



compassion & choices

Support. Educate. Advocate. Choice & Care at the End of Life

## ***Breaking Down Barriers to Quality End-of-Life Care***

*Why we support Medicare Reimbursement for End-of-Life Consultation*

Funding “The Conversation” Ensures Patient-Centered Care and  
Freedom From Unwanted Intervention

Serious illness, death and dying are difficult subjects to talk about for individuals, their families, and health care professionals. Americans procrastinate when it comes to matters involving death and dying. Too little discussion takes place between patients and their physicians regarding end-of-life treatment preferences. Only half of terminally ill patients have conversations with their physicians regarding end-of-life treatment choices, such as hospice care or other end-of-life care preferences (*Archives of Internal Medicine*, 2009;169 (10):954-962).

Poor communication about end-of-life care preferences can often cause distress for both patients and their families. Without such communication, patients and families may feel abandoned. As individuals approach the end of their lives, more can and should be done to educate them about treatment choices. Health care should focus on the needs and desires of the patient. HR 1898, the Life Sustaining Treatment Preferences Act of 2009, introduced by Congressman Earl Blumenauer (D-OR) and Charles Boustany (R-LA), would provide coverage under the Medicare Program for consultations regarding physician orders for life-sustaining treatment (POLST). This conversation helps individuals communicate with their health providers about what care they do, or do not, want to receive.

These conversations lead to orders containing the individual’s treatment decisions, signed by a physician, that follow the person through all end-of-life health care settings. A decade of research has demonstrated that orders for life-sustaining treatment effectively convey treatment preferences, guiding medical personnel to provide or withhold interventions. Without such medical orders, emergency medical personnel may be required to provide treatments that are not consistent with the individual’s preferences. Without Medicare reimbursement, and other constructive steps, these conversations are much less likely to occur.

HR 1898 will lay the groundwork so all seriously ill Americans have the tools to make informed medical care decisions, convey their care plans as clearly as

possible, and feel confident their wishes will be known and respected by health care personnel. These tools will help the dying choose between acute care and hospice care, avoid unwanted medical interventions, and do a much better job of explaining why and when to choose hospice care.

An estimated 90 million Americans live with serious and life-threatening illnesses. That number is expected to more than double over the next 25 years as baby boomers age (*National Palliative Care Research Center*). Terminally ill patients who talk over end-of-life treatments with their doctors spend less money and do not die any sooner, but die more peacefully than those receiving aggressive care (*Archives of Internal Medicine, see above*). HR 1898 would authorize Medicare to reimburse health care professionals for time spent discussing patient preferences, and encourage discussion about all available treatment options available. It also creates a grant program to support the development and expansion of POLST programs, providing necessary resources to states and local communities.

Currently, the Medicare system pays billions of dollars for intensive, sometimes unwanted, medical interventions, but won't pay a doctor a few dollars to have a conversation with a patient and the family about their choices and expectations, and to engage the patient and the family to decide what they want to have happen.

As a result, there is often no planning for care at the end of life. If a crisis occurs, the patient can be subjected to unwanted, futile and often painful medical procedures. Such care does not reflect the individual's values, beliefs or informed choices, but is a "default" approach that kicks in when patients' wishes are unclear. It is time to modernize end-of-life care decision making to better meet the needs of patients and their families.

Medicare pays for acute care services provided to beneficiaries, but generally does not pay for informed discussions between beneficiaries. Such a discussion would allow beneficiaries to decide if they want such acute care in the last months and years of life.

### **Communication leads to better end-of-life care and more peaceful deaths**

Several recent studies have demonstrated the benefits of better end-of-life communication.

### **More information leads to better informed patient choice, improves quality of life for terminally ill**

A study of 323 cancer patients who had died found that those who had end-of-life talks were three times less likely to spend their final week in intensive care, four times less likely to be on breathing machines, and six times less likely to be resuscitated. “End-of-life discussions are associated with less aggressive medical care near death and earlier hospice referrals. Aggressive care is associated with worse patient quality of life and worse bereavement adjustment.” (*Journal of the American Medical Association*, 2008;300 (14):1665-1673).

Better end-of-life communication will benefit the most vulnerable elderly. Poor and minority patients are the least likely to have a discussion about end-of-life care with their physician. According to one recent study, about 49% of blacks and 43% of Hispanics had discussed end-of-life care preferences within four to seven months of their diagnosis, compared with 53% of whites and 57% of Asians. Most physicians find it easier to talk with a patient about chemotherapy options, than end-of-life choices and anxieties (*Archives of Internal Medicine*, see above).

### **Informed patients get more appropriate care, the care they want**

Billions of dollars are spent each year in the United State on intensive treatments for older patients in the last six months of their lives (*2008 Dartmouth Atlas of Health Care*). Terminally ill patients who talk with their doctors about end-of-life treatments can extend and improve the quality of life, and die more peacefully than those receiving aggressive care. Patients who have “The Conversation” tend to opt for effective palliative care in a hospice or at home, rather than wasteful treatments like emergency resuscitation, ventilators to breathe for them and movement to a hospital’s intensive care unit.

Dying individuals have the right to decide whether to stay in the acute care system or enter hospice care. The acute care system continues to aggressively treat patients up to the end of life, regardless of side effects that may shorten it, or make it unendurable. When death arrives, heroic measures are often used to try to wrest them back to life.

In the hospice care system, pain and anxiety are managed, appetite stimulants are given if needed, and patients receive the food and fluids they enjoy and that their body can handle. Patients are not forced to take treatments, and medications with side effects that they can’t stand, and which no longer can save their life, are withdrawn. Ironically, this is the care most likely to prolong your life and improve its quality. In hospice care, individuals can die peacefully without the trauma of heroic measures.

Hospice care is often more in line with what patients want. If it is, they can substantially reduce wasted expenses for many terminal illnesses. If half of the estimated 566,000 American adult cancer patients who died in 2008 had the end-of-life discussion, the projected savings would conservatively be \$77 million (*Archives of Internal Medicine, see above.*)

**Compassion & Choices** is a nonprofit organization working to improve care and expand choice at the end of life. As a national organization with over 30 chapters and 40,000 members, we help patients and their loved ones face the end of life with calming facts and choices of action during a difficult time. The organization is non-judgmental, affirmative and inclusive. Learn more at [www.CompassionAndChoices.org](http://www.CompassionAndChoices.org).