



PALLIATIVE CARE AND HOSPICE EDUCATION AND TRAINING ACT

BACKGROUND

Palliative care improves quality, controls cost, and enhances patient and family satisfaction for the rapidly expanding population of individuals with serious or life-threatening illness. In 2000, less than one-quarter of U.S. hospitals had a palliative care program, compared with nearly three-quarters in 2013. This growth comes in response to the increasing numbers and needs of Americans living with serious, complex and chronic illnesses and the realities of the care responsibilities faced by their families. Palliative care is a relatively new medical specialty and more must be done to ensure patients and providers understand the benefits of palliative care and that an adequate palliative care workforce is available to provide the comprehensive symptom management, intensive communication and level of care coordination that addresses the episodic and long-term nature of serious, chronic illness.

BILL SUMMARY

PALLIATIVE CARE AND HOSPICE EDUCATION CENTERS

Establishes 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.

PHYSICIAN TRAINING

Authorizes grants or contracts to schools of medicine, teaching hospitals and graduate medical education programs to train physicians (including residents, trainees, and fellows) who plan to teach palliative medicine. Such programs will provide training in palliative medicine through a variety of service rotations, such as consultation services, acute care services, extended care facilities, ambulatory care and comprehensive evaluation units, hospice, home health, and community care programs. Programs will be required to develop specific performance-based measures to evaluate the competency of trainees.

ACADEMIC CAREER AWARDS

Establishes a program to promote the career development of physicians who are board certified or board eligible in Hospice and Palliative Medicine and have a junior (non-tenured) faculty appointment at an accredited school of medicine. Eligible individuals must provide assurance of a full-time faculty appointment in a health professions institution and commit to spend a majority of their funded time teaching and developing skills in interdisciplinary education in palliative care.

WORKFORCE DEVELOPMENT

Establishes fellowship programs within the new Palliative Care and Hospice Education Centers to provide short-term intensive courses focused on palliative care. Supporting the team approach to palliative care, the fellowships will 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 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.

CAREER INCENTIVE AWARDS

Provides grants or contracts for eligible health professionals who agree to teach or practice in the field of palliative care for at least 5 years. Eligible individuals include: advanced practice nurses, social workers, physician assistants, pharmacists, or students of psychology who are pursuing a doctorate, master's or other advanced degree with a focus in palliative care or related fields in an accredited health professions school.

NURSE TRAINING

Creates special preferences in existing nurse education law for hospice and palliative nursing, in education, practice and quality grants, workforce development, and nurse retention projects.

PALLIATIVE CARE EDUCATION AND AWARENESS

Provides for the establishment of a national campaign to inform patients, families and health professionals about the benefits of palliative care and the services that are available to support patients with serious or life-threatening illness. Directs the dissemination of information, resources and materials about palliative care services to health professionals and the public in a variety of formats, in consultation with professional and patient stakeholders.

ENHANCED RESEARCH

Directs the National Institutes of Health to use existing authorities and funds to expand palliative care research to advance clinical practice and improve care delivery for patients with serious or life-threatening illness.



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.

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 healthcare system. In fact, 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 or unwanted hospitalizations and interventions. However, **the delivery of high-quality palliative care cannot take place without sufficient numbers of healthcare professionals with appropriate training and skills.**

What Is Palliative Care?

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 is patient- and family- centered—it focuses on **matching treatment to achievable patient goals 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 traverse throughout the course of a serious illness. **Palliative care can be offered alongside life-prolonging and curative therapies for individuals living with serious, complex, and eventually terminal illness and includes hospice care.**

Why Is a Palliative Care and Hospice Education and Training Bill Needed?

Healthcare providers need better education about pain management and palliative care. Students graduating from medical and nursing school today 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 Institute of Medicine 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.” 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, studies show an “overall pattern of inattention to palliative and end-of-life care ... still appears to predominate in the pediatric world.”⁶ **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.**

How Significant is the Shortage of Palliative Medicine Physicians?

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.**

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 hospice and palliative medicine workforce shortage.

Indeed, 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.

- 1 Temel JS, Greer JA, Muzikansky A, Gallaher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ. Early palliative care for patients with metastatic non-small cell lung cancer. *NEJM* 363(8):733-742 (2010).
- 2 Connor SR, Pyenson B, Fitch K, Spence C, Iwasaki K. Comparing hospice and nonhospice patient survival among patients who die within three-year window. *J Pain Symptom Manage*. 2007;33(3):238-236.
- 3 Hanson LC, Usher B, Spragens L, Bernard S. Clinical and economic impact of palliative care consultation. *J Pain Symptom Manage*. 2008;35:340-346.
- 4 Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008;168(16):1783-1790.
- 5 Penrod JD, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: effects on hospital cost. *J Palliat Med*. 2010;13(8):973-979.
- 6 "4 Professional Education and Development." Institute of Medicine. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: The National Academies Press, 2014.
- 7 Lupu D. Estimate of current hospice and palliative medicine physician workforce shortage. *J Pain Symptom Manage*. 2010;40(6):899-911.

