

Hospices and End-of-Life Care in Montana

Draft Briefing Paper

By Pat Murdo
Legislative Analyst
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The Children, Families, Health, and Human Services Committee directed staff as part of its study under Senate Joint Resolution No. 15 to look at consumer-directed health care. One of the requested components was an examination of end-of-life care, including hospices. As part of this review, staff also obtained data resulting from House Bill 742 in the 2005 Session, which authorized a health care declaration registry to be housed in the Attorney General's Office.

Costs -- Should they be part of the question?

The issue that connects hospice and end-of-life directives to the study on access to health care and delivery is partly one of recognizing that personal choice regarding methods of treatment remains a consideration at the end of life. But the touchy issue of costs associated with efforts to maintain life is a factor for some people. One estimate is that 10 to 12% of the total health care budget goes toward end-of-life medical care.¹ A 1996 report in the *Journal of the American Medical Association* estimated that the use of hospice care and end-of-life directives, or advance directives, could save between 25% and 40% of health care costs spent in a dying person's last month.²

But costs weighed against a person's life is a touchy subject. So the question posed by researchers typically is framed: "... how much of those additional hospitalizations, tests and doctor visits resulted in better care or better quality of life?" That's how Julie Appleby stated the question in an Oct. 19, 2006, *USA Today* article. Appleby reported that an estimated 27% of Medicare's annual budget is spent on care of people in their last year of life. She noted that a September 2006 poll by USA Today/Kaiser/ABC, which asked whether "it is better to keep a terminally ill person alive as long as possible, regardless of the expense, or to make a judgment as to whether it's worth the expense," resulted in 48% of the respondents saying expenses should be considered and 40% saying costs should not be counted. Of those 65 and older, 60% of the respondents were in favor of and 28% against considering expenses.³

Quality of Life -- A part of the answer?

For people who dislike the thought of aggressive or heroic measures being used to prolong lives that may lack quality, hospice and end-of-life directives are two approaches intended to provide some quality of life or input regarding treatment at life's end. Hospice incorporates the idea of palliative care, keeping a person comfortable and surrounded when possible by family in the person's own home. Some hospice programs in Montana work primarily on an outpatient basis. Others work through hospital services. A few are free-standing residential facilities.⁴ Montana law recognizes both inpatient

¹Center for Advance Palliative Care, <http://64.85.16.230/educate/content/elements/expendituresforeolcare.html>

²EJ Emanuel, "Cost Savings at the end of life: what do the data show?" *JAMA*, 1996; 275: 1907-1914., as referenced at: <http://64.85.16.230/educate/content/elements/expendituresforeolcare.html>

³Julie Appleby, et al., "Debate surrounds end-of-life health care costs", *USA Today*, Oct. 19, 2006. The article included a map from the Dartmouth Atlas Project at Dartmouth Medical School that showed costs for the last six months of a Medicare patient. In Montana the average was \$13,028.69 compared with the national average of \$16,776.92.

⁴Hospice programs in Montana include: Aspen Hospice in Stevensville, a for-profit organization that works in the community; Big Horn Hospice in Hardin, which is an independent agency licensed by the state; Hospice of Missoula; Partners Hospice, also in Missoula; Rocky Mountain Hospice in Billings,

and outpatient services as part of a hospice program.⁵

Choosing exit terms

End-of-life directives are written declarations that allow someone 18 years or older to determine whether they want to avoid unnecessary life-sustaining treatment when faced with an irreversible or incurable condition that -- without life-sustaining treatment -- would result in death within a "relatively short time" in the opinion of an attending physician or advanced practice registered nurse. Montana's law avoids specific time frames and ambiguity over questions of what might constitute "recovery". The "relatively short time" has been criticized for being vague but also praised for leaving some flexibility to those who make decisions for a patient unable to voice an opinion. Individuals can craft their own documents and specify time frames or terms.

HB 742 in the 2005 session established a registry in the Attorney General's office for people to deposit their advance directives and make them available to appropriate health care providers.⁶ Since creation of the registry, 6,800 people have submitted directives and 475 health care providers have registered. Any health care provider can access the registry using a patient's name, social security number, and mother's maiden name, but health care providers who register have better search capacity, according to Joan Eliel who works with the registry. The office primarily spreads the word about its secure registry through the Office of Aging in the Department of Public Health and Human Services and through Montana State University Extension Services. Contact with health care providers has been limited, Eliel said.

Possible issue

Statutes in Title 50, chapter 10, give do-not-resuscitate guidelines to health care providers, but there is a question about how staff in group homes for the developmentally disabled are told to operate. The issues are:

- who decides for a developmentally disabled person when a condition is terminal;
- whether, out of concern for liability issues, group home staff are told to resuscitate, even if in their opinion as care gives the effort deprives a group home resident of a peaceful death when death appears imminent; or
- whether resuscitation at all times is a protection against the potential for devaluing a life of someone who can't speak for themselves.

What is the best approach given competing issues?

Bozeman, and Butte; Big Sky Hospice in Billings, with a Columbus team; and Peace Hospice in Great Falls, with additional locations in Fort Benton, Choteau and Conrad. Hospital-based hospices will be identified after the completion of the health care survey that is being conducted under the SJR 15 study.

⁵50-5-101, MCA. Definition:

(27) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

- (a) an inpatient hospice facility, which is a facility managed directly by a medicare-certified hospice that meets all medicare certification regulations for freestanding inpatient hospice facilities; and
- (b) a residential hospice facility, which is a facility managed directly by a licensed hospice program that can house three or more hospice patients.

⁶The website is: <http://www.doj.mt.gov/consumer/consumer/advancedirectives.asp>.