March 20, 2023

The Honorable Bernie Sanders
Chairman
United States Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
United States Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Submitted via HealthWorkforceComments@help.senate.gov

RE: Response to Healthcare Workforce Request for Information

Dear Chairman Sanders and Ranking Member Cassidy,

Thank you for the opportunity to provide information regarding current healthcare workforce shortages and potential ways to address them. We appreciate the committee’s focus on these difficult challenges and the significant impact on patients and clinicians.

The American Academy of Hospice and Palliative Medicine (AAHPM) is the professional organization for physicians specializing in Hospice and Palliative Medicine. AAHPM’s 5,600 members also include nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have timely access to high-quality, equitable palliative and hospice care.

For more than 30 years, AAHPM has been dedicated to expanding patient and family access 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. The following comments focus on the existing and projected workforce shortages among physicians and other health professionals who comprise interdisciplinary palliative care teams. We discuss the policies needed to support specialty training as well as supplement the specialty workforce caring for our nation’s most medically vulnerable patients – those with serious illness and/or near the end of life.
Transforming Care of People with Serious Illness

The U.S. Census Bureau projects that the population aged 65 and over will approximate 83.7 million by 2050, almost double that in 2012. As the population ages, the number of people living with serious, complex, and chronic illness will continue to grow. (Serious illness is a health condition that carries a high risk of mortality and either negatively impacts a person’s daily functioning or quality of life or excessively strains their caregivers.) Many of the problems of our healthcare system – high costs, overutilization, lack of coordination, preventable transitions between healthcare institutions, and poor quality – become particularly evident during extended chronic and serious illness. We believe palliative care offers the solution.

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, ALS, and MS – and involves the relief of pain and other symptoms that cause discomfort, such as shortness of breath and unrelenting nausea. Palliative care is patient- and family-centered – it focuses on matching treatment to achievable patient goals and supporting patients and their families/caregivers during and after treatment to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients can often traverse throughout the course of a serious illness. Palliative care can be provided from the time of diagnosis and offered alongside life-prolonging and curative therapies for individuals living with serious, complex, and eventually terminal illness. Hospice care is palliative care tailored for individuals near the end of life.

Importance of Increasing Educational Opportunities in Palliative and Hospice Care

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.

An expanding 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 healthcare system as a whole. Palliative care is associated with enhanced quality of life for patients, higher rates of patient and family satisfaction with medical care, reduced hospital expenditures and lengths of stay, and other positive outcomes – including longer patient survival time. 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. Hospice care has also been associated with lower cost of care, better outcomes (such as relief of pain), and even longer life, despite its focus on comfort rather than treatment aimed at cure.
Workforce Challenges Impacting Care for People with Serious Illness

Despite the growing need for palliative care, the U.S. is unable to meet patient and health system demand because of a significant shortage of trained providers and insufficient numbers of faculty to train the next generation of these providers.³

Researchers at Duke University, the University of Alabama at Birmingham, and the Mayo Clinic examining the palliative care workforce crisis estimate an absolute growth rate of no more than one percent in palliative care physicians over the next 20 years, with the number of persons eligible for palliative care growing by over 20 percent during that same period, resulting in a ratio of only one physician for every 26,000 patients by 2030.⁴ Similarly, the George Washington University Health Workforce Institute found that current training capacity for Hospice and Palliative Medicine is insufficient to provide hospital-based care and keep pace with growth in the population of adults over 65 years old.⁵ These projections may even underestimate the shortfall, due to the current rapid expansion of community-based palliative care, such as in outpatient and home-based settings.

The public health emergency (PHE) created by the coronavirus and continuing impact of “long COVID” has only exacerbated the need for knowledge and skills in serious illness care, putting a spotlight on an already existing palliative care workforce shortage and the importance of providing better training to all healthcare providers who will be called upon to care for the seriously ill.

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.” The lack of provider knowledge results in too many patients with serious illness receiving painful or ineffective treatments that do nothing to prolong or enhance their lives.

The need for trained providers is borne out by other major institutions working to provide evidence-based policy recommendations. A 2019 National Academies of Sciences, Engineering and Medicine workshop convened to examine workforce issues related to serious illness care found that “to provide high-quality care to people of all ages living with serious illness, it is critical that the nation develop an adequately trained and prepared workforce consisting of a range of professionals, including physicians, nurses, social workers, direct care workers, and chaplains.”⁷

We also see significant disparities in access to palliative and end-of-life care among those who are Black, Indigenous, and People of Color, as well as in rural and low-income communities.⁸,⁹ These populations are often diagnosed with late-stage illness and have inferior outcomes likely leading to increased suffering. A recent survey by the National Hospice and Palliative Care Organization that examined barriers to hospice care for underserved communities found that a lack of representation and diversity among healthcare staff is among the key access issues, suggesting a need to not only to grow but to diversify the palliative care and hospice workforce.¹⁰
Addressing the Hospice and Palliative Care Workforce Shortage

To help improve quality of care and quality of life for the growing and diverse population of patients with serious illness throughout the continuum of care, we urge the Committee to advance the bipartisan Palliative Care and Hospice Education and Training Act (PCHETA) as part of its efforts to address healthcare workforce shortages.

PCHETA was reintroduced in the 117th Congress by Senators Tammy Baldwin (D-Wisc.) and Shelly Moore Capito (R-W.V.) who plan to reintroduce the bill in the 118th Congress. This bipartisan legislation recognizes the importance of well-trained, interprofessional healthcare teams to ensuring high-quality, coordinated, person-centered care. Modeled after the existing geriatric education programs in the Public Health Service Act, PCHETA would establish Palliative Care and Hospice Education Centers to provide an infrastructure for expanding interdisciplinary education and training in palliative care and provide for career incentive awards for physicians, nurses, physician assistants, social workers, and other health professionals. PCHETA also would create opportunities to train and retrain faculty to provide instruction in interprofessional team-based palliative care, draw existing clinicians to practice in this field, and enhance opportunities to provide training through a variety of service rotations including community care programs.

We believe enacting PCHETA will go a long way in helping our nation meet current health workforce challenges as well as those of the future, including future pandemics. Palliative care has been a vital component of COVID-19 care. But with palliative care and hospice teams stretched thin in the wake of the PHE, addressing the critical shortage of health professionals with knowledge and skills in palliative care is even more urgent, particularly as the United Nations predicts future pandemics are likely to be more frequent and more deadly.

PCHETA can also play a role in our nation’s response to the dual public health crises of undertreated pain and overdose deaths. By exposing students (medical, nursing, PA, pharmacy) to palliative care education and training early on – before they choose the area in which they will practice – these health professionals will develop skills in assessing and managing pain, leading to more effective, evidence-based pain care and prescribing. PCHETA also expands the number of trained faculty in medical, nursing, and other health professions schools who can incorporate appropriate pain management education into their teaching. Additionally, the bill requires the National Institutes of Health (NIH) to expand and intensify research programs in pain and serious illness care. Currently only a fraction of one percent of NIH funds are spent in this area. This holds great potential to strengthen clinical practice and healthcare delivery, including multimodal pain and symptom management.

AAHPM is not alone in championing PCHETA. It has enjoyed strong bipartisan support in Congress (and previously passed the House twice), as well as broad support from more than 60 national and state organizations. We urge you to consider this legislation as you develop workforce proposals and to ultimately advance PCHETA in the Senate to ensure our nation has the robust, well-trained workforce necessary to ensure access to high-quality, equitable care for the expanding and diverse population of patients with serious illness, as well as their families and caregivers.
Addressing Distribution of the Hospice and Palliative Care Workforce

AAHPM applauds your leadership in examining the healthcare needs of our nation’s rural and underserved populations and crafting bipartisan legislation to incentivize specialty physicians to serve in rural America where significant barriers limit access to specialty care – including palliative and hospice care.

The Academy supports the Provider Training in Palliative Care Act, and we urge the committee to include this legislation as you develop a workforce package. Introduced by Sens. Jacky Rosen (D-Nev.), Lisa Murkowski (R-Alaska), and Tina Smith (D-Minn.) as S. 2890 in the 117th Congress, this bill would allow National Health Service Corps (NHSC) participants to apply for a deferral of their service obligation for one year in order to receive training in palliative care. Currently, those participating in the NHSC may receive a deferral to pursue additional training in health services such as pediatrics, obstetrics and gynecology, dentistry, and mental health. Notably, the Committee attempted to add palliative care last year during consideration of the PREVENT Pandemics Act (Sec. 227 of the AINS to S. 3799, 117th Congress), but the section ultimately was not included in the Consolidated Appropriations Act, 2023 (P.L. 117-328).

We also support the Specialty Physicians Advancing Rural Care (SPARC) Act and recommend that the Committee incorporate its provisions in any workforce package. Reintroduced this Congress by Senators Jacky Rosen (D-Nev.) and Roger Wicker (R-Miss.) as S. 705, the SPARC Act would help address the shortage of physicians in rural communities by creating a student loan repayment program for specialist physicians and non-physician specialty providers practicing in rural areas. We urge your continued attention to policies such as this, which aim to improve access to specialty care in rural areas, particularly as projections of the future hospice and palliative medicine workforce capacity predict the greatest shortages in rural areas.

For these programs to substantially increase the number of hospice and palliative medicine professionals practicing in rural and underserved areas, we need legislation such as PCHETA to ensure we have the faculty and programs to train more individuals. These bipartisan bills will complement PCHETA and, together, meaningfully address our nation’s current healthcare workforce challenges and help ensure a robust, well-trained workforce for the future.

Thank you again for the opportunity to provide feedback on health care workforce shortages. AAHPM leaders stand ready to work with the committee to address the issues discussed here to improve care and quality of life for millions of Americans facing serious illness, along with their families and caregivers. Please direct questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,

Tara C. Friedman, MD FAAHPM
AAHPM President
REFERENCES


