say they would want everything possible done to prolong life, but roughly nine out of 10 of her patients say they would want care to be focused on their comfort – not sustaining life – if their brain was not functioning, according to Meier.

Dr. Gene Rudd, an ob-gyn and senior vice president of the Christian Medical & Dental Associations, said such conversations are part of good health care and should be encouraged. However, he worries that the provision could require that physicians use standardized language to counsel patients.

"It's nothing novel here," he said. "The novelty is the government then may be deciding that it can say what ought to be said in those sessions, not the fact that they ought to have these sessions and these discussions. It's standard care."

Still, health professionals say, these discussions are too rare. That's largely because Medicare doesn't explicitly pay for the service, discouraging doctors from taking the time to talk with patients about the issues. Private insurance companies often base their own payment policies on Medicare's.

Currently, physicians generally classify the conversations under a funding code covering counseling and discussion of issues such as marital problems and depression associated with a job loss, Epperly says.

Medicare typically pays \$92.33 for a 40 minute consultation, which Epperly says "drastically underpays for the complexity and the importance of this discussion," adding that the creation of a new code – as called for in the House bill – would better value its importance.

Under the current payment system, Epperly notes, doctors could see five patients or complete a more lucrative procedure in the time it would take them to have an in-depth end-of-life consultation.

Meier, who also works as a professor of geriatrics and internal medicine at Mount Sinai School of Medicine, agrees: "It's time consuming, it takes skills and it is so poorly paid that it is basically an act of charity ... Physicians who are in a fee-for service environment legitimately cannot really afford to have" such conversations."

"In my view, (the House bill) is a small and mostly symbolic effort to redress that imbalance of which physician services get paid for and which don't," she says.

In addition to the payment issues, doctors often don't have such conversations because of time constraints and the sensitive nature of such talks. The shortage of primary care doctors has also contributed to the problem, experts say.

According to Epperly, as a result, only one out of five patients who should have such a consultation actually does.

Both opponents and proponents of the legislation acknowledge that it could produce significant savings. Studies show that 25 percent of the Medicare budget is spent on people during their final year of life – with 40 percent of that spent in the final month.

Opponents worry that the cost savings might give doctors incentives to discourage treatment when they talk with their patients. The non-profit policy group Americans United for Life posted the following statement on its Web site: "The provisions that address end-of-life issues must be amended to leave no room for an interpretation that would pressure healthcare providers to make decisions based on cost rather than best medical care."

Proponents say several studies show that having such conversations not only saves money but improves quality of care.

Researchers found patients with advanced cancer who had end-of-life care conversations with physicians had significantly lower health care costs in their final week of life while higher costs were associated with worse quality of care, according to a 2009 study published in the Archives of Internal Medicine.

In addition, hospice has been shown to improve quality of life and reduce costs during the end of life. Patients using hospice care save Medicare close to \$2,400 per beneficiary, researchers from Duke University concluded in a 2007 study. Meanwhile, research has found that hospice patients lived an average of 29 days longer than similar patients who did not enroll in hospice, according to a 2007 study in the Journal of Pain and Symptom Management.

Congress has waded into this issue before. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the Hospice Education Consult, which provides Medicare coverage for a one-time hospice consultation that examines end-of-life care.

However, in order for that consultation to qualify for payment, the patient must be diagnosed with a terminal illness and have a prognosis of six months or less to live. Also, the act did not create a unique funding code.

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They're not out to kill granny

Attacks on health care reform may unfairly harm valuable hospice programs fighting to retain their Medicare funding.

By The Denver Post

Posted: 08/10/2009 01:00:00 AM MDT

President Obama and Democratic lawmakers aren't hoping to save money by encouraging the terminally ill — or anyone — to die prematurely. Yet that is one of the unfortunate misunderstandings swirling around the heated debate over health care reform.

Worse, that misconception comes at a time when an important effort is underway to repeal cuts to Medicare, enacted by the Bush administration, that hurt those who care for terminally ill patients as they approach the end of life. Hospice-care providers could see cutbacks that average as much as 7 percent of their Medicare reimbursements for patients in the next few years.

The cuts would begin in October, and hospice professionals say the lost reimbursements would drive many smaller hospice operations in rural

Colorado out of business.

In these days of high deficits, government should save money when it can. But cutting funding to hospice care makes little sense since it actually saves money for the government and hospitals. A study by the Robert Wood Johnson Foundation, funded by Duke University, found that hospice care saves \$2 billion a year, or about \$2,300 in Medicare costs per patient.

As both of Colorado's U.S. senators have argued, Congress should overturn the coming cuts.

Though hospice care is growing and becoming better understood in our society, the palliative approach remains veiled in misconceptions.

Lawmakers have proposed in health-care reform legislation that Medicare cover consultations with terminally ill patients and explain the range of options beyond traditional, fight-to-the-last, curative care. That includes hospice, in which health care professionals work with patients and family to find ways to make the final days as pain-free and dignified as possible.

It does not include encouraging patients to give in and die in some misguided hope of saving money.

Hospice care also doesn't simply depend on painkilling drugs to accomplish its mission. Rather, it relies on teams of diverse professionals who work with patients and families so they can remain hospital-free as much as possible, and who provide education,

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physical therapy and counseling.

At any given time, as many as 25 percent of patients in a hospital intensive-care unit aren't expected to survive, Maureen Tarrant, president and chief executive of the Health One Sky Ridge Medical Center in Lone Tree, told us.

Those patients deserve to know about the full range of options available to them.

Meanwhile, Medicare reimbursements cost taxpayers \$147 million for care that covers the last year of life, and a third of that is for the last month of life, says Bev Sloan, Denver Hospice's chief executive.

Investments in programs that help patients and their families make informed decisions do far more than help save money; they also help families and patients deal with the difficult emotions that come with a life nearing its end.

Choosing either a curative or palliative course is a personal and individual decision. But our society should do its best to understand and respect either choice, and provide both types of care as responsibly as it can.

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