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## Access to hospice care beneficial in final years

Saul Friedman | Gray Matters

August 9, 2008



I have a serious problem with those studies and stories that suggest Medicare is spending too much money caring for beneficiaries in their last two years of life.

The questions beg to be asked: How much is too much? Who wants to save money on the dying? And what's the alternative?

I would be afraid of the answers in our profit-driven, market-based health care system. Who hasn't heard what economist Dean Baker calls "granny bashing," the charge from billionaire conservatives like Peter Peterson that spending on older Americans and their "entitlements" - Social Security and Medicare - are "unsustainable"?

First of all, it's dishonest nonsense to put the two programs together; their purposes and financing are far different. They are neither "entitlements" nor welfare. Social Security, into which older Americans have spent a lifetime contributing, is self-sustaining. That's more than can be said for the billions poured into Bear Stearns or the sands of the Middle East, with no return, save the dead and ruined lives.



Saul Friedman

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Older Americans have also paid and continue to pay their way into Medicare with high premiums, co-pays and deductibles. If expensive private insurance companies got out of the way, Medicare could prosper and cover all of us.

More important, it is time to put aside the "myths of the high cost of old age and dying," which is the title of a report earlier this year from the International Longevity Center. The three physicians who wrote it concluded "limiting acute care for the very old would save only a small fraction of the nation's total health care bill. The proportion of Medicare spending [on] beneficiaries in the last year of life has remained stable over the past two decades."

Besides, they added, many older people (like me) who receive aggressive care paid for by Medicare enjoy years of fruitful and taxpaying living. And, "The older people are, the less likely they are

to receive aggressive care when dying."

In 1983 Medicare recognized the need and started paying for hospice or palliative care for the terminally ill, allowing them to end their lives in their beds at home. Medicare pays the cost of hospice care when a physician certifies the patient has six months or less to live; although hospice care can continue if the patient lives longer.

Medicare and its costs are not the problems, says Penny Hollander Feldman, director of the Center for Home Care Policy and Research and vice president of Research at the venerable Visiting Nurse Service of New York. Most patients in hospice don't last six months, she noted. The problem, she says, is that not enough home health care nurses are trained to deal with frail patients who need palliative or hospice care.

Patients "aren't fools," she told me, because they know when such care is needed, even if their doctors and nurses don't. And terminally ill patients are more comfortable at home than in a hospital, where nurses and doctors are trained to keep people alive by artificial machines, often despite the patient's wishes.

With help from a grant, Feldman and her team, have created a training program in Advanced Illness Management, as a model for home care nurses in New York to provide care throughout a person's illness, in consultation with the doctors, family and

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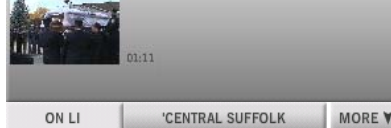


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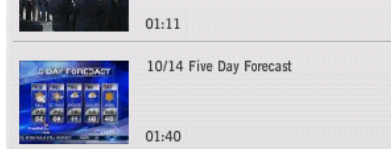
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the patient. Feldman said she hopes the model, which has been operating in Queens, can be used elsewhere in the country. She was in Washington recently to host a conference on improving geriatric home care.

Feldman also noted the health care system and too many nurses and doctors fail to confront the end-of-life issues. "We are working to train people to better understand palliative care," she said.

Palliative care, a relatively new medical discipline, is given when a dying patient and/or the family agree that aggressive, curative treatment should no longer be used. The patient is free to change these instructions.

Nurses trained in Advance Illness Management, who monitor patients throughout their illness, may consult with the patient and the family and intercede with the attendant nurses and doctors to determine when palliative and hospice care become necessary. Having seen hospice care at its best, I can't overestimate the comfort, information and skill the hospice nurse can bring to a patient and the family.

The New York Visiting Nurse Service, which gives home health care to 30,000 patients daily, is one of the largest and best-known hospice providers, with about 3,000 hospice patients each year. There are, of course, other hospice providers.

Despite the growth of the hospice movement and the desire of patients to die at home, more than 70 percent of patients die in hospitals or nursing homes, and too often, says Feldman, these frail and vulnerable men and women, receive poor treatment and die alone. Or the nursing home rushes the patient off to the hospital, where life and suffering may be artificially prolonged.

As a result, families and care givers should note, Medicare in early June issued new regulations that set out the rights of hospice patients. These are the first overhaul of the regulations since 1983.

Among other things, patients or their designated health care proxy have the right to choose their doctor and receive effective pain control. The regulations require better coordination of patient care, counseling, and taking into account the physical, psychological and spiritual needs of the patient "to ensure the personal well-being, comfort and dignity through the dying process." The regulations will take effect Dec. 2.

WRITE TO Saul Friedman, Newsday, 235 Pinelawn Rd., Melville, NY, 11747-4250, or by e-mail at saulfriedman@comcast.net.

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