

From the Editor

End-of-Life Care



Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD

As the Founding Executive Director of the University of the Sciences in Philadelphia's Health Policy Institute, Dr. Stefanacci is building on his recent tenure as a Centers for Medicare and Medicaid Services (CMS) Health Policy Scholar. In that role, he spent a year working on policy development and implementation of the Medicare Part D Pharmacy Benefit, particularly regarding access issues for frail elders.

Dr. Stefanacci has a long and passionate history in long-term care (LTC). Having served as medical director for several nursing facilities and continuing care retirement communities, he is well versed in the needs of LTC facility residents. Additionally, Dr. Stefanacci's geriatric experience includes over a decade as a medical director of a large primary care private practice, a full risk provider group, a Medicare + Choice (M+C) HMO, and a Program for All-inclusive Care for the Elderly (PACE) initiative in Philadelphia.

A graduate of A.T. Still University, Dr. Stefanacci completed his clinical training at the University of Medicine and Dentistry of New Jersey in Internal Medicine and a fellowship in Geriatrics at the same institution.

Dr. Stefanacci serves on the board of trustees at A.T. Still and previously for the National PACE Association. He also is an active member of the American Medical Directors Association (AMDA), American Society of Consultant Pharmacists (ASCP), and American Geriatrics Society (AGS). Recently, he was recognized as a American Geriatrics Society Fellow (AGSF). In addition to writing and lecturing extensively, Dr. Stefanacci serves on the editorial boards of *Caring for the Ages*, *LTC Interface*, *Jefferson's Health Policy Newsletter*, and *The Journal of Quality Healthcare*.

From the day we are born, we can count on one simple fact: just as there is a beginning to life, there will be an end. As Medicare providers, our job is not only to make life last as long as possible, but just as importantly, to help ensure that the quality of life be as healthful as possible. Several years ago, the focus of medical science was primarily concentrated on extending life expectancy at all cost. Feeding tubes and lengthy stays in the intensive care unit characterized the last days of life for many seniors. More recently, the focus has shifted to improving the quality of life and the dignity of dying, rather than simply prolonging the inevitable.

Much of this issue of *Medicare Patient Management (MPM)* is dedicated to end-of-life care, with a focus on how to best improve the quality of this care. Not surprisingly, some of its content covers the important topic of hospice care, which despite its tremendous benefits, is still underutilized. In addition, this issue includes a discussion on acquiring experience that can be utilized to improve the process of delivering end-of-life care.

Hospice Care

The term "hospice" can be traced back to medieval times when it referred to a place of shelter and rest for weary or ill travelers on a long journey. The name was first applied to specialized care for dying patients in 1967 by Dame Cicely Saunders, MD, who founded St. Christopher's Hospice—the first modern hospice—in a residential suburb of London, England. Dr. Saunders introduced the idea of specialized care for the dying to the United States during a 1963 visit to Yale University. Given to medical students, nurses, social workers, and chaplains, her lecture about the concept of holistic hospice care included photos of terminally ill cancer patients and their families, and showed the dramatic differences before

and after symptom control (ie, palliative) care. This lecture launched a chain of events, which resulted in the development of hospice care as we know it today.

It was not until 1979 that the Health Care Financing Administration (HCFA), now referred to as the Centers for Medicare and Medicaid Services (CMS), initiated demonstration programs at 26 hospices across the country to assess the cost-effectiveness of hospice care and help determine what a hospice is and what it should provide. It took

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an additional 7 years before the program became permanent as the Medicare Hospice Benefit.

As you will read in this issue of *MPM*, all too often, hospice is not utilized early enough in the end-of-life process. Hospice should be considered when the treatment goals have changed from curative to palliative care. It is important to remember that hospice is not only able to assist in the management of pain and other symptoms in a patient's home, but also may provide emotional and spiritual support to both the patient and their family.

Medicare pays for hospice care under the Medicare Part A benefit. An attending physician and hospice medical director must certify that the patient has an advanced illness with a life expectancy of 6 months or

less. As with other benefits under Medicare Part A, medications needed to treat the underlying hospice diagnosis are covered.

The Legal Side

Besides the obvious quality-of-care issues that should lead physicians to strive for improvements in the delivery of end-of-life care, there are legal issues that need to be considered. Perform a search on the Internet for "pain management in the elderly" and the first entries to appear include a list of law firms more than willing to sue a clinician or institution for not providing appropriate end-of-life care, especially over the issue of pain management.

One such site states that, "Senior citizens are undertreated for pain far more often than younger patients. According to various studies, 40% to 80% of elderly nursing home residents suffer needlessly due to inadequate pain treatment." The site goes on to say that some health care professionals erroneously believe that the elderly are less sensitive to pain, give weak doses of pain medications in the fear that older patients cannot tolerate opioids, and that undertreatment of pain in an elderly patient is a form of elder abuse.

Ten states have laws that deal specifically with pain management. In California, for example, the Pain Patient's Bill of Rights (Health and Safety Code §§124960–124961) gives patients the right to request or reject the use of pain medications. The bill mandates that patients suffering from severe chronic pain be provided with proper treatment, including opiates, if appropriate.

Medicare Part D, the new prescription drug benefit, offers Medicare beneficiaries greater access to medications as a result of reduced out-of-pocket expenditures. Of course, this requires Medicare beneficiaries to enroll in a plan and then have their physicians' prescribe medications that can best treat their ailments and any associated pain. Understanding how this program works is vital to ensure access to medications that are deemed necessary. Providers who do not

understand this complex system will cause frustration for all involved, resulting in delays in gaining access to important medications for Medicare beneficiaries. Hopefully, previous writings in *MPM* on this topic have provided readers with the knowledge to navigate these waters.

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Delivering Results

To improve outcomes for Medicare beneficiaries during the last stage of their lives, an understanding of the opportunities that exist in the current health care system through programs such as hospice and Medicare Part D is a must for all providers. In addition, the development of new innovative programs based on patients' needs and desires is needed to improve outcomes for Medicare beneficiaries. It is widely acknowledged that, "Knowledge is power." The foundation for this knowledge is based on personal experiences and, hopefully, from reading and sharing ideas within the pages of *MPM*.



Richard G. Stefanacci,
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Letters

The Medicare D "Boondoggle"

As a retired Massachusetts community pharmacist for over 50 years, it is difficult for me to approve the Medicare D Prescription Plan in its present format and intent.

Medicare D has been endangered by allowing the pharmaceutical industry and the insurance companies to set their own prices and agenda without oversight by the present administration and its staunch supporters in Congress. They have been given the power to charge what they want and remain the highest priced purveyors in the world of necessities of life, medications that are used to maintain and keep many of us alive.

They not only can set the prices but declare what is available and what is not. Doctors will no longer be able to prescribe what they think is the best medication for the patients. They will have to conform to the dictates of the pharmaceutical industry and insurance companies. It is well beyond the pale of what "the market will bear."

AARP, the most powerful advocate for the elderly, now must surely see what Medicare D really means to the seniors of today and the boomer generation in the future. It must use all in its power to remedy the "donut hole" and all of the other above-mentioned pitfalls.

In the language of our "Greatest Generation," "it is the biggest boondoggle that ever came down the Pike."

I must invoke my favorite quote of Harry Truman. More truer words have not been uttered. It is as apropos today as it was 60 years ago or more. "If you can't convince them, confuse them!"

Charles "Chuck" D. Gerstein
Pocasset, MA