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Chronic Kidney Disease ITC1

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PATRICIA A BOMBA MD FACP
10 WOOD STONE RISE
PITTSFORD NY 14534-3667



exceeds 50% at ages 40 to 49 years and remains greater than 25% up to age 74 years (5). Finally, our study does not address the use of diagnostic ultrasonography after inconclusive mammography as Dr. Schattner describes.

Brian L. Sprague, PhD
University of Vermont
Burlington, Vermont

Constance D. Lehman, MD, PhD
University of Washington School of Medicine
Seattle, Washington

Anna N.A. Tosteson, ScD
Giesel School of Medicine at Dartmouth
Lebanon, New Hampshire

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Can the United States Buy Better Advance Care Planning?

TO THE EDITOR: We found Halpern and Emanuel's article (1) provocative but not representative of the recommendations of the recent Institute of Medicine report, "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life" (2). Halpern and Emanuel state that "one of the [Institute of Medicine] Committee's central recommendations, to reimburse physicians for engaging patients in advance care planning, merits careful consideration." To clarify, the specific recommendations around clinician-patient communication and advance care planning focus on establishing quality standards for these concepts that are measurable, actionable, and evidence-based and recommend tying "such standards to reimbursement" (2).

Improving advance care planning and end-of-life communication is complex and cannot be addressed with a single central recommendation. Several changes must occur synergistically to move the needle on this issue. The 507-page re-

port recommends a multidimensional approach to improving advance care planning, including enhancements in professional training and education, system and policy change, and public engagement. It defines advance care planning as a process of planning and discussion that occurs over time, recognizes the limitations of the living will, and distinguishes advance directives from actionable medical orders. We direct readers to the life-cycle model of advance care planning presented in the report (2), which emphasizes a wellness-illness approach toward planning and normalizing conversations around end-of-life care. Such a model has been developed and implemented in New York (3-5).

Rather than acute care-based reactive models, advance care planning should occur long before the patient arrives in the intensive care unit, a time when many patients do not have the capacity to make medical decisions. Clinicians in upstate New York identified inadequate reimbursement as a barrier to end-of-life discussions. In response, Excellus BlueCross BlueShield developed a comprehensive reimbursement model for thoughtful discussions with seriously ill persons who might die in the next year coupled with well-informed, shared decision making which has led to completion of New York's Medical Orders for Life-Sustaining Treatment (MOLST).

This reimbursement model includes face-to-face time with the patient, discussions with the patient's family that may not take place in person, and care planning to support MOLST orders. Eligible clinicians (physicians, nurse practitioners, and physician assistants) are trained to conduct these discussions and enrolled in electronic MOLST (eMOLST), New York's electronic form and discussion completion system that serves as the state's registry. Use of eMOLST ensures that all clinicians who access this electronic registry in an emergency retrieve MOLST and documentation of the discussion, ensuring end-of-life care for patients and families that is consistent with their preferences.

Patricia A. Bomba, MD
Excellus BlueCross BlueShield
Rochester, New York

Salimah H. Meghani, PhD, MBE, RN
University of Pennsylvania
Philadelphia, Pennsylvania

Disclosures: Drs. Bomba and Meghani served on the Institute of Medicine Committee on "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life." Authors have disclosed no conflicts of interest. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=L15-0135.

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The Doctor: For Life and at the End of Life

TO THE EDITOR: I share Pizzo's concerns (1) about handing off patients and, in a sense, wiping our hands free as these patients enter a different phase of their life with their illness. I am a medical oncologist and have noticed a change in the past few years where the hospice programs seem to pressure me to hand the care off to the hospice palliative care physician.

I have always told patients that hospice will be my eyes and ears, but I will still be the captain of the ship. I now feel like this is a lie. Hospice services in my area do not seem to want me involved anymore, most certainly because of changes in reimbursement and the desire to control the utilization of palliative care.

I am concerned that my training that stressed continuity has been abandoned. We now hand patients off to hospitalists when they are sick and to hospice when they are dying—2 times when it seems that continuity would be most important.

Joseph Kash, MD
Edward Hospital
Naperville, Illinois

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TO THE EDITOR: Most persons in the United States will now die of multiple chronic conditions, with the timing of death being unclear until the last few days. Persons alive at 70 years of age face nearly 3 years of self-care disability in the last phase of their lives, with a series of private arrangements and health care supports. It seems that "palliative care" should not be mostly the province of specialists but a highly valued skill of virtually all physicians. Furthermore, it seems that Pizzo's comments (1) on the last part of life should focus more on nursing homes, home care, long-term care financing, continuity for persons living with disabilities associated with aging, and related topics. The Institute of Medicine report actually does address these issues, but they have not been discussed in the professional or public press.

Joanne Lynn, MD, MA, MS

Altarum Institute, Center for Elder Care and Advanced Illness
Washington, DC

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