

American Academy of Hospice and Palliative Medicine

Testimony for the Record Before the House Energy and Commerce Health Subcommittee Hearing Entitled *“Examining Legislation to Improve Public Health”*

Thursday, September 8, 2016

Chairman Pitts, Ranking Member Green, and members of the Subcommittee, the American Academy of Hospice and Palliative Medicine (AAHPM) would like to thank the House Energy and Commerce Health Subcommittee for the opportunity to share our Academy’s views on **H.R. 3119, the Palliative Care and Hospice Education and Training Act (PCHETA)**. AAHPM particularly offers its gratitude to Congressman Engel for his strong leadership on this important legislation.

AAHPM is the professional organization for physicians practicing Hospice and Palliative Medicine. AAHPM’s nearly 5,000 members also include nurses and other health and spiritual care providers who are committed to improving the quality of life of seriously ill patients and their families/caregivers. For close to 30 years AAHPM has been dedicated to expanding access of patients and families to high-quality palliative care and advancing the discipline of Hospice and Palliative Medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research, and public policy.

This written testimony discusses how Congress can help improve care for the expanding population of patients with serious illness or multiple chronic conditions. We encourage the Subcommittee to consider the needs of these patients and support PCHETA as part of its efforts to improve the nation’s health.

H.R. 3119 would expand opportunities for interdisciplinary education and training in palliative care, including through new education centers and career incentive awards for physicians, nurses, physician assistants, social workers and other health professionals. The bill would also implement an

awareness campaign, to inform patients and health care providers about the benefits of palliative care and hospice and the services available to support individuals with serious or life-threatening illness, as well as direct funding toward palliative care research to strengthen clinical practice and healthcare delivery.

AAHPM's leadership stands ready to further discuss how PCHETA can help advance the Subcommittee's goals for the healthcare system and to answer any questions the Subcommittee has going forward with regard to improving care for patients and families/caregivers through the provision of high-quality palliative care.

BACKGROUND

Defining the problem

By 2050, the population aged 65 and over is projected by the U.S. Census Bureau to be 83.7 million, almost double that in 2012. As the population ages, an increasing number of people will be living with serious, complex and chronic illness. According to the Medicare Payment Advisory Commission (MedPAC), in 2010 more than two-thirds of Medicare beneficiaries had multiple chronic conditions while 14 percent had six or more. Treatment of chronic and serious illnesses, such as heart disease and cancer, now accounts for nearly 93 percent of Medicare spending.

Many of the problems of our health care system—high costs, overutilization, lack of coordination, preventable transitions between health care institutions, and poor quality—become particularly evident during extended chronic and serious illness. But a growing body of medical research has documented the benefits of high-quality palliative and hospice care for patients and families, for hospitals and payers, and for the health care system as a whole.

Palliative care is an essential part of the solution

AAHPM believes that palliative care providers and organizations, including hospices, are integral to meeting the “triple aim” of better care for individuals, improved health of populations, and lower

growth in health care expenditures. Indeed, the National Priorities Partnership has highlighted palliative and end-of-life care as one of six national health priorities that have the potential to create lasting change across the U.S. healthcare system.

Palliative care is an interdisciplinary model of care aimed at preventing and treating the debilitating effects of serious and chronic illness, such as cancer, cardiac disease, respiratory disease, kidney failure, Alzheimer's, AIDS, ALS, and MS. It can be provided from the time of diagnosis and involves the relief of pain and other symptoms that cause discomfort, such as shortness of breath, unrelenting nausea, etc. Palliative care can be offered alongside life-prolonging and curative therapies for individuals living with serious, complex, and potentially terminal illness and includes hospice care.

Palliative care focuses on matching treatments to achievable patient goals, in order to maximize quality of life from diagnosis to death. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences, as well as expert assessment and management of physical, psychological and other sources of suffering across the multiple settings (hospital, post-acute care, ambulatory clinics, home) that patients traverse through the course of a serious illness. Evidence and experience show that seriously ill patients and those with multiple chronic conditions and functional impairment—many of whom are Medicare's highest need and highest cost beneficiaries—strain these systems significantly.

Recent studies have demonstrated that high-quality palliative care and hospice care not only improve quality of life and patient and family satisfaction, but can also prolong survival.¹⁻⁵ Furthermore, palliative care achieves these outcomes at a lower cost than usual care, by helping patients to better understand and address their needs, choose the most effective interventions, and avoid unnecessary/unwanted hospitalizations and interventions.

However, delivery of high-quality palliative care cannot take place without sufficient numbers of healthcare professionals with appropriate skills. By supporting H.R. 3119, AAHPM believes the Subcommittee can help build a healthcare workforce more closely aligned with the nation's evolving

healthcare needs. PCHETA will help close the large gap between the number of health care professionals with palliative care training and the number required to meet the needs of the expanding population of patients with serious illness or multiple chronic conditions.

Workforce Challenges

The reality today is healthcare providers need better education about pain management and palliative care. Students graduating from medical and nursing school have very little, if any, training in the core precepts of pain and symptom management, communication skills, and care coordination for patients with serious or life-threatening illness. The 2014 Institute of Medicine (IOM) report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* noted that “major gains have been made in the knowledge base of palliative care.”⁶ The report documented, however, that “these knowledge gains have not necessarily been matched by the transfer of knowledge to most clinicians caring for people with advanced serious illnesses.” Moreover, the IOM noted that an “overall pattern of inattention to palliative and end-of-life care ... still appears to predominate in the pediatric world.” This lack of healthcare provider knowledge results in too many patients with serious illness receiving painful or ineffective treatments that do nothing to prolong or enhance their lives.

At the same time, despite the growing need for palliative care, the field has been unable to meet patient and health system demand because of a significant shortage of specialist providers. The current gap between those practicing in the field and the number of physicians required to meet current need is likely huge—possibly several thousand physicians. A 2010 article published in the *Journal of Pain and Symptom Management* provides the findings of an AAHPM task force established to assess whether a physician shortage existed and to develop an estimate of the optimal number of Hospice and Palliative Medicine physicians needed to meet current and future needs.⁷ It was determined that an acute shortage of hospice and palliative medicine physicians exists, with the current capacity of fellowship programs insufficient to fill the gap.

As of August 2016, there were a total of 119 Hospice and Palliative Medicine training programs accredited by the Accreditation Council for Graduate Medical Education and 15 training programs accredited by the American Osteopathic Association. For the 2015-2016 academic year, these programs were training just 296 physicians in Hospice and Palliative Medicine. At this rate, today's training programs would produce fewer than 6,000 new Hospice and Palliative Medicine certified physicians *over the next 20 years*.

Yet AAHPM estimated 6,000+ full time equivalents—or 8,000 to 10,000 physicians—would have been required to meet the needs in hospice and palliative care programs back in 2010 (most recent workforce estimates), with up to 18,000 physicians needed if all hospices and palliative care programs were then using exemplary staffing models. These scenarios did not take into account future expansion of need due to population growth and aging or expansion of palliative care services into community settings such as nursing homes, home care, and office practices, all of which have exacerbated the hospice and palliative medicine workforce shortage.

The current Hospice and Palliative Medicine physician shortage can be attributed in large part to faulty Medicare policy. Despite the fact that the majority of patients receiving palliative care and hospice services are Medicare beneficiaries, and that palliative care has been repeatedly shown to increase value in health care by improving quality while reducing costs compared to usual care, Medicare does not invest in the training of Hospice and Palliative Medicine physicians. Instead, Hospice and Palliative Medicine specialty training is entirely dependent on private-sector philanthropy or institutional support because the Balanced Budget Act of 1997 placed a limit on the number of Medicare-supported residency slots before Hospice and Palliative Medicine was formally recognized as a medical subspecialty by the American Board of Medical Specialties. Given the instability of such funding, this is not a sustainable or rational way to train our nation's Hospice and Palliative Medicine physicians.

Nonetheless, noting that “hospice and palliative medicine specialists will never be sufficient in number to provide regular face-to-face treatment of every person with an advanced serious

illness,” the IOM report recommends expanding training opportunities to ensure clinicians across disciplines and specialties who care for people with serious illness are competent in “basic palliative care,” including communication skills, interprofessional collaboration, and symptom management.

Modeled after the existing geriatric education centers, PCHETA would establish Palliative Care and Hospice Education Centers to improve the training of interdisciplinary health professionals in palliative care, develop and disseminate curricula relating to palliative care; support the training and retraining of faculty; support continuing education; provide students with clinical training in appropriate sites of care; and provide traineeships for advanced practice nurses.

H.R. 3119 would also provide for training of physicians who plan to teach palliative medicine, academic career awards for junior medical faculty who commit to spend a majority of their funded time teaching and developing skills in interdisciplinary education in palliative care, and career incentive awards for other eligible health professionals who agree to teach or practice in the field of palliative care.

Finally, PCHETA would further provide supplemental training for faculty members in medical schools and other health professions schools (including pharmacy, nursing, social work, chaplaincy and other allied health disciplines in an accredited health professions school or program, such as a physician assistant education program) so healthcare providers who do not have formal training in palliative care can upgrade their knowledge and skills for the care of individuals with serious or life-threatening illness as well as enhance their interdisciplinary teaching skills.

Expanding Research to Improve Health Care Delivery

PCHETA also aims to strengthen clinical practice and improve health care delivery for patients living with serious or life-threatening illness, as well as their families, by directing funding toward palliative care research. Research funding for palliative care and pain and symptom management comprises less than 0.1 percent of the National Institutes of Health annual budget. From methods for improving communication and decision making to evidence-based treatments for relieving distressing

symptoms of serious illness such as fatigue, nausea, shortness of breath, pain, and confusion, PCHETA would direct an expansion and intensification of research in these important areas.

Raising Awareness

While building the workforce and research base for the field will address key barriers to accessing palliative care services, more must be done to ensure patients and providers are aware of the benefits of palliative care. According to the Institute of Medicine, there is a “need for better understanding of the role of palliative care among both the public and professionals across the continuum of care so that hospice and palliative care can achieve their full potential for patients and their families.” PCHETA would direct the implementation of a national education and awareness campaign so that patients, families, and health professionals understand the essential role of palliative care in ensuring high-quality care for individuals facing serious or life threatening illness.

AAHPM urges the Subcommittee to move swiftly to advance H.R. 3119 and improve the care of patients with serious or chronic conditions by expanding patient and family access to high-quality palliative care. AAHPM looks forward to working with the Subcommittee to improve public health and maximizing the contribution of hospice and palliative medicine physicians and the interdisciplinary palliative care team in that effort. Thank you again for taking the Academy’s written comments into consideration. Please contact Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org if you have any questions.

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