Aligning Graduate Medical Education with the Changing Health Care Landscape:

Growing the Hospice and Palliative Medicine Physician Workforce

The American Academy of Hospice and Palliative Medicine (AAHPM) believes policymakers can help build a health care workforce more closely aligned with the nation's evolving health care needs through efforts to 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. 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. Reforming the nation's graduate medical education (GME) system to support fellowship training in Hospice and Palliative Medicine (HPM) and grow the HPM physician workforce is essential to meeting the "triple aim" of health care reform.

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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.

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 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. 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.

Workforce challenges

Delivery of high-quality palliative care cannot take place without sufficient numbers of healthcare professionals with appropriate skills. Despite the growing need for palliative care, however, the field has been unable to expand to meet patient and health system demand because of a significant shortage of trained providers.

As of April 2015, there were a total of 106 hospice and palliative medicine training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). For the 2014-2015 academic year, these programs were training just 265 physicians in hospice and palliative medicine. At this rate, today's training programs would produce roughly 5,300 new hospice and palliative medicine certified physicians *over the next 20 years*.

Yet in 2010, AAHPM estimated 6,000+ full time equivalents—or 8,000 to 10,000 physicians—were required to meet then current needs in hospice and palliative care programs, with up to 18,000 physicians needed if all hospices and palliative care programs used 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 can be expected to exacerbate the HPM workforce shortage.

Investing in a physician workforce that brings value to health care

The 2014 Institute of Medicine (IOM) report *Graduate Medical Education That Meets the Nation's Health Needs* points out "it has never been more critical for the nation's graduate medical education (GME) system to produce a physician workforce that meets the evolving health needs of the population." The report recommends developing a "physician workforce better prepared to work in, lead, and continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost."

Because the number of people living with serious and complex chronic illness is expected to skyrocket over the coming decades, HPM training capacity needs to expand considerably. The IOM report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* report stated: "…entities such as health care delivery organizations, academic medical centers, and teaching hospitals that sponsor specialty-level training positions should commit institutional resources to increasing the number of available training positions for specialty-level palliative care."

The current HPM 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 HPM 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 HPM physicians. Because the Balanced Budget Act of 1997 placed a limit on the number of Medicare-supported residency slots—before HPM was formally recognized as a medical subspecialty by the American Board of Medical Specialties—specialty training in HPM is entirely dependent on private-sector philanthropy or institutional support. Given the instability of such funding, this is not a sustainable or rational way to train our nation's HPM physicians.

Policy change is needed now

Public policy aimed at increasing residency positions is sorely needed, and programs that offer high value and/or demonstrated shortage should get top priority. Further, GME policy must recognize that health care delivery has changed since the 1960s, when public financing of GME began, and that the priorities of the present funding structure are out of alignment with the existing reality. The IOM's report on GME in fact encourages "innovation in the structures, locations, and designs of GME programs." The Council of Medical Specialty Societies' Position Statement on GME Financing, to which AAHPM is a signatory, similarly suggests that future GME financing should acknowledge the costs of developing and sustaining new training venues that will optimally be used to educate medical professionals from all backgrounds in team-based skills required for the future. The nature of team-based HPM practice naturally lends itself to these innovations. Fellows meet patient needs and their own educational requirements in homes, skilled nursing, and long-term care settings across the U.S., while a team approach is employed to educate other health care providers and promote integration of palliative care principles across health care systems. AAHPM seeks to collaborate with partners who share these priorities for reforming GME financing.

AAHPM Policy Recommendations

In order to reform the nation's GME financing system to align with the evolving health care landscape and improve care for the expanding population of patients with serious illness or multiple chronic conditions, the American Academy of Hospice and Palliative Medicine recommends:

- Expanding GME funding for hospice and palliative medicine and primary care so that funding more appropriately reflects the health care needs of the U.S. population
- Developing innovative models for GME financing, including considering all payers of health care services as sources of funds
- Lifting the cap on residency position funding to allow for development and expansion of ACGME-accredited training programs in high-value/high-need specialties such as hospice and palliative medicine
- Eliminating the 0.5 weighting factor for subspecialty training, or creating an exception for hospice and palliative medicine
- Revising the current hospital-based GME financing system to reflect changes in health care delivery towards non-acute settings and the diversity of training needs of different medical specialties
- Encouraging and funding innovative fellowship models, including midcareer and part-time options that would qualify physicians for board certification in hospice and palliative medicine
- Providing meaningful and timely loan forgiveness for physicians pursuing careers in hospice and palliative medicine

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