

The benefits of expanded physician assistant practice in hospice and palliative medicine

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ABSTRACT

Patients with advanced or terminal illness, especially racial and ethnic minorities, would benefit from greater access to hospice and palliative care. Expanding the PA role in these areas would help fill gaps in both access and patients' understanding of what hospice and palliative care can offer. This article describes why hospice and palliative care are needed, what PAs can and do offer hospice and palliative care delivery, and what challenges should be overcome to expand PA practice in hospice and palliative care. The article also reviews the legislative outlook for PA practice in hospice care.

Keywords: physician assistants, hospice, palliative care, end-of-life, underserved patients, advanced illness

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How people experience advanced illness and death in the United States is a public health concern as well as a bedside care concern. Physician assistants (PAs) can help relieve suffering and align healthcare services with patients' wishes. PAs, physicians, and NPs can accomplish these goals by working in hospice or palliative medicine settings, referring patients to these services when appropriate, and expanding their skills in palliative care in a variety of practice settings.¹⁻³ The Patient Protection and Affordable Care Act's focus on patient-centered care and population health management and recognition of the value of palliative care for patients besides those with cancer are driving the need to expand a workforce knowledgeable in palliative approaches to care.³⁻⁵ Furthermore, the high costs of potentially futile treatments for advanced illness necessitate multidisciplinary stewardship of healthcare resources.⁶ PAs are poised to play a vital role in this context. However, the PA role and value in hospice and palliative care is not well understood and their services provided in hospice settings are not reimbursable under Medicare guidelines.⁷

Key points

- PAs are trained in many of the skills necessary to deliver high-quality hospice and palliative care.
- Although PAs can be reimbursed by Medicare for palliative care, hospice care reimbursement excludes PA services at this time. A current federal legislative bill, if passed, will change this.
- Healthcare managers managing hospice and palliative care or related services can assess their operations for added or expanded PA practice.
- PAs and PA educators can pursue opportunities to improve hospice and palliative care skills while all parties advocate for expanded PA practice regulation in hospice and palliative care.

Hospice and palliative medicine focus on symptom control, psychosocial support for patients and families, and realistic goal-setting in the context of advanced or terminal illness.⁸ Hospice care, a type of palliative care, is available specifically to patients who are terminally ill. Palliative care services have a broader application in symptom control (for example, chronic pain management) and improving quality of life for patients with advanced, chronic, or life-limiting illness.⁹ Expanding the application and reach of this supportive care would also improve continuity of care in the team-based model. Despite widening insurance coverage on a national scale and growth of palliative care services in hospitals, care delivered near the end of life is not getting better for everyone.¹⁰ Agency for Healthcare Research and Quality (AHRQ) data from 2014 indicate that Hispanic, American Indian, and Alaskan Native patients report worsening care at the end of life compared with previous years.¹¹ According to the AHRQ report, Hispanics report receiving care inconsistent with their end-of-life wishes and inadequate pain management compared with non-Hispanic white patients. American Indian and Alaskan Natives receive later referral to hospice, effectively reducing the opportunities to receive benefits such as psychosocial support and services to improve the quality of remaining life.¹¹ Additionally, a recent study of 3,035 older adults found that black patients were less likely to want hospice (63.8%) compared with their white counterparts (79.2%, $P < 0.001$).¹² Although the reasons for this have not been determined, factors may include inadequate knowledge of and access to palliative services, mistrust of the health system, and different views of the role of family and spirituality compared with groups with higher rates of using hospice.¹³

Recognizing nuance in patients' preferences for palliative care demands an expanded healthcare workforce knowledgeable in these modalities. Notably, many PAs are taking care of underserved populations in both rural

and urban areas.¹⁴⁻¹⁶ Expanding practice for PAs along the care continuum may increase access to services for underserved groups.

PAs are trained in the very skills central to quality care in hospice and palliative medicine: basic management of pain, dyspnea, depression, and anxiety; and basic discussions about prognosis, treatment goals, suffering, and code status.³ Advanced skills in hospice and palliative care can be built on these basic skills and are developed further with clinical experience—true for any clinician. Yet, the Centers for Medicare and Medicaid Services (CMS) does not recognize the services of a PA in the delivery of hospice care when those services are provided for the medical condition that qualifies the patient for hospice.^{17,18}

The current role of the PA in palliative medicine is not widely publicized. Little is known about the actual numbers of PAs practicing in hospice and palliative care.^{18,19} Building a base of professionals with palliative medicine skills is necessary if wider and earlier access to hospice and palliative care is the goal.^{20,21}

PUTTING THE PA IN PALLIATIVE MEDICINE

A shortfall is projected in physicians trained in palliative medicine. In 2010, an American Academy of Hospice and Palliative Medicine task force concluded that 2,787 to 7,510 full-time equivalents (6,000 to 18,000 individual physicians) were needed to adequately staff hospice and palliative care needs at that time.²² The task force noted that an increase in palliative-trained advanced practice nurses could relieve this constraint. PAs were not mentioned. Earlier, in 2002, the Health Resources and Services Administration noted the shortfall in trained providers and indicated that PAs could help fill the gap.²³ The inclusion of PAs in hospice and palliative care has been echoed since then; a 2014 Institute of Medicine report stressed the importance of expanding workforce effectiveness in delivering quality services using an interprofessional education and collaboration framework.^{24,25}

Collaboration with physicians has been a hallmark of PA practice since the profession's inception, and this continues in palliative medicine.^{26,27} A rapidly aging population coupled with large numbers of patients taking advantage of hospice—1.5 to 1.6 million patients in 2013—in the context of workforce shortages is ripe for PA expanded practice in hospice and palliative care.²⁸

PAs are trained in the core areas integral to the delivery of palliative care.³ Preparation in palliative care and end-of-life care are specifically required of all PA training programs by Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) standards.²⁹ Finding innovative ways to teach palliative care concepts and reinforcing this with required clinical experiences (or strongly encouraged elective experiences)

may lead to more comprehensive understanding of palliative care and increase PA interest in the field.^{30,31} Furthermore, the very basis of PA training and practice stipulated by the ARC-PA emphasizes the role of interdisciplinary collaboration and teamwork in the delivery of care to patients across the lifespan. Of note, the Palliative Care and Hospice Education and Training Act (in the US House Subcommittee on Health at the time of this writing) will provide money and technical support to train healthcare professionals in hospice and palliative care.³² The bill is intended to amend the Public Health Service Act to increase faculty in palliative care at medical schools, nursing schools, social work schools, and PA programs; promote research and training in hospice and palliative care; and support faculty career development in the palliative discipline.

Multidisciplinary collaboration is not only the ethos of hospice and palliative care, but a regulatory requirement of hospice care in particular.³³ Yet, PAs often are left out of regulation concerning care in hospice and palliative care, including state law concerning palliative care and Medicare hospice coverage.^{17,34} This omission needs to be rectified for the good of patients and their access to services.

At present, PAs cannot be reimbursed for services provided in the hospice setting.

A 2013 survey conducted by the American Academy of PAs (15,925 respondents) identified a small number (12) of PAs practicing primarily in hospice and palliative care.¹⁹ However, the survey indicates that about 16% of surveyed PAs are practicing primarily in related disciplines such critical care (n=118), oncology (n=240), pediatric critical care (n=37), pediatric oncology (n=20), surgical oncology (n=66), trauma surgery (n=126), emergency medicine (n=1,708), pain management (n=241), and radiation oncology (n=30), which often involve palliative skills. In addition, respondents reported working in hospices (n=49), long-term care facilities (n=132), hospital EDs (n=1,416), and intensive/critical care hospital units (n=326) along with other clinical settings serving patients with advanced illness. This further signifies the opportunities PAs have to positively affect palliative-type care for patients with advanced illness.

Additionally, 32% of survey respondents report their primary specialty as primary care. Conversations about advance care planning often take place in primary care offices and may occur over multiple visits when patients and PAs have long-term care relationships. Getting underserved patient populations the information needed to make

informed choices about care in advanced illness falls heavily on the shoulders of PAs, who have become critical providers of services in poorer communities.^{14,35}

OVERCOMING BARRIERS TO PRACTICE

The two main barriers to PA practice in hospice and palliative care are ignorance about PA training and practice and regulations blocking PA practice in hospice settings. Because the CMS and Social Security Act provisions were written before the substantial growth in the PA profession, PAs are not included in these provisions and therefore cannot be reimbursed for services provided in the hospice setting.^{7,17} The Medicare Patient Access to Hospice Act, if passed, will tear down a significant barrier to PA practice in a large subset of palliative care—hospice. The act, introduced in the US House by Rep. Lynn Jenkins (R-Kans.) and Senate by Sen. Michael Enzi (R-Wyo.), proposes to amend the Social Security Act so that PAs can be reimbursed under Medicare for providing care to hospice patients.^{36,37}

Physicians or their organizations are reimbursed by health insurers for palliative medicine services provided by PAs under current procedural terminology (CPT) and International Classification of Disease-Clinical Modification (ICD-CM) codes.^{18,38,39} The ICD-10 code of Z51.5 used by physicians for palliative care encounters can be used by PAs providing services designated by the physician as can the ICD-10 codes for disease-specific care.

Another important development is the early 2016 start of Medicare reimbursement for advance care planning conversations between patients and their providers.⁴⁰ This will likely create more opportunities for PAs to discuss end-of-life decision making with patients. This move by Medicare to recognize time spent discussing end-of-life decision making is critical to expanding patients' understanding of their options. This important aspect of comprehensive patient care has ultimately succeeded despite its exclusion from Affordable Care Act in 2010.⁴¹

Federal Medicare regulation aside, the PA role can vary between states. For example, medical or physician orders for life-sustaining treatment, signed by a patient's healthcare provider, document the patient's preferences about interventions in advanced illness or near the end of life.⁴² However, regulations vary by state on who can sign these documents aside from a physician. Uniform recognition of a PA's signature across all states would further solidify the PA role in partnering with patients about decision making in advanced illness.

For example, the New York State Palliative Care Information Act of 2011 does not include PAs in its mandate that physicians and NPs provide information on palliative care to appropriate patients.³⁴ This is concerning because 2015 Bureau of Labor Statistics data indicate that New York State has the largest number of

employed PAs (11,760) of any state.⁴³ State PA societies, often working closely with state medical societies, are in the best position to engage state legislatures on these matters and should do so with the support of their constituent PAs.

ADVOCATE, ACCLIMATE, AND AGGREGATE

Advocate All parties working in the delivery of PA services can publicize the current PA role in hospice and palliative care and support expanded PA practice in hospice care. PAs, physicians, nurses, patients, and families can contact elected representatives and urge them to support legislative efforts such as the Medicare Patient Access to Hospice Act and the Palliative Care and Hospice Education and Training Act. If passed, these laws will need to be well

PA's can help meet the growing need for hospice and palliative care services.

publicized so that relevant industries can prepare to incorporate the PA's expanded role.

Acclimate PAs, along with PA educators and healthcare service line managers, can respond to the growing need for hospice and palliative care services by furthering their education on these topics, connecting PA students with robust clinical experiences in hospice and palliative medicine, and connecting students with mentors in hospice and palliative care.

Aggregate Health services administrators, including quality improvement leaders, can collect data on their PAs working in hospice and palliative care or related areas such as oncology and critical care, survey patients about PA practice in these areas, and determine what value current or additional PA staff add to care delivery. For example, PA delivery of care in cancer care settings demonstrated equivalent mortality and intensive care transfers as well as decreased length of stay, readmissions, and consults when evaluated against a traditional physician resident model.⁴⁴ Similar findings have been noted for the medical intensive care setting, where palliative approaches to care and care near the end of life are encountered.⁴⁵

The psychosocial aspects of hospice and palliative care practice demand providers capable of meeting patients and families where they are emotionally supporting them through the most difficult times in their lives. PAs have demonstrated a greater orientation toward providing psychosocial care and a willingness to engage seriously ill patients and families, compared with oncologists.⁴⁶

Notably, PAs are playing a substantial role in at least one CMS-funded innovation project aimed at optimizing palliative care for communities.⁴⁷ The Four Seasons Community Palliative Care delivery model in western North Carolina uses specially trained providers (including PAs) to gather point-of-care data on symptoms and patient outcomes. The organization has a history of demonstrating improved care delivery using PAs and NPs.²⁷ The CMS-funded project's goal is to improve patient outcomes, patient and family care satisfaction, and reduce total costs for patients with advanced and life-limiting illnesses, creating a sustainable and replicable model for Medicare.

The need for hospice and palliative care services is growing as the United States deals with evolving healthcare reform and continued disparities in healthcare access for racial and ethnic groups. PAs can help meet this need by widening their practice in palliative medicine, including hospice care. If PAs and others recognize the PA role in the systemwide change necessary for palliative care improvements for populations, patients and families can have improved care experience in all settings, including hospice and palliative care.^{20,48} **JAAPA**

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