

Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: I am Margaret Flinter.

Mark Masselli: Margaret, I would like to point out a recent study that couldn't make a better case for an overhaul of our nation's health care system. The study, led by a team of researchers at Columbia University, looked at health spending, behavioral health risk factors like obesity and smoking, and a 15-year survival rate for men and women ages 45 to 65 in both the United States and 12 other developed countries. What they found was that not only did the survival rates for American men and women in that age group fall over the past 30 years compared to these other countries. But that poor health care was most likely to blame, not the usual obesity or traffic accidents or high murder rates that we would normally associate as culprits for high mortality rates.

Margaret Flinter: Well, it is astonishing, Mark. And if you think about it, our country which spends twice as much on health care compared with other developed nations has poor health care to blame for decreased life expectancy. I am not sure there isn't more here that we will find beneath the surface of the research. One positive I will mention from this study though is that the United States had faster declines in smoking between 1975 and 2005 than almost all of the other countries. And you know, as well as I, from traveling in other countries, it is astonishing how much people are smoking in cities across the world.

Mark Masselli: That is true. I hope you can say the same about obesity rate some day soon. And this study couldn't provide more evidence for Health Reform to lead us in a better direction.

Margaret Flinter: Well, let's switch topics for now and introduce today's guest. We are going to delve into a subject that's being taught more and more about in health care. It's the subject that many of us even in health care should be better educated about. Dr. Diane Meier is a palliative care expert. She directs the Center to Advance Palliative Care and the Palliative Care Institute at the Mount Sinai School of Medicine in New York City. And we are happy she can join us today.

Mark Masselli: But no matter what the story, you can hear all of our shows on our web site Chcradio.com. You can subscribe to iTunes to get our show regularly downloaded. Or if you would like to hang on to our every word and read a transcript of one of our shows, come visit us at Chcradio.com. You can become a fan on Facebook and also follow us on Twitter.

Margaret Flinter: And as always, if you have feedback, email us at Chcradio.com. We would love to hear from you. Now, before we speak with Dr. Meier, let's check with our producer Loren Bonner for the Headline News.

Loren Bonner: I am Loren Bonner with this week's Headline News. The Department of Health announced a brand new investment in Community Health Centers under the Affordable Care Act. More than \$727 million in grant funds went to Community Health Centers across the country to upgrade and expand their facilities. HHS Secretary Kathleen Sebelius said, "Community Health Centers serve as a lifeline for many Americans."

Kathleen Sebelius: This is a critical piece of health care delivery. It is about people having a doctor and a nurse and practitioner, so they can go to, connect to their neighborhood.

Loren Bonner: The new funds will allow Community Health Centers to serve an additional 745,000 patients as well as provide much needed employment opportunities in both rural and urban underserved communities. The new grant money builds on a \$2-billion investment in Community Health Centers and the Recovery Act. HHS is looking out for workers who may lose coverage from their employers. Many companies say they may choose to drop employee health insurance benefits because of new rules which they believe will raise their cost significantly. HHS has granted waivers to 29 companies, including McDonald's, which made headlines when the chain announced that regulations could force it to strip workers off existing coverage. The waivers on the new rules phase out annual limits on coverage for limited benefit plans. It's flu season and the Centers for Disease Control and Prevention issued the nation's annual flu guidelines. However, Co-Assistant Secretary for Health at HHS says, "The new universal recommendation is based on lessons learned from last year."

The major message this year is this new universal recommendation that we are promoting. And last year, we learned that everybody is at risk that everybody is vulnerable. So a new recommendation that's very important for this season is that everybody six months and older should get the flu shot, should get it as soon as it's available in your community.

Loren Bonner: The agency said, "It's especially important that pregnant women, young children, health care workers, parents with infants and people with chronic conditions get vaccinated." A Michigan judge became the first to rule that the health care law is constitutional. A Christian legal center based in Ann Arbor, Michigan filed the lawsuit against the health care legislation. It is just one of dozens of lawsuits being brought nationally in opposition to the health care law. In a more high profile lawsuit that involves 20 states, a Florida judge is expected to rule later this week on whether the multi-state suit against the health care overhaul can proceed. Another case filed by the State Attorney General in Virginia is scheduled for a hearing on October 18th. All cases involve the question of whether the constitution gives Congress the authority to require that every American citizen carry health insurance.

This week on Conversations, we are discussing palliative care which involves improving the quality of life for patients and families facing serious illness. Most hospitals have a palliative care program available but it's rare that a patient could find this type of care in the hustle and bustle of an emergency room. Dr. Tammie Quest, a palliative and emergency medicine doctor at Emory University Hospital in Atlanta wants that to change.

Tammie Quest: If you look at the statistics for hospice and end-of-life care in the country, about 2.4 million people die each year and just under a million people a year get hospice care. All the other people that do not get hospice care and do not achieve the home doctor, a non-institutional, that often are the patients we see in the emergency department.

Loren Bonner: Quest who is also the director of the Center for Palliative Care at Emory University says, "The ER serves as an entry point for many people with serious, acute and chronic life-threatening conditions."

Tammie Quest: Emergency clinicians will be required to deal with physical, spiritual, psychological and social aspects of care as in interfaces in the emergency settings.

Loren Bonner: While the collaboration between emergency medicine and palliative care remains rare, it's a growing concept as both fields seek to create a more patient-centered approach to emergency care for the seriously ill or dying. So far, only a handful of hospitals around the country have implemented this kind of program but Quest is confident others will catch on. She is currently working on a new project in conjunction with Northwestern University where they have taken the palliative care curriculum and modified it for emergency clinicians. Today, the project has trained over 140 emergency clinicians from all over the country. These clinicians act as teachers for others or, as Quest puts it, change agents who will create new cultural norms in the emergency care system. Let's turn now to our interview with Dr. Diane Meier who can tell us more about palliative care.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Diane Meier, Director of the Center to Advance Palliative Care and the Palliative Care Institute at Mount Sinai School of Medicine in New York City. Welcome Dr. Meier. It's been almost 40 years since the first hospice was built in the United States and we are proud to say that it was done by Connecticut's own Florence Wald who brought the idea from St. Christopher's in London back to the United States. But the term "palliative" is newer and perhaps not well understood by folks outside of health care. Can you first describe what palliative care means and how is it different from the original concept of hospice care?

Diane Meier: Both excellent questions. Palliative care is a form of medical treatment that is focused on the patient and the family's quality of life. So

specifically, palliative care experts pay attention to symptoms like pain or shortness of breath or depression or fatigue. We pay attention to making sure that patients and families have all the information they need to make the best decisions for themselves, so there is a big focus on communication and adequate time spent, getting your questions answered and understanding what your situation is and what your choices are, and the pros and cons of your choices for you personally and for your family. And then the third component is making sure that no matter where you are getting care, whether you are at home, whether you are in a hospital, that all the decisions that you make are followed and honored no matter where you are getting your care, so that there is real continuity. And I think the important distinction between palliative care and hospice is that hospice in the United States, thanks to Florence Wald and Dame Cicely Saunders and others, is actually now a federal Medicare benefit. There is a Medicare hospice benefit. And when policy makers wrote the law allowing Medicare to pay for hospice care, they were very concerned about cost. And in order to reduce the costs of the hospice program, they set up two very restrictive eligibility criteria for getting hospice care. The first was that the doctor had to say you are likely to be dead within six months if the disease followed its usual course. So it assumed that you could identify people who were likely to be dead in six months from people who weren't, and that was the faulty assumption. But also, it assumed that patients and families were willing to be labeled as terminally ill, willing to accept the label of dying which for most of us is not something we are particularly interested in. And the second restriction on access to hospice is that you, the patient, actually had to agree to give up insurance coverage for treatment focused on cure or life prolongation. And I don't think it will come as any surprise to this audience and most of us want to live as long as we can and we don't want to give up any treatments that might potentially help us to do that. So as a result, hospice has become a treatment of last resort for people in the very last week to months of life. In fact, the typical length of time in hospice is actually less than a month in this country even though it's supposed to be a six-month benefit. So the problem there is that hospice has been really restricted to people who are very close to death, who are clearly actively dying or in the last few weeks of life. Unfortunately, way before that time, most patients with chronic disease or serious or advanced illness have major palliative care needs but they are not ready for hospice. They are not dying and they are still benefiting from treatment. So the palliative care field grew up in response to the need of people for palliative care who were not eligible for hospice because they were not yet dying and they were not ready to give up beneficial treatment that might help prolong their life or cure them.

Margaret Flinter: Well, thank you very much for clarifying that. And let me ask you, Dr. Meier, the name of the Center to Advance Palliative Care implies there is a need to move this idea or approach to managing serious or terminal illness forward. So tell us more about this. Is it the art and the science of the care itself that needs to be advanced or is it attitudes and responses to the idea of palliative care that you are working to advance at the center.

Dr. Diane Meier: All of the above. The Center to Advance Palliative Care works to improve public and professional awareness and understanding of palliative care and how it is not limited to the dying or the terminally ill but, in fact, is appropriate for people from the point of diagnosis of the serious illness. You may have seen some of the press in August around a study published in the New England Journal of Medicine that showed that lung cancer patients who got palliative care along with best cancer care from the day of their diagnosis live three months longer than patients who just got best cancer care and didn't get palliative care. So, actually, palliative care has not only been shown to improve the quality of life for patients and families with serious illness, there are now four different studies showing that it also prolongs life. And so we really need to understand that it's not terminal care, it's life-prolonging care that also improves quality of life. Many people say, "Well how could that be? How could care focused on quality of life actually prolong life?" And I think if you set back a minute and think about it, if you are miserable, you are in pain, you are short of breath, you are not sleeping, you are not eating, you are very tense and anxious and depressed, it's easy to understand how you would die sooner because you don't feel well and you can't function well, and all the normal things we do to keep ourselves well, you can't participate in because you feel too rotten. And the other reason that I think that palliative care has been shown to prolong life in a number of different settings is it helps to avoid dangerous places like hospitals and emergency departments unless you really need to be there for a surgical procedure, for example. The risk of being in the hospital when you are pretty sick and your immune system is not up to its normal level is quite high of hospital-acquired infections and other types of hazards of being in the hospital. So I think part of the reason that people live so much longer with palliative care is that palliative care teams meet patient's and family's need so they don't have to go to the hospital in the middle of the night for an emergency because the emergency never happens.

Mark Masselli: Dr. Meier, it will be a long time before the country forgets the image of town all meetings during the Health Reform debate in which physician counseling on the end-of-life care was recast as government death panels. For many of us in health care, we saw the legislation as a way to recognize that the conversations and counseling that need to take place between physicians and family members when the end of life is approaching takes time and to provide reimbursement for that time, just like we do for procedures and exams. Were you surprised the venom of the public and how does that shape any thoughts about future legislation in this area?

Dr. Diane Meier: Well, I mean first of all, those were all lives and they were lives that were promulgated for political purposes in an attempt to strengthen one party at the expense of another. And I hope the public is aware of that, that it was pure demagoguery. And in fact, these conversations mostly need to occur long before somebody is sick enough to die, long before someone has a terminal

illness. And I am a primary care doc and I have conversations with all of my patients when I first meet them or within a few months of meeting them about who they would trust to make decisions if they were unable to make their own decisions, about kind of who they are as a person and what their goals for their remaining years on the planet might be. I mean these are conversations that all of us should be having with our doctor because all of us could step out of our office, our homes today and be hit by a truck, and it's impossible to predict that.

Margaret Flinter: Dr. Meier, you have referenced that New England Journal of Medicine and Dr. Atul Gawande also cited that in his New Yorker article titled "Letting Go, What Should Medicine Do When It Can't Save Your Life." And it talked about – I think it was La Crosse, Wisconsin where a community of physicians were recognized as having very low end-of-life cost for elderly patients or elderly patients in that community had low end-of-life cost. And that success seemed to be a part due to a community-wide practice or ethic of having the conversation by end-of-life decisions while patients were healthy and well. And you have referenced that. Is this the focus we need to take to get organized medicine community of physicians to make this the standard in practice?

Dr. Diane Meier: I think it should be, but again, I want you and your audience to understand that the implications of the language, using language of end of life and terminal care is the suggestion that somehow these decisions involve an acceptance of death or an acceptance of earlier death, and that is false. In fact, what the decisions that patients and family need to make are, where they want to be when they are very sick, and most of us want to be at home, and what kind of support they would need to do that. In fact, as I said, these kinds of discussions and decisions actually result in a longer life but occurring with better quality and usually in the setting of the patient's choice which most of the time is at home. So, our language confuses us because when we talk about end-of-life discussions or terminal care, the implication whether conscious or not, is that these are decisions about giving up a chance of a longer life and the opposite is true.

Mark Masselli: Dr. Meier, the Palliative Care Institute at Mount Sinai in New York City is recognized as the model program and I know it's one of your personal goals to spread palliative care to all hospitals in America. Have you established national best practices and evidence-based guidelines to help physicians and nurses in hospitals in the community to advance their own palliative program?

Dr. Diane Meier: Yeah, absolutely. The Center to Advance Palliative Care along with other national palliative care organizations developed something called the National Consensus Project for Quality Palliative Care, and there is a set of domains and guidelines or what constitutes high quality palliative care. And then, subsequent to that, the National Quality Forum, which is the nation's leading quality standard setting body and it's a public/private entity that's funded both from the private sector and by the government, adapted the National Consensus

Project guidelines into a National Quality Forum endorsed framework and preferred practices for palliative care. So there are national consensus based quality guidelines that teams of professionals, nurses, doctors, social workers, others can use as they are developing and trying to build a high-quality program for their community.

Margaret Flinter: This is Conversations on Health Care. Today, we are speaking with Dr. Diane Meier, a palliative care expert at Mount Sinai in New York City. Dr. Meier, we are very concerned, as you are, with the training of the next generation of health care professionals. Tell us a little bit about your approach to teaching and training new young health professionals in this arena, who needs to be on the team, and are there any particular innovative training approaches to this very sensitive area of health care?

Dr. Diane Meier: That is the most important question we have discussed in this whole conversation. If we do not train future generations of doctors, nurses, other health professionals to deliver a high-quality palliative care, we shouldn't expect anything different than what we have been getting in the past. And I am sorry to tell you that up until now, and even in the present, most medical students, nursing students, interns, residents can finish their training without any substantial or significant exposure to the field of palliative care. So I will say to your audience "do not be surprised if your physician does not know how to manage pain, if your physician does not know what to do about shortness of breath, if your physician does not know how to help you get the services and supports you need in order to be able to stay at home. Your physician has a very good excuse, he or she was not trained." So there is nothing more important than paying attention to the needs of the next generation. So what we propose and what is actually occurring at the Mount Sinai School of Medicine is that all medical students and interns and residents actually participate in palliative care consultation teams.

Mark Masselli: Dr. Meier, when you look around that country in the world, what do you see in terms of innovations and who should our listeners at Conversations be keeping an eye on?

Dr. Diane Meier: People should be following me on Twitter because I really try to keep a pretty current stream of links to things that are going on in the field on Twitter. In addition, we have a web site for the public called Getpalliativecare.org that has links to programs in your community. And by connecting with them, you can identify things going on in your community.

Margaret Flinter: Today, we have been speaking with Dr. Diane Meier, Director of the Center to Advance Palliative Care and the Palliative Care Institute at the Mount Sinai School of Medicine in New York City. Dr. Meier, thank you so much for being with us today.

Diane Meier: Thank you so much for inviting me.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities into everyday lives.

Margaret Flinter: This week's bright idea focuses on a program that's combating obesity by helping pre-schoolers establish lifelong healthy diet and exercise habits. The NAP SACC program, which stands for the Nutrition and Physical Activity Self-Assessment for Child Care program, aims to stop obesity before it starts. Rather than focusing and changing the habits of the already overweight or obese children and teens, NAP SACC helps younger children establish the diet and the exercise routines that will enable them to maintain a healthy weight as they grow up. Central to the NAP SACC program are research findings which indicate the damaging effects of inactivity on young children's bodies and their brains. In the past decade, pre-schoolers have become increasingly sedentary. Now, they are only active 12% of the day. And right now, about 25% of children are rather overweight or obese in the pre-school years. This trend is due largely to their educators' belief that classroom lessons rather than playing makes children smarter. But the researchers behind NAP SACC say, "Not so, this model is misguided." Public health experts say, "Studies show that kids who are physically active, who have lots of opportunity to skip and run and climb are better readers and score better later on on standardized test." With 74% of children age 3 to 6 in some form of non-parental care, preschools and daycare centers are crucial places to make these changes. The NAP SACC program consists of a self assessment conducted by the school or daycare administration which identifies target improvement areas, including better nutrition, physical activity, and personal health and wellness for the staff. NAP SACC support staff then help administrators in implementing and revising their action plans in a way that complements rather than disrupt their current curriculum. The NAP SACC program was developed in 2000 through the CDC's North Carolina Healthy Weight Initiative. Already it's being used in thousands of preschools and daycare centers across the country. By changing the way preschools approach children's cognitive and physical development, NAP SACC's preventive strategy for fighting child with obesity for preventing childhood obesity is helping children establish healthy diet and exercise habits for life. Now, that's a bright idea.

This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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