End-of-Life Care in the United States: Current Reality and Future Promise – A Policy Review

“Improving end-of-life care should be a national priority, not just from a cost perspective, but from a quality perspective, because we can do much better” (Carlson, 2010, p.17).

Caring for Individuals at the End of Their Life

The present state of end-of-life care in the United States is evaluated, focusing on statistics of disparities in access to and type of care provided across the country.

Although only a few portions of the Patient Protection and Affordable Care Act deal with end-of-life care reform, the multiple innovative efforts occurring at state and local levels are proving very effective in improving end-of-life care.

Possible improvements and obstacles to those improvements, and the involvement of the profession of nursing are highlighted.

The focus of this investigation is to determine if the evidence supports the following imperative: that the money spent for end-of-life care be spent in a manner that benefits the patient and complements his or her wishes.

Executive Summary

Data collection and analysis of that data are vital to developing effective outcome measures when it comes to improvements in the cost and quality of delivered health care.

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Hospice and Palliative Care

One solution to end-of-life care, the hospice movement, has seen incredible growth in the United States over the past several decades. It has been over 40 years since hospice care began in the United States. Since that time, “hospice has grown into a business that served over 1 million Medicare beneficiaries, from more than 3,300 providers in 2008, according to the Medicare Payment Ad-

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visory Commission” (Zigmond, 2010, p. 6). The history of hospice in the United States dates back to 1963, when Florence Wald, then the dean of the school of nursing at Yale University, invited Dr. Cicely Saunders from London to give a series of lectures on hospice care. “Dr. Cicely Saunders, the matriarch of the worldwide hospice movement, clearly had an impact as shortly after her visit and lecture series, the first hospice in the United States opened in Branford, Connecticut, in 1973” (Connor, 2007, p. 90). Today, hospice focuses on, “caring, not curing and, in most cases: care is provided in a patient’s home. Care can also be provided in freestanding hospice centers, hospitals, and nursing homes or other long-term care facilities. Hospice services, which include care management for all aspects of the patient, include family support as well” (National Hospice and Palliative Care Organization [NHPCO], 2011a, ¶ 2).

Palliative care is defined by the World Health Organization (WHO) as, “an approach that improves quality of life for patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of problems, including physical, psychological, social, and spiritual” (WHO, 2011). NHPCO (2011a) also adds, “palliative care extends the principles of hospice care to a broader population that could benefit from receiving this type of care earlier in their disease process. Palliative care, ideally, would segue into hospice care as the illness progressed” (¶ 3). Certainly both palliative care and hospice have a rightful place and play extremely important roles in end-of-life care. Hospice and palliative care programs exist across the United States, both in for-profit and not-for-profit sectors, as well as in stand-alone organizations or as components of larger health care models. “Palliative care programs are rapidly becoming the norm in American hospitals, with more than 70% of large (more than 200 bed) hospitals reporting the presence of a program in the American Hospital Association’s 2006 annual hospital survey” (Weissman, Meier, & Spragens, 2008, p. 1294).

A policy discussion would not be complete or fair without mention of the ways that the hospice and palliative care movements have improved end-of-life care for patients and their families. There is a growing understanding of hospice and palliative care among most people in society, as the realization that hospice is not a place but rather a concept gains momentum, and patients opt for palliative care services earlier in their illness. We must not fail to acknowledge the great work accomplished by hospice and palliative care professionals. This effort must continue to expand in order to reduce access disparities across the nation. “The challenge for hospice and palliative care providers can be boils down to achieving unfettered access to quality palliative care for all who need it” (Connor, 2007, p. 98).

Problems

While use and advantages of palliative care and hospice are gaining momentum at unprecedented speed, there remains disparity in access geographically. In addition to general access disparities, the type of care patients receive at the end of their life varies according to where they live and what acute care facility they happen to be a patient in. In 2001, Raphael, Ahrens, and Fowler discussed the likelihood of dying in a hospital in the United States as depending on, not patient preference, but rather on number of hospital beds, and physician per patient statistics, which varied greatly across the nation. Medicare beneficiaries in some western and northwestern states had a less than a 20% chance of dying in a hospital, while chances for those in southern and eastern states could be greater than 50% (Raphael et al., 2001).

Research supports the fact this issue is still apparent; geography continues to play a role in end-of-life care today. McKinney (2010) points out that for patients with advanced cancer, the likelihood they will spend their last days in a hospital intensive care unit depends largely on where they live, and which hospital they seek care in. Unfortunately, Goodman and colleagues (2010) found little evidence that treatments are aligned with patient wishes. The report, which examined 235,821 Medicare patients with advanced cancer who died between the years of 2003-2007, found significant variations in end-of-life care from region to region. “Roughly 29% of patients died in a hospital, and that number reached as high as 46.7% in the borough of Manhattan in New York, to as low as 17.8% in Cincinnati, Ohio and 7% in Mason City, Iowa” (McKinney, 2010, p. 6).

Not only is there disparity in whether patients go to and utilize acute care services, but also, once there, there is disparity in what types of care they receive in those acute care organizations. Extensive variation was found in length of stay, number of physician visits, percentage of patients with 10 or more physicians, and transfers to hospice services. Wennberg and associates (2004) found striking variation in all categories.

Medicare, the largest health plan in the United States, is highly influential in end-of-life care because of the large number of beneficiaries who die each year. Numbers vary depending on the source, but according to the Medicare Payment Advisory Commission (MedPAC), “about a quarter of the total Medicare budget is spent on services for beneficiaries in their last year of life, and 40% of that is in the last 30 days of their life” (Raphael, 2001, p. 458).
Multiple studies declare that of the total outlay for all Medicare costs, 30%-40% occur in the last year of life for beneficiaries (Hogan, Lunney, Gabel, & Lynn, 2001; Raphael et al., 2001). One key factor involving end-of-life care and financing includes increased numbers of older Americans, which by 2050 is predicted to reach 72.2 million (Raphael et al., 2001). By that time it is also estimated that some 27 million people, most of whom will have multiple chronic diseases, will also need some type of long-term care services (Caffrey, Sengupta, Moss, Harris-Kojetin, & Valverde, 2011).

Chronic disease is an important item to review when discussing end-of-life care, because hospice patients are no longer predominately cancer patients, but also now have diagnoses that include multiple chronic conditions. According to the National Health Statistics Report, in recent years, hospice has become increasingly used by people with noncancerous diagnosis, the rate of which has increased from 25.3% in 2000 to 57.2% in 2007 (Caffrey et al., 2011). Another factor that cannot be overlooked is that many of these future older Americans will originate from ethnic and racial minority groups; therefore, end-of-life care and reform efforts must include an assessment and understanding of the care needs for these culturally diverse groups. Since a large payer of hospice services is Medicare, there is no doubt that political debate exists when discussions about payment for this care are undertaken. However, one thing is certain, discussions regarding quality of care, health policy, and disparity must begin to occur and cannot be dismissed due to the fact these conversations are difficult to have from an ethical and legal perspective. Components of these conversations must include the cost of end-of-life care in acute settings and possible hospice and palliative care contributions as solutions to decrease those costs.

Additional problems exist related to ill-defined quality standards, and decreased numbers of professionals working in hospice or palliative care across geographical pockets, especially in rural areas of the United States. End-of-life care issues remain unsolved as a result of an inability of a nation and its people, including political leaders, to discuss what is inevitable for all — mortality. End-of-life ethical and political policy conversations are difficult and, at times, avoided. There is unwillingness or uneasiness at best, to approach this subject head on.

**The Patient Protection and Affordable Care Act**

This national avoidance became blatantly evident when misconceptions from a portion of the 2010 Patient Protection and Affordable Care Act (PPACA) that would have enabled physicians to be reimbursed for having advanced care planning discussions with patients, was publicized as something that would result in a “death panel” that would “ration health-care care in the United States” (Brody, 2011). As a result, the portion of the PPACA dealing with advanced planning conversations was deleted from the final version of the policy. Unfortunately, the true intent of this portion of the proposed act was not realized by the public or policymakers, since it was dismissed too rapidly for consideration. In the end, as with multiple other facets of end-of-life care, the fallout for not addressing this issue results in financial impact to the nation, as well as a quality of life impact for the individuals and families who require end-of-life care for advanced illness in the United States.

Ironically virtually no portion of the PPACA deals with reform, reimbursement, or policy changes related to end-of-life care. There are minor sections of the PPACA that can have an effect on end-of-life care, but no portion relates directly to this vital and hugely important aspect of American health care. Unfortunately, the result is the unique needs of the terminally ill remain poorly addressed in the United States health care system. Perhaps one of the most concerning concepts when it comes to end-of-life care is the fact that so often the care provided is not necessarily the care the patient and family have elected, wanted, or even understood.

**Advance Directives**

The SUPPORT study, which was funded by the Robert Wood Johnson Foundation and enrolled patients over a 5-year period, was conducted to analyze decision making in patients near the end of life. Other goals of the study included gaining an understanding of communication about end-of-life interactions between patients, their families, nurses, and physicians. Results indicated that a significant number of critically ill patients did not want aggressive life-prolonging care (Celso, & Meenrajan, 2010; Fitzsimmons, Shively, & Verderber, 1995; Smith et al., 2003). Unfortunately, due to multiple reasons, including delayed timeliness in executing advance care planning until patients are terminal and out-of-date or unavailable documents (Tilden et al., 2010), issues remain involving patients advocating for themselves, families advocating for their loved ones, and health care professionals providing care that may or may not be consistent with patient preference. Perhaps the best reason for meaningful discussion and policy reform to occur is a genuine concern for a better patient experience when it comes to end-of-life care. We cannot dismiss the Triple Aim of the Institute for Health Care Improvement, which dictates the pursuit of an improved patient experience, improved health of the population at large, and reduced per capita costs (Berwick, Nolan, & Whittington, 2008). To that end, the United States simply cannot
overlook all that hospice, palliative care, and advance directives have to offer to individuals and families who face serious, life-threatening advanced illness issues.

**Expert Opinion**

According to NHPCO, a non-profit organization representing over 2,900 hospices in the United States, none of the PPACA that deals with accountable care organizations (ACO) mentions hospice or palliative care programs. ACOs are organizations that will have local accountability for managing populations of people throughout a continuum of lifetime care. ACOs will need to share reimbursement and determine cost-sharing strategies for all providers involved. They will also be required to care for a minimum of 5,000 enrollees and will be paid on a pre-defined outcomes measure basis. NHPCO was so dismayed that there was no mention of end-of-life care in the final ACO regulations that they communicated this fact to the Center for Medicare & Medicaid Services (CMS). In a letter dated June 6, 2011 to Dr. Donald Berwick, CMS administrator, NHPCO President and CEO J. Donald Schumacher stated, “many dying patients in institutions have unmet needs for symptom management, emotional support and being treated with respect.” He went on to say, that “it is essential that hospice and palliative care organizations be partners in ACO’s in order to contribute to the success of these new care models, and care for patients across the continuum of their lifetime” (NHPCO, 2011b).

The American Hospital Association (AHA) recommends multiple items that should be a focus of national quality efforts; one of those recommendations is for greater self-determination related to end-of-life care (Carlson, 2010). The AHA endorses personal tools to end-of-life care (Carlson, 2010).

**The Critical Role of Nursing**

The Institute of Medicine (2010) in *The Future of Nursing* report calls for the need to transform nursing education, stating that nurses are critical to the success of health care reform, and that nurses need to take their rightful place in leadership endeavors, achieve higher levels of education, practice to the fullest of their ability, and be full partners with other health care professionals.

Multiple studies discuss educational deficiencies and lack of comfort levels that nurses have when it comes to conducting follow up or clarification discussions with patients about end-of-life care or treatment options (Malloy, Virani, Kelly, & Munvevar, 2010; Reinke, et al., 2010; Wittenberg-Lyles, Goldsmith, & Ragan, 2011). Changes in nursing education must occur in order to prepare professional nurses to become advocates and experts in end-of-life care. When assessing the adequacy of skill of health care professionals to initiate and conduct end-of-life conversations there are noted voids and problems.

Reinke and colleagues (2010) identified several skill sets that nurses felt were important but underutilized in end-of-life care conversations. They concluded end-of-life care interventions should address not only system and policy changes, but also improvements in individual nurse’s communication skills regarding end-of-life conversations (Reinke et al., 2010).

“Nurses can play a pivotal role in patient and family illness and care awareness by facilitating palliative care communication and supporting the conceptual shift to early palliative care” (Wittenberg-Lyles et al., 2011, p. 305). The communication problem exists for physicians as well. Part of this problem originates from poor preparation of professionals in their primary and early health care education programs. While many programs are adapting methods to include didactic training programs, the real experience comes from actual conversations, which of course, is not something a text or video can accomplish. Programs like the End of Life Nursing Education Consortium and continued efforts in physician mentoring and role modeling in end-of-life care conversations will prove very beneficial (Wittenberg-Lyles et al., 2011).

The development and spread of palliative care efforts and hospice education for professionals and the general public will continue to have an impact on growth and acceptance of end-of-life conversations. It is also important for individual professionals, as well as the organizations they work within, to continue to foster and participate in opportunities and experiences that will enhance ability and comfort levels regarding end-of-life conversations. This effort will be of utmost importance for not only physicians, but also for nurses.

“Communication is the cornerstone of basic nursing practice and a fundamental skill across all settings of care is to identify the patient’s goals of care. As patients and families continue to face serious illness, transition to palliative care, and make difficult decisions, nurses will play a critical role and remain as the predominant professional at the bedside” (Malloy et al., 2010, p. 172). Physicians most often will champion the initial conversation with patients and families, but nurses have a responsibility and professional ethic to be present for the patient and family after initial conversations take
place. “Nurses accompany patients on their journeys; through such ongoing and intimate encounters, they support patients in confronting the weariness of living and dying” (Ferrell & Coyle, 2008, p. 247). Health care professionals, including nurses, must be vigilant about understanding their communication style and engaging in educational opportunities that enhance their ability to conduct effective end-of-life conversations with patients and families.

**Future Promise and Possible Obstacles**

The Patient Self-Determination Act of 1991 required all Medicare participating organizations notify patients of their rights to complete an advance directive for health treatments (American Nurses Association, 1991). The overall goal of advance directives is to allow patients to retain control over the life-prolonging treatments they receive. Current health policy sometimes fails patients in this respect, as families can argue patient’s choices may change over time, or there can be delays in producing existing documents, or failures in executing the documents all together. While the intent of the federal mandate was well intentioned, it resulted in continued confusion and sporadic compliance by patients and families in completion of advance directives.

At approximately the same time as the passage of the federal Patient Self-Determination Act, another paradigm in advance care planning was initiated that had a goal of turning patient treatment preferences and advance directives into medical orders. The Oregon state legislature introduced a new program to improve adherence to patients’ wishes for end-of-life care. The Patient Order for Life Sustaining Care (POLST) paradigm was created to provide a mechanism to communicate patient preference for end-of-life care treatment across care settings. The POLST document turns patient treatment preferences into medical orders, with an overall goal of ensuring that wishes for treatment are honored. “The National Quality Forum and other experts have recommended nationwide implementation of the POLST paradigm” (Hickman, Sabatino, Moss, & Nester, 2008, p. 120).

Some barriers to POLST use do exist. “The most potentially problematic barriers are detailed statutory specifications for out of hospital do-not-resuscitate orders in some states. Other potential barriers include limitations on the authority to forgo life-sustaining treatments in 23 states, medical conditions in 15 states, and witnessing requirements for out of hospital do not resuscitate orders in 12 states” (Hickman et al., 2008, p. 119). Multiple studies regarding use of POLST across care settings have been conducted to determine usefulness in understanding and following patient wishes. Results of studies yield a strong tie between use of POLST forms and adherence to patients’ self-determined wishes across care settings (Hickman et al., 2010; Schmidt, Hickman, Tolle, & Brooks, 2004). Studies also revealed that patients with POLST medical orders were less likely to receive unwanted care (Hickman et al., 2010; Tilden, Nelson, Dunn, Donius, & Tolle, 2000). Multiple research studies confirm that POLST can have a positive impact on the ability of an individual to self-determine his or her end-of-life preferences.

Access to end-of-life care services is another problem. Access includes awareness of palliative and hospice services, payment and financial coverage for those benefits, and acceptance of benefits from a cultural or religious perspective. Goldsmith, Dietrich, Qingling, and Morrison (2008) concluded that significant disparities in public and educational access to hospital palliative care services exist. “Hospice care is a beneficial, yet underutilized service in advanced dementia. Hospice professionals cite prognostication as the main hindrance to enrolling patients with dementia into hospice” (Mitchell et al., 2012, p. 45).

Current reform and health policy have affected hospice organizations in several ways, the largest of which is decreases in reimbursement related to cuts from Medicare, the largest payer of hospice services. There is also increased scrutiny and regulatory efforts in the form of an additional recertification requirement of face-to-face meetings between patient and physician or nurse practitioner at time of recertification of care, which became effective January 1, 2010 (Morrow, 2010). In an industry with narrow profit margins, reimbursement reductions could worsen the already existing access problems.

Other items involving end-of-life care are present in the historic Patient Protection and Affordable Care Act. Hidden deep and not well publicized are at least two provisions that may have an impact on end-of-life care. They both relate to hospice. One section of the PPACA amends current law to eliminate the requirement for children to elect curative versus hospice care through Medicaid and CHIP programs. A second area deals with adults, “in section 3140, the PPACA authorizes a three year long Medicare Hospice Concurrent Care demonstration project involving a study to determine whether patients benefit when Medicare authorizes payment for receipt of concurrent curative treatment and hospice care” (Cerminara, 2011). The project, which does not have a start date, will begin as soon as the Secretary of Health and Human Services establishes parameters and outcome measurements, and will involve 15 hospice programs nationwide. Astonishingly, other than the previ-
ously mentioned items, there are no other portions of the PPACA that directly relate to end of life care. Once more people understand what hospice and palliative care can provide related to quality of life and a peaceful dying process, a major culture shift can begin to occur. The result would be an environment where end-of-life conversations occur prior to a patient’s actual end of life. Sometimes awareness occurs because we either experience it ourselves or know someone who has experienced caring for a loved one at the end of his or her life. Despite explosive political debate, the answer really does involve a conversation.

The American Academy of Hospice and Palliative Medicine has multiple recommendations for health care reform. One of those recommendations refers to advance directives and specifically the POLST. The recommendation includes an endorsement to provide reimbursement for physician consultations that would determine goals for medical care. Nothing makes more sense, and seems farther away from death panels than prudent, frank, and transparent conversations about an individual’s wishes.

The experience or wishes of the patients cannot be overlooked, especially in end-of-life care when a cure cannot be offered to patients for whatever they are suffering from. From an ethical perspective, shouldn’t that be required to be conveyed? Should end-of-life care be recognized as an ethical obligation of health care providers and organizations, and what exactly does that mean? Patients must have a say in what is important to them and ultimately decide their personal wishes. Patients need to determine what defines high-quality dying for them, and decide on how they want to manage their end of life, as it relates to death (Cramer, 2010; Howell & Brazil, 2005).

Conclusion

Paying attention to health care policy, or lack thereof, or the conflicted policy Catch-22s, when it comes to end of life care is a critical responsibility of all health care professionals. In discussing the type and magnitude of changes necessary to implement cost-effective, ethically considerate, culturally acceptable changes in end-of-life care, there will no doubt continue to be difficult and painful conversations, both on individual and political fronts. But, the conversations must occur, and cannot be ignored simply because they are difficult to have. Perhaps, most importantly, the political community, who are often those who write the policy that needs to be executed, must recognize that local, organizational, and state efforts cannot be delayed related to lack of movement on a federal front. There are many examples of great work being done with regard to end-of-life care across America that have nothing to with policy or federal government intervention, and these efforts must increase and continue.

All health care professionals must realize the power they have on two levels, as individuals and as a profession, when it comes to end-of-life reform and improvement efforts. Health care professionals have an ethical responsibility to assist patients to achieve the care and life they want for their last days, and in many cases that may involve assisting them to die with dignity in a surrounding of their choice, and embraced by those they have loved for a lifetime. Hopefully, this article has created a heightened sense of awareness for health care professionals, especially nurses, to pay attention to reform efforts in the United States. Nurses, physicians, and other health care professionals have the ability, knowledge, and power to help shape new regulations and laws when it comes to end-of-life care. Although it is 2012, the insight of Ira Byock, a leading palliative care physician and long-time public advocate for improving end-of-life care, still holds true today. He summarized the current state of end-of-life care and points the way to where we must go by saying:

A tidal wave of social change is headed our way. For the first time in human history, in the third millennium, there will be more old people than young people on the planet. In addition to the graying of the population, there will be more physical distance between families, smaller families, fewer caregivers, more chronic illness, and increased technological advances. These trends are all converging to create the perfect storm; a social tsunami of care giving that threatens to overwhelm our children’s generation and us. We must rise to the challenges and build a model of healthcare that will determine the quality of care we receive tomorrow (2004, pp. 214-215).

Plan for Action

Unless we take personal, professional, and political action today, we will not be able to afford to die with dignity in the future. For multiple reasons that include an aging population, escalating health care spending, and an approach to end-of-life care that often does not conform to the wishes of patients, we cannot delay action. We need to have honest and transparent advance care planning conversations with our families and our physicians. We need to become comfortable talking about dying with those we love and interact with the most, in order to become comfortable talking about end-of-life care publically. All health care professionals should strive to create an environment for patients where the philosophy of palliative care and hos-
pice is understood. Goals of this environment would include increased knowledge about hospice and palliative care, greater symptom control for patients with end-stage diseases, improved advance care planning, better quality of life, and ultimately less money spent on achieving better outcomes for patients facing end-of-life illness and disease.

Interactions between politicians and health care professionals, especially those involved in hospice and palliative care, must accelerate. Professionals in these fields must continue strong advocacy efforts to let the political world know what they do, and what promise their care offers related to improved quality of life and decreased overall spending. Such interactions should include tours of facilities, visits with patients and families, and letters and phone calls to politicians on specific issues that are important to the hospice and palliative care industry. These action items would cost very little, and perhaps only result in an investment of time for those involved.

Opportunities to develop advance care directives are often missed. To that end, we must revisit Medicare reimbursement for physicians participating in voluntary advanced care planning consultations, and end discussions surrounding “death panels” for good. Physicians often have a clear understanding of what defines quality of life for their patients, and this clear understanding, which takes time to develop, involves multiple discussions and explanations that physicians need and want to participate in with their patients. The positive end result would be assurance patients’ wishes are understood, documented, and ultimately attainable. While health care professionals can lead the effort aimed at better advanced care planning, politicians play a vital role in assuring that policy makes sense and is not confusing to those who need it. It is simply not prudent of such a smart nation to refuse to pay physicians for this extremely important part of health care planning.

POLST legislation must continue to accelerate and expand to assure acceptance of medical orders that are understood clearly and cross all care continuums in every state. It seems possible that if several states can achieve success in overcoming legal barriers related to POLST implementation, all states can achieve it. The important and expanding work of the POLST paradigm must continue. It is incumbent upon lawmakers to create global policies that enable POLST to be available to those who critically needed it in order to enhance smoother care transitions between providers, and decrease unwanted treatment by clarifying patient’s wishes into actual medical orders. The public needs to understand POLST and for whom it is intended. National television and radio commercials addressing POLST and advance care planning could have positive promotional effects, especially if hosted by the next President of the United States of America. It’s too important not to consider.

The Medicare Hospice Concurrent Care Demonstration Project (as defined in the PPACA) needs to begin in order to analyze the effects of concurrent care with relation to quality of life and financial outcomes for both rural and urban demographics in the United States. This concurrent approach will address current hospice and palliative care access issues that relate to patients needing to make curative versus palliative decisions independently. A concurrent approach would also address a second population of patients who need end-of-life care but do not have a terminal cancer diagnosis, such as dementia or congestive heart disease. Demonstration results will need to be analyzed by an authoritative body such as CMS or MedPAC for final determinations as to whether quality of life was enhanced and cost savings were realized. If results are positive, then the Medicare hospice regulations that define eligibility will need to be revised. From a nursing perspective, perhaps less money would be spent treating patients who are guided into hospice care through a strong palliative care effort where symptoms are controlled and care is gradually transferred, rather than in a hurry, with short lengths of stay, as exists today for many hospice patients.

Educational voids related to end-of-life care curriculums for both medical and nursing schools should be addressed. It is important curriculums include practice and mentoring in the area of end-of-life conversations since proficiency in this type of communication will not be realized through didactic teaching alone. Conversations are critical to understanding what each patient wishes for end-of-life care.

Efforts focused on medical, fraud, waste, and abuse must continue. Monies recovered for these reasons could be used for end-of-life care initiatives and start-up processes for education and advocacy efforts. While most providers are well intentioned and follow all federal and state regulations, those that do not should continue to be identified and removed from the health care service arena.

Hospice and palliative care professionals must ensure their voice is heard when it comes to creation of policy. Local, state, and grassroots end-of-life programs should continue to be developed, financed, and evaluated. While some financing may come from grants or private sources, states should actively assess what they can do to assist financing any initiative that promotes or enhances end-of-life care.

Simply put, we can begin to control the cost of end-of-life care and afford to die with dignity if we act today. We all have a role to
play in securing a better means to our end, and creating a nation where quality of life and personal choice are not only a priority but also a responsibility.

REFERENCES


ADDITIONAL READING