



FLORIDA HOSPICES AND PALLIATIVE CARE

THE HOSPICE E-NEWS

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ARTICLE ADDRESSES PALLIATIVE CARE'S ROLE IN NATIONAL HEALTHCARE REFORM

“Palliative Care Seeks its Home in National Health Care Reform,” in the current *Journal of Palliative Medicine*, is by Dr. Diane E. Meier, director of the Center to Advance Palliative Care at Mt. Sinai School of Medicine, and Larry Beresford, a freelance health care journalist. They say, **“Palliative care professionals have experience-derived insights that could help inform the larger national conversation underway about health care reform.** Evidence is growing that palliative care adds value in such areas as patient-centered care, chronic disease management, care coordination, and helping patients make complex treatment choices that honor their needs and wishes.”

But what is the entry for those professionals into the current debate about healthcare reform? Meier and Beresford say, **“Leaders in the field agree that palliative care has much to contribute to the larger process, but whether we will be able to contribute our insights on their merits—or find a way to mobilize our political capital and claim a seat at the table where reform is planned—remains to be seen.”**

Dr. Howard Tuch, health policy fellow of the Hospice of the Florida Suncoast and chair of the American Academy of Hospice and Palliative Medicine (AAHPM) public policy committee, says, **“You hear a lot of people in Washington these days talking about the problems of end-of-life care, but they don’t mean the same thing that we do. They talk about the end of life in the context of the last two years of a Medicare beneficiary’s life, the disproportionate costs and geographic variations of their medical care, and how to bring those costs under control. Policy makers are asking in a general way what on earth can be done about this problem, but they don’t necessarily think of palliative care as a solution.”**

“Members of Congress and staff on the committees where health care reform legislation will emerge generally are more familiar with hospice than with palliative care,” a Congressional aide who was interviewed for the article says. She adds that the current debate on reform will not focus on payment or provider categories, but on accountability for the kind of care that patients receive. **“The concept of palliative care makes absolute sense within the larger continuum of care and approaches such as episodes of care or the bundling of hospital and postacute care,”** she says. **“But this has to be broader than Congress. Congress isn’t going to stick its neck out for something the public isn’t clamoring for.”**

Tuch says that the palliative care field isn't as clear as it needs to be on what it's asking for in healthcare reform. AAHPM "is working through its public policy and research committees to translate our practice, research, and training priorities into a specific advocacy, and legislative agenda," he says.

Dr. Charles von Gunten, of the Institute for Palliative Medicine at San Diego Hospice "believes that palliative medicine has great relevance to efforts to reform the health care system." He says, "We need a solid plan for what we want to do... We also need to avoid the trap of preciousness, believing that we're wonderful for doing God's work for those poor dying patients." **Von Gunten "calls it a mistake to present palliative care as an alternative -- since it should be considered mainstream, high-quality health care."** He concludes, "To me it's all about being willing to think big enough. Palliative care could influence every corner of the health care system. We just need to own it, and boldly step forward."

The article includes updates on health care reforms, advocacy tips and more on where palliative care fits in and what experts in the palliative care field want. (*Journal of Palliative Medicine*, 2009;12(7):593-597)

PAIN NOTES

- * **Last week, the FDA approved Onsolis, a pain medication designed to help with breakthrough cancer pain.** Onsolis is an absorbable film that is worn on the inside of the cheek. Because Onsolis delivers fentanyl, which can be abused, Onsolis was approved with a Risk Evaluation and Mitigation Strategy (REMS). The REMS requires that it be available through a restricted distribution program which requires both patients and pharmacies to register to participate. (*FDA News Release*, 7/16)
- * **The most recent issue of the American Pain Foundation's *Pain Monitor* focuses on the recent FDA action regarding acetaminophen.** It refers readers to the APF FAQ at www.painfoundation.org/QandA/Acetaminophen&Opioids.pdf. It also contains a link to its position statement on the FDA ruling which requires additional warnings on OTC pain relievers, at www.painfoundation.org/PositionStatements/PS042909_FDARulingOTC.pdf. (*Pain Monitor*, 7/2009)
- * **Your mother might not approve, but using your favorite curse words may help you cope with pain.** A study originally published in *NeuroReport* tested how long college students could keep their hands immersed in ice water. One group could repeat their favorite expletive, while another could only chant a neutral word. **The volunteers who swore lasted about 40 seconds longer and reported less pain.** *Scientific American* says, "How swearing achieves its physical effects is unclear, but the researchers speculate that brain circuitry linked to emotion is involved. Earlier studies have shown that unlike normal language, which relies on the outer few millimeters in the left hemisphere of the brain, expletives hinge on evolutionarily ancient structures buried deep inside the right half. One such structure is the amygdala, an almond-shaped group of neurons that can trigger a fight-or-flight response in which our heart rate climbs and we

become less sensitive to pain. Indeed, the students' heart rates rose when they swore, a fact the researchers say suggests that the amygdala was activated.” (*Scientific American*, 7/12)

PUBLIC POLICY NOTES

* **Representative Artur Davis, (D-Alabama) recently introduced the Medicare Quality Cancer Care Demonstration Project Act of 2009 (Bill HR 2872).** The bill would establish a national demonstration project to “improve the quality and cost effectiveness of cancer care to Medicare beneficiaries,” and would “authorize Congress to direct CMS to implement the *Quality Cancer Care Demonstration (QCCD) project.*” Dr. Patrick Cobb, president of the Community Oncology Alliance, said, “The Quality Cancer Care Demonstration project offers a means of moving forward immediately, and an architecture for a solution to the current crisis in cancer care.” (*US Fed News*, 7/17; *PRNewswire*, 7/8)

* **Massachusetts is considering a healthcare payment system that will reward doctors and hospitals for practicing preventive care.** A state panel proposed a plan that “would replace the existing fee-for-service system with one that compensates providers ahead of time for the care their patients will likely require over the course of a given contract period, such as a month or year.” **Lynn Nicholas, president of the Massachusetts Hospital Association, said that the state “shouldn’t lose focus on more immediate cost saving measures like medical malpractice reform and better practices around end of life care.”** (*AP*, 7/16)

* **Donald H. Taylor, Jr., of Duke University’s Sanford School of Public Policy, says that those who oppose the proposed public option for health insurance in the belief that government insurance doesn’t work are wrong.** Taylor cites the role of Medicare in promoting hospice care in this country, and says, “Most private insurance companies followed the lead of Medicare and now cover hospice services for their terminally ill customers, because hospice has been shown over and over to improve quality of life for patients and families who are in very trying circumstances.” **He adds, “Medicare coverage of hospice helped transform a group of idealists into a plausible industry with many for-profit providers, one that has done much good.”** The article is online at www.newsobserver.com/opinion/columns/story/1610496.html. (*The News & Observer*, 7/17)

* **The White House is drafting legislation that would shift the control of Medicare rate adjustments from Congress to an independent executive agency.** The primary role of the agency would be to set payment rates for Medicare Parts A and B through issuing two annual reports. Congress would be able to block those proposals within 30 days, and the president would have veto power over the agency’s actions. The current Medicare Payment Advisory Commission (MedPAC) has only advisory powers. (*McKnight’s Long Term Care News*, 7/17)

* **California Congresswoman Susan Davis (D) recently met with medical experts at San Diego Hospice and The Institute for Palliative Medicine to discuss “threats to**

quality patient care services, ... support for education and evidence-based research in palliative medicine.” Another issue the group discussed was “the government’s role in paying for the medical training of specialists in the new specialty of hospice and palliative medicine.” (*East County Magazine*, 7/15)

* An “Opinion” article in *The Spokesman-Review* says that the \$1 billion in stimulus money that has gone for research into best practices for a number of diseases is warranted, “because the rising cost of health care affects us all. Cost-benefit analyses and adhering to best practices are vital to reining in health-care inflation. We must set priorities and closely scrutinize spending on procedures and treatments with low chances for success. This is especially true with end-of-life care and heroic measures to save extremely premature babies. In some cases, extending care to all would mean limiting care for some. These are hard choices, but we can’t avoid them.” (*The Spokesman-Review*, 7/19)

HOSPICE & PALLIATIVE CARE NOTES

* A recent study from Governors State University in Illinois found that the knowledge of hospice exhibited by caregivers of minority elderly hospice patients “increased access to hospice among minority patients who otherwise would not opt for hospice or enroll too late for comprehensive hospice care services. Furthermore, the highest level of knowledge—acquired through caregivers’ health care occupations—appears to influence hospice care after hospice enrollment. Caregivers with that level of knowledge made requests for changes in site of care and/or additional services that may enhance the quality of hospice care that their loved ones receive.” (*American Journal of Hospice & Palliative Medicine*, 2009;26(3):165-171)

* A University of Utah study of the motivation of hospice volunteers found, “in order of overall importance: to help others and learn, foster social relationships, feel better, and pursue career goals. Younger volunteers reported stronger career motivations, and retired and unemployed volunteers reported stronger social motivations. Volunteer coordinators should consider these motivations in communicating with potential and current volunteers, with special emphasis on compassion for those in need and the importance of helping, on fostering hospice volunteering as a learning experience, and in accessing and building social networks around hospice volunteering.” (*American Journal of Hospice & Palliative Medicine*, 2009;26(3):188-192)

OTHER NOTES

* In *Newsweek*, “One in Sickness, One in Health” examines the issue of deathbed marriages. One clinical psychologist says, “It takes some of the pressure off because you will not have to live up to the expectations of what it's like to be married on a day-to-day basis.” And according to the article, “Planning a wedding also gives the terminally ill something to look forward to: a little bit of hope and wonder in what is otherwise the

grimmiest hurry-up-and-wait scenario possible.” Such planning can “improve patients’ moods and, sometimes, their prognosis,” as well as possibly providing closure. See the article by searching www.newsweek.com for “deathbed” without the quotes. (*Newsweek*, 7/09)

* In response to a recent *JAMA* article, “Religious Coping and Use of Intensive Life-Prolonging Care Near Death in Patients with Advanced Cancer” (*JAMA*, 2009; 301(11):1140-1147), writer Tomer Trevor Levin objects to the wording of end-of-life goals of care. Levin, of Memorial Sloan-Kettering Cancer Center, says, “Preferences for heroics’ and ‘do everything possible’ ... are value-loaded medical metaphors that are prone to misperception. A physician may understand that they refer to futile end-of-life treatment or cardiopulmonary resuscitation, but a patient may not have this shared perspective. ... Patients may interpret the opposite of ‘heroic’ as cowardly, and the opposite of ‘doing everything’ as ‘doing nothing.’ Would patients prefer a physician who uses heroic measures or cowardly measures? Would patients prefer a physician who is willing to do everything for them or a physician who only goes halfway on their behalf?” (*JAMA*, 2009;302(3))

* In the *Journal of Palliative Medicine*, the reviewer of *The Lonely Patient: How We Experience Illness*, by Dr. Michael Stein, calls this an “exceptional” book. Speaking of the reader, reviewer Dr. Elizabeth J. Collins says, “Not only will he or she be put in the shoes of the patient, he or she will also be the doctor, the family, and the stranger in the hospital elevator.” Collins laments the lack of references in the book, but says, “I highly recommend this book to caregivers, physicians, nurses, anyone with patient contact. I also think families of patients with new or chronic illness would benefit greatly, as Stein enables each of us to ‘walk in their shoes.’” (*Journal of Palliative Medicine*, 2009;12(6):567)

* A long article in *The New York Times*, “Why We Must Ration Health Care,” examines ways of valuing human life when examining healthcare costs. Author Peter Singer, professor of bioethics at Princeton University, asserts that healthcare is already rationed, either by what your employer can afford to buy for you in the way of insurance, or, in the public sector, by “long waits, high patient copayment requirements, low payments to doctors that discourage some from serving public patients and limits on payments to hospitals.” Singer notes that even countries where the government limits health care coverage, such as Canada and Britain, enjoy higher levels of confidence in their health care systems (73% each) than does the United States (56%). (*The New York Times*, 7/15)

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