

# The Bomba Letter

*Dedicated to the challenges of elder abuse and palliative care.*

**MEDAmerica**  
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## Welcome

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In New York State, the Palliative Care Information Act becomes effective February 9, 2011. This law requires physicians and nurse practitioners to offer terminally-ill patients, with a life expectancy of less than six months, information and counseling concerning palliative care and end-of-life options.

It is important to not confuse the requirements set by this new law and the broader context of palliative care. According to the National Consensus Project for Quality Palliative Care, palliative care is both a philosophy of care and an organized, highly structured system for delivering care.

Philosophically, palliative care affirms life and views dying as a normal process. The intent is to neither hasten nor postpone death. Palliative care provides relief from pain and symptoms, integrates psychological and spiritual care, uses an interdisciplinary team approach and provides a support system for the "family", as defined by the patient.

Palliative care aims to relieve suffering and improve quality of life for patients with advanced illness and their families and is offered simultaneously with all other appropriate medical treatment to manage the underlying illness from the time of diagnosis.

When I started practice in the late 1970's, providing care that focused on relieving suffering and improving quality of life was referred to as the "art" of medicine. I learned the basic pillars of palliative care from my patients, predominantly frail elders, who recognized my discomfort in speaking about death. They taught me that the care I provided needed to be focused on what was important to them, their personal goals for their care and the need to negotiate the goals for care over time.

As a result of the lessons learned from my patients, my most valued "teachers", I learned the value of both the science and the art of medicine. I also learned that nothing is as valuable in motivating behavioral change as storytelling.

Thus, I am honored to share an essay by David H. Klein, president and chief executive officer, Excellus BlueCross BlueShield, Rochester, NY published in Bloomberg Business Week on January 20, 2011. Mr. Klein shared his personal story in an essay, "Limits of Medicine". There are many lessons learned, including the value of shared informed medical decision-making from the time of diagnosis, a key element of palliative care.

The story highlights how difficult – as well as time-consuming – these conversations can be. In the Soap Box, I will address the removal of "Voluntary Advance Care Planning" from the Medicare Annual Wellness Visit and the need to focus on the real reform required in the reimbursement of these difficult conversations by CMS, including what is being done by Excellus BlueCross BlueShield to address the issue.

*Pat*

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## The Limits of Medicine

*David H. Klein, president and chief executive officer,  
Excellus BlueCross BlueShield, Rochester, NY*

Published in Bloomberg Business Week, January 20, 2011

In July 2008, my wife Linde was diagnosed with advanced squamous cell carcinoma of the oral cavity. Her subsequent treatment has led me to view American medical care from a different perspective. What Linde and I have learned over the past two years has broadened my fundamental beliefs about medicine. In sum, while amazing advances have been made and miracles are occurring, medicine is still very much an art.

I've spent nearly 40 years in the business side of the health care industry, including the last seven as CEO of a health plan. I believed my network of contacts would serve us well. I presumed there were unambiguous answers to questions about the best treatment plan and the best providers.

What I learned was that for uncommon diseases like Linde's, if not all diseases generally, clear answers don't always exist. I will never forget one doctor telling me that the information I sought was not available and that I would have to trust my gut. This is pretty incredible when you think about how much as a society we spend on health care.

The new federal health care reform law promotes the adoption of health-information technology and supports comparative effectiveness research to understand the marginal contributions of new drugs, devices and procedures. But what we learned with Linde's treatment is that data on innovations, especially for less common diseases, isn't sufficient to broadly create evidence-based medicine.

### Risk Adjustments

Often medical research, even when coordinated and summed across the industry, does not have enough patients suffering with a particular disease to test alternative treatments using scientific -- trial and error -- methods. I can't tell you how many times I heard from physicians that every patient is different.

The same deficiency exists for assessing a practitioner's expertise with a particular treatment for a disease. To evaluate a doctor or treatment, it's necessary to risk adjust for differences in patients. Generally, it's more challenging to care for an older patient than a younger one. Similarly, treating patients with diabetes are more difficult than those without. There are a myriad of risk factors and standardizing for them is difficult if not impossible.

This has implications for what we call consider the best places to receive care and how doctor performance should be reported. We really don't want clinicians to avoid riskier cases to achieve better grades.

### Work in Progress

In the face of these limitations, clinicians often rely on their understanding of underlying disease processes to decide the best course of action. Leading medical organizations convene panels of experts to provide opinions about the most effective approach for diagnosis and treatment. The work of these panels is important, but sometimes their opinions are later found to be wrong.

The recently developed human genome provides promise for gaining disease process insight, but it's a work in progress.

Said in other words, there isn't as much hard science as one would like.

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## The Limits of Medicine

*David H. Klein, president and chief executive officer,  
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Published in Bloomberg Business Week, January 20, 2011

So what do we do? I wish there was an answer that offered real value. After all, I'm a business executive who runs a health plan providing benefits to thousands of employees. I'm also a taxpayer who supports government programs. Unfortunately, there are no such assurances, but there are steps we can take.

### Best Course

As a society, we need to be honest about treatment limitations. Patients should be well informed about what the industry knows and doesn't know. There should be candor about the likelihood that care will make them worse instead of better. Patients should be empowered to be the treatment decision makers.

In recognition of the uncertainty patients face, we need to compassionately acknowledge pain and fear. We need to counsel that aggressive intervention isn't always the best course of action.

I share these conclusions not to suggest dissatisfaction; Linde and I are grateful for her care. Her clinicians included our country's most respected doctors who did what they were trained to do -- to aggressively seek cure.

Rather, these observations are offered to challenge the U.S. health-care industry to be more explicit about medical treatment being as much an art as a science and to provide emotional and spiritual support to improve patient and caregiver experience.

### Course of Disease

There may be an economic benefit to this. As patients learn more about the limits of medicine, some may choose less intensive and costly care. As a nation, our health-care spending increases as patients near the end of life.

Since its onset, Linde's cancer has come back twice. The first time, she continued a courageous and valiant fight. The second time, she learned that further treatment would be painful, risky and probably leave her partially disabled and deformed. She was further told that the likelihood of having an extended, high quality life was remote.

With that knowledge, she opted for palliative care favoring quality of life over extending life. My acceptance of her decision, while difficult, was the best way I could show my love and support.

Linde commends her clinicians for being great teachers. They were candid, patient, used non-clinical terms, and shared their uncertainty about the effectiveness of suggested treatment. Their support of her as the decision maker was wonderful.

Linde and I have opted to share our journey because we hope the understanding of medicine we have developed will be helpful to others.

## Palliative Care

### Palliative Care Information Act NEW! New York State Public Health Law

The Palliative Care Information Act (Chapter 331 of the Laws of 2010) amended New York State Public Health Law by adding section 2997-c. Effective February 9, 2011, this law requires physicians and nurse practitioners to offer terminally-ill patients information and counseling concerning palliative care and end-of-life options.

Under the law, information and counseling concerning palliative care and end-of-life options must be provided to patients with an illness or condition that is reasonably expected to cause death within six months. Palliative care, as defined by the law, is "health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care." For further information, view [Palliative Care – Professionals](#) web page at [CompassionAndSupport.org](http://CompassionAndSupport.org).

### National Healthcare Decisions Day

Mark April 16, 2011 on your calendars for the third annual [National Healthcare Decisions Day](#) (NHDD)! The NHDD initiative encourages everyone 18 years of age and older to express their wishes regarding healthcare based on their personal goals for care and for providers and facilities to respect those wishes, whatever they may be.

Join the [NHDD New York State Coalition](#)!

### Social Media Update

For the latest end-of-life news, follow me on twitter at [Twitter.com/PatBombaMD](https://twitter.com/PatBombaMD) or "like" us on Facebook at [Facebook.com/CompassionandSupport](https://Facebook.com/CompassionandSupport).

I'm posting information to the sites on the latest news related to issues such as advance care planning, MOLST, the Family Health Care Decisions Act and the Palliative Care Information Act.

I created the Community Conversations on Compassionate Care Cause page to encourage initiating advance care planning early.

Facebook also created a [MOLST community page](#) that displays Wikipedia articles and related posts about MOLST.

We have created a CompassionAndSupport YouTube Channel: <http://www.youtube.com/user/compassionandsupport> that houses videos that are also housed in the [CompassionAndSupport Video Library](#).

I'll be using social media tools this year to better reach professionals and the public. Please let me know if you have any information that you'd like me to post to Twitter or Facebook.

## Soap Box

*Patricia A. Bomba, M.D., F.A.C.P., vice president and medical director, geriatrics  
Excellus BlueCross BlueShield, Rochester, NY*

"The art of living well and the art of dying well are one." This key element of Epicureanism, the school of philosophy founded by Epicurus, is embodied in the philosophy of hospice and palliative care.

Epicurus, an ancient Greek philosopher and founder of Epicureanism, believed the purpose of philosophy was to attain a happy, tranquil life, characterized by peace and freedom from fear, the absence of pain, and living a self-sufficient life surrounded by friends. He taught that pleasure and pain are the measures of what is good and evil; death is the end of the body and should therefore not be feared; the gods do not reward or punish humans; and, the universe is infinite and eternal.

His philosophy aligns with the teaching from my patients, who confronted me with my own mortality and taught me that we have one life to live, we all die and should be "in charge" of our own death. To be in charge at a time when we may lose the ability to decide and make medical decisions, it is critically important to begin the planning process early.

Encouraged by my patients in the early 1980's, I spoke with patients on a regular basis at the time of annual physical exams or periodic health exams. The framework for discussion after the exam was a review of the "[Ten Commandments for Healthy Living](#)." The tenth commandment focused on encouraging active participation in planning for future health care and long term care needs, engaging in conversation and completing an advance directive.

Over the years, multiple studies and further personal experience has affirmed what my patients taught me. When given the opportunity, people welcome the opportunity to talk, share their wishes, and plan for their death.

By incorporating a systems approach that framed advance care planning as a wellness initiative, I learned to focus the discussion based on the patient's behavioral readiness to participate in advance care planning. This helped improve the efficiency and effectiveness of the conversation. Further, this systems approach made it easier for everyone 18 years of age recognize their rights under the Patient Self-Determination Act. An approach that integrates behavioral readiness is the basis of the evidence-based, award-winning "Five Easy Steps" of the [Community Conversations on Compassionate Care \(CCCC\)](#) program.

The new [Annual Wellness Visit \(AWV\), Including Personalized Prevention Plan Services \(PPPS\)](#) originally included "Voluntary Advanced Care Planning" as part of the annual wellness visit, as defined in CMS MLN Matters MM7079:

Note: "Voluntary Advanced Care Planning refers to verbal or written information regarding an individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions and whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive."

## Soap Box

*Patricia A. Bomba, M.D., F.A.C.P., vice president and medical director, geriatrics  
Excellus BlueCross BlueShield, Rochester, NY*

Unfortunately, inclusion of voluntary advance care planning was withdrawn. Contrary to some reports in the press, advance care planning was not afforded a separate reimbursement. Rather, the new AWW identified Advance Care Planning as something to be discussed at the wellness visit, on a voluntary basis. This approach is consistent with federal legislation, the Patient Self-Determination Act. Indeed, this is what disappoints me most about the withdrawal by CMS.

We have been successfully framing advance care planning as a wellness initiative with providers, members and the community for nearly a decade. In our [End-of-Life Care Survey of Upstate New Yorkers: Advance Care Planning Values and Actions, Summary Report, 2008](#), 90% of Upstate New Yorkers (18 years of age and older) thought it was important to discuss.

Inclusion of voluntary advance care planning in the wellness visit in no way encourages the tough, thoughtful, time-consuming conversation or series of advance care planning conversations needed to ensure shared, informed medical decision-making when a seriously ill and/or frail individual chooses to complete a Medical Orders for Life-Sustaining Treatment (MOLST) form, New York State's approved POLST Paradigm Program. This is where major reform is needed.

While traditional Evaluation & Management (E&M) codes will cover advance care planning, the reimbursement is inadequate given the time spent. Further, non face-to-face (FTF) discussion with a health care agent, surrogate or family and telephone conversations are "non-covered benefits" under Medicare.

In November 2009, Excellus BlueCross BlueShield launched a program to teach physicians "how to have this tough conversation" and "how to get paid for it." Under a collaborative partnership with community physicians, Excellus BlueCross BlueShield created a reimbursement model for thoughtful advance care planning conversations that take into account the time spent in conversation. Our model covers non-FTF telephone conversations and conversations with health care agents, surrogates and family. For further details, view [Provider Training](#) in the [MOLST Training Center](#) on the community website, [CompassionAndSupport.org](#).

In summary, direct reimbursement for advance care planning is essential to support the time and effort required to effectively provide individualized person-centered care and thoughtful advance care planning discussions for seriously ill patients. These time intensive physician services are **NOT** covered by Medicare and should be. I will be working on expanding the model this year. I hope that CMS will look to do the same.

In New York State, the Palliative Care Information Act now requires physicians and nurse practitioners to offer terminally-ill patients information and counseling concerning palliative care and end-of-life options. While physicians may feel burdened by this new law, it may be helpful to recognize that caring for seriously ill patients approaching the end of life is the ultimate in professionalism. Physicians and health care professionals are provided an opportunity to help patients live well until their final breath, rather than merely waiting to die.

## 2011 Calendar of Events

*(Details on the events below will be posted on our [Events page](#) in the future)*

Feb 16 – 19	<b>2011 AAHPM Annual Assembly</b> , Vancouver, CA
Feb 23	<b>"Wild Ride: Ambulance History in the Empire State"</b> . G. W. Corner Society for History of Medicine at the Rochester Academy of Medicine. Rochester, NY
Mar 3 – 4	<b>2<sup>nd</sup> Annual Medical Director Leadership Summit: End-of-Life Care</b> , Miami, FL
Mar 31	<b>NYSHSA Housing/Assisted Living Conference</b> , Syracuse, NY
Apr 2	<b>Nancy Sills Memorial Lecture, Senior Citizens Law Day at Albany Law School</b> , Albany, NY
Apr 4	<b>Women of Spirit</b> , Church of the Transformation, Pittsford, NY
Apr 7 – 8	<b>Westchester/Southern Region Collaborative for Palliative Care Spring 2011 Conference – Carpe Diem: The Impact of Palliative Care on Practice, Policy and Essential Conversations</b> , Westchester, NY
Apr 11	<b>Advance Care Planning Presentation</b> , Valley Manor, Rochester, NY
Apr 16	<b>2011 National Health Care Decisions Day</b>
Apr 25	<b>MOLST Presentation</b> , Valley Manor, Rochester, NY
Apr 26 – 30	<b>2011 Aging in America Conference</b> , San Francisco, CA
Apr 28 – 29	<b>NYSHFA DON/Managers Conference</b> , NY
May 11 – 15	<b>2011 AGS Annual Scientific Meeting</b> , Landover, MD
May 15 – 18	<b>2011 Empire State Association of Assisted Living Conference</b> , Bolton Landing, NY
May 19 – 20	<b>New York Medical Directors Association Annual Meeting</b> , Albany, NY
Jun 16	<b>Muscular Dystrophy ALS Support Group Presentation</b> , Rochester, NY
Jun 23 – 24	<b>3<sup>rd</sup> Annual End-of-Life Care Leadership Summit</b> , Chicago, IL
Dec 2	<b>NYALTCA</b> , Syracuse, NY

If you know of other events related to Elder Abuse or Care at the End-of-Life, please [forward them to me](#), and I will add them to our calendar of events for the next edition of this newsletter. Thank you.

[Access archives of prior publications of "The Bomba Letter."](#)

For further information on Elder Abuse and Long Term Care, visit [Med America's website](#).  
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