Committee News

Challenges to Improving Palliative Care and the Role of an Anesthesiologist

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Palliative care is founded on the principle of providing support for patients facing life-threatening chronic illness at all stages of disease. Due to the nature of palliative care as a relatively new specialization, several barriers exist for patients to receive proper palliative care, ranging from provider unfamiliarity to monetary issues. Only 14% of 56.8 million people who need palliative care receive it (asamonitor.pub/3XyNsE1). Many rural areas within the United States lack access to palliative care, with only 17% of small, rural hospitals (defined as having between 50 to 100 beds) having palliative care programs (asamonitor.pub/2ReGzob). Even with a palliative care team, many urban hospitals underutilize these teams due to providers and patients misunderstanding when palliative care should be used. Given the demand and underutilization of such an important resource, a targeted approach to increasing access to palliative care is imperative (*J Palliat Med* 2023;26:831-6). Anesthesiologists and pain medicine physicians can work to eliminate these barriers by educating patients and other physicians about palliative care as well as advocating for better insurance coverage and access in rural areas.

Recent surveys of providers and patients have identified many misconceptions that undermine the importance and need for palliative care. Providers often equate palliative care with end-of-life care, making them more likely to delay relevant conversations until the later stages of disease

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(*J Hosp Palliat Care* 2023;26:42-50; *BMC Palliat Care* 2020;19:47). Although all providers can start preliminary palliative care, more complicated symptom management and care goals require the intervention of a palliative care expert (*ASA Monitor* 2015;79:28-30). Early involvement by palliative care specialists during patient treatment has been shown to increase patient quality of life and decrease costs to the health care system. Physicians are not the only ones with misconceptions regarding palliative care. Patients often seek palliative care solely in hospice situations, making discussions about the topic seem like they are "giving up" (*J Hosp Palliat Care* 2023;26:42-50). One of the most effective methods of getting patients to accept care from a palliative care specialist is to differentiate between palliative care and hospice (*BMC Palliat Care* 2022;21:25). Often, a patient's cultural or religious beliefs can differ from the core principles of palliative care. This can cause health care providers to be hesitant to start conversations about palliative care and patients to be dismissive. As anesthesiologists begin to collaborate more with palliative care teams and learn more about the philosophy, they can help to address misconceptions for patients and other physicians they come across in the perioperative setting.

Access issues are often significant barriers in providing palliative care. In rural areas, the palliative care system is heavily fragmented, making coordination between palliative care specialists and local providers challenging (*BMC Palliat Care* 2022;21:25). This scarcity of palliative care specialists in rural areas worsens the issue (*BMC Palliat Care* 2022;21:25). Despite the rapid increase in the number of palliative care specialists since 2008, when the first American Board of Medical Specialties-certified examination was administered, there's still a glaring shortage of palliative care providers in rural areas. For instance, Alaska has 16 palliative medicine physicians who must cover 663,000 square miles (asamonitor.pub/3Xwcgv9). This lack of funding for rural palliative care produces a net negative revenue in these hospitals. Studies have shown palliative care to reduce costs by $4 for every $1 invested into these programs (*J Pain Symptom Manage* 2018;55:1216-23). Anesthesiologists in rural areas can begin to fill this gap in palliative care by requesting that their respective hospitals start palliative care teams where they may be beneficial.

Reimbursement for palliative care is an issue since all members of an interdisciplinary palliative care team cannot bill patients for their services like physicians can (asamonitor.pub/3ZaXBIe). The lack of financial incentives makes creating an interdisciplinary palliative care team challenging where resources are already low (such as in rural areas). Targeting the financial barriers to palliative care would require working to improve not only reimbursement but also the price of palliative care for disadvantaged patients. Although hospice is fully covered by either Medicare or Medicaid, early palliative care still has some out-of-pocket costs, such as the standard copay. This makes a key piece of the puzzle (early intervention by palliative care teams) very difficult to use in the treatment of those who are financially burdened. Unhoused patients (a group with the highest rate of chronic life-threatening illnesses) often lack health insurance, which further hinders them from receiving any form of palliative care (*BMC Palliat Care* 2018;17:67). A survey of the unhoused also found that palliative care was not their priority due to the financial constraints of regular treatment (*BMC Palliat Care* 2018;17:67). Some states have made efforts to reduce the costs of palliative

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care for some patients and improve reimbursements for palliative care teams. For instance, most states have age requirements or strict definitions of palliative care services required for coverage by Medicaid-run programs, but California and Arizona have recently established broader definitions of palliative care services while also including all age ranges as eligible for the benefit (asamonitor.pub/3ASlAlm). Additionally, 19 states have adopted billing codes allowing for in-patient interdisciplinary palliative care team consults (asamonitor.pub/3ASlAlm). Despite these efforts, roughly only half of Medicare/Medicaid participants nationwide utilize end-of-life care (asamonitor.pub/477YZxb). Following in the footsteps of states that have successfully improved insurance coverage for the disadvantaged is the first part of making palliative care widely used.

Anesthesiologists have an increasingly larger role in palliative medicine since the American Board of Anesthesiology acknowledged specialization in hospice and palliative care in 2006 (*ASA Monitor* 2015;79:28-30). ASA stands for value-based advanced care planning and reaffirmed this stance in a statement issued in 2023 emphasizing the need for improvements in palliative care (asamonitor.pub/4eaJAP0). Anesthesiologists who specialize in pain medicine and palliative care can play a crucial part in multimodal pain management in patients with cancer or other advanced illnesses. They can work in close collaboration with palliative medicine professionals, using opioid-sparing interventional techniques. Anesthesiologists continue to advocate and to be leaders in palliative care policymaking. By working closely with the state legislature, we can improve Medicaid coverage and funding for palliative care, especially in rural areas.

Proper education to providers and the public regarding palliative care, increased funding for rural palliative care programs, and fewer financial obstacles to palliative care can all help to mitigate barriers to this important treatment. It has been proven time and time again that this service is vital for patients going through life-threatening illnesses. It should be the duty of the medical community to support this group of patients by working to decrease the number of barriers to palliative care. Anesthesiologists can play an integral role in this process by coordinating their care between the medical and surgical specialties, especially in the perioperative settings, by appropriately identifying and triaging patients who will need pain and complicated symptom management in the future. ■