

LETTERS TO THE EDITOR

Article About Palliative Care Omitted Important Information

I am responding to an article by Anne M. Reb, MS, NP, titled "Palliative and End-of-Life Care: Policy Analysis," in the January/February 2003 issue (Vol. 30, pp. 35–50). Although the author provided readers with a comprehensive overview of the important issues in palliative care and related legislation on Capitol Hill, she excluded important information in several areas within her article.

Despite the paradigm shift that does not differentiate palliative care from end-of-life care (Davis, Walsh, LeGrand, & Lagman, 2003; Sepulveda, Marlin, Yoshida, & Ullrich, 2002), the author distinguished the two. She provided readers with the latest data from *Means to a Better End: A Report on Dying in America Today* (Last Acts, 2002), yet she excluded the revised and broadened definition of palliative care from the World Health Organization (Sepulveda et al.; World Health Organization, 2002). This definition promotes integration of palliative care earlier in the course of illness. Earlier integration of palliative interventions is widely recognized as a way to promote coordination and continuity of care and falls into the management of the disease itself (Davis et al.; Sepulveda et al.).

Reb described the lack of reimbursement structures as a barrier to palliative care. However, as experts in the field address earlier palliative interventions, reimbursement for these efforts can be captured under traditional and existing reimbursement coding (Promoting Excellence in End-of-Life Care, 2003; von Gunten, Ferris, Kirschner, & Emanuel, 2000). Reb asserted that Medicare and Medicaid reimburse advanced practice nurses (APNs) 70%–80%. However, Medicare is the federal mandate for reimbursement fee structures for APNs regardless of state-specific practice acts. The Balanced Budget Act of 1997 was amended in 1999 to provide Medicare Part B reimbursement to APNs at 85% of what physicians receive for services in the *Physician Fee Schedule* (Buppert, 1999; Federal Register, 1998). State-specific practice acts determine the extent to which APNs can receive Medicaid reimbursement, if at all (Kuebler & Berry, 2002).

Reb described that most palliative-care experts have focused research on the hospice model of home care despite the fact that the majority of deaths occur in the acute-care setting. Palliative-care colleagues from acute-care settings such as the Cleveland Clinic, a World Health Organization demonstration project, have contributed extensively to palliative-care research, as well as colleagues from Mt. Sinai Medical Center in New York, NY; the University of Michigan in Ann Arbor; Case Western Reserve University in

Cleveland, OH; the U.S. Department of Veterans Affairs (Promoting Excellence in End-of-Life Care, 2003); the University of Texas M.D. Anderson Cancer Center in Houston; and Beth Israel Medical Center in New York to name a few.

The author discussed the Community-State Partnerships to Improve End-of-Life Care in two separate areas as an exception to the rule. Yet the Robert Wood Johnson Foundation has awarded \$11.25 million to 21 broad-based, multidisciplinary coalitions working to promote policy change and quality comprehensive palliative care (Midwest Bioethics Center, n.d.). The Michigan Governor's Commission on End-of-Life Care worked in tandem with the Michigan State Partnership to address important issues, not separately as pointed out in the article. Reb identified two graduate-level nursing programs offering palliative education, but she failed to mention the initiative funded by the Michigan Department of Community Health, which produced and disseminated graduate palliative nursing self-training educational materials and piloted them at six universities. The Michigan Nurses Association currently is offering continuing education credits for this material (Kuebler & Moore, 2002).

Although Reb described a weak link to formalized standards in palliative care, nothing was mentioned about the work under way by the Center to Advance Palliative Care. National experts have been recruited and are participating in a National Consensus Project for Quality Palliative Care: Essential Elements and Best Practice. These guidelines and standards, which are under development, will help promote competent palliative practices, regardless of specialty, for all patients.

Although Reb attempted to discuss favorable legislative initiatives pertinent to influencing palliative-care practices in the United States, I would like to note that despite the 22 bills that were introduced in the 107th Congress to address end-of-life or palliative practice, the only bill that achieved successful support and became law was the Nurse Reinvestment Act. Of the 22 bills, only 7 received slightly more than 10% cosponsorship (Goldstein & Lynn, 2002). The current legislative state of affairs, as it relates to changes in palliative practices in the United States, is anything but favorable. As Goldstein and Lynn wrote, "At this time, only a few bills have come before Congress attempting to improve care at the end of life; those do not have substantial action, and they do not reflect any coherent view of needed reforms. This is a prescription for inertia in public policy" (pp. 825–826). Tremendous efforts are under way, as pointed out by Goldstein and Lynn, but much work is required to ensure legislative support and continuity of care.

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The Author Responds

Kuebler reviewed issues in a number of areas, including (a) language/practice, (b) reimbursement, (c) education/health systems research, (d) quality and standards, and (e) legislation. I will address the issues raised in each of these areas.

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