Center to Advance Palliative Care
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March 20, 2023

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

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

RE: Request for Information – Health Care Workforce Shortages

Dear Chairman Sanders and Ranking Member Cassidy,

Thank you for the opportunity to provide input on ways in which the Senate Committee on Health, Education, Labor and Pensions (HELP) can address the current health care workforce shortage.

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to ensuring that all persons living with serious illness have access to high-quality, equitable care that addresses their symptoms and stresses, including access to specialty palliative care services. Palliative care specifically refers to specialized medical care for people living with a serious illness, focused on providing relief from the symptoms and stress of the illness. It is an *added* layer of support, working in partnership with other providers and can be provided along with curative treatment. A strong and consistent evidence base indicates that palliative care – delivered from the point of diagnosis – improves quality of life, reduces caregiver and clinician burden, and reduces avoidable utilization and spending.

CAPC appreciates the steps the HELP Committee is taking to better understand the root causes of the current health care workforce shortage within the US. As the population ages, there will be higher incidence of serious or complex illness that would benefit from specialty palliative care services. However, calculations confirm that the current pipeline of specially-trained clinicians is insufficient to meet growing demand, with a greater number of board-certified Hospice and Palliative Medicine (HPM) physicians leaving the field than entering it in the coming years. One study found that one-third of palliative care clinicians (including physicians, nurses, and social workers) reported burnout, and more recent surveys conducted by the Palliative Care Quality Collaborative found that nearly one-third of palliative care program leaders are concerned about the burnout of their current staff. While the COVID-19 pandemic helped validate the need for specialty-trained palliative care clinicians, it also strained an already over-stretched workforce.

To help address the health care workforce crisis in this country, we offer the following recommendations in order to, first, preserve the current workforce, and, second, build a pipeline for the next generation of providers.

Workforce Preservation

Exposing Mid-Career Professionals to Palliative Care and/or Other Patient-Centered Specialties.
Despite the recent strain on palliative care clinicians, studies have found that the practice of palliative medicine results in high clinician satisfaction, and studies in other countries have found a lower

prevalence of burnout for palliative care physicians when compared to those in other specialties. There are myriad reasons for these differences, but chief among them is the opportunity to connect deeply and meaningfully with patients, ensuring true person-centered care. It is this type of emotionally rewarding experiences that attracted so many clinicians to their profession in the first place; yet there are few specialties in the US health care system that actually practice in this way.

Unfortunately, palliative care is still a relatively new field, and many clinicians in training may not be aware of this option when it comes time to specialize. The economics of medical training in particular may also create pressure for clinicians to select more lucrative specialties. And while many mid-career professionals might be interested in pursuing another specialty – particularly one like palliative care that could potentially extend their longevity in the workforce – few can afford to step away from their full-time jobs to complete fellowship training that may require them to relocate and be compensated at a fraction of the salary they receive.

Therefore, to meet the demand for palliative care services AND to support those in other fields who are considering leaving clinical work entirely, **we recommend the development of a federally-supported program to enable mid-career rotations in palliative care services**. Physicians and nurses could apply to work full-time or part-time on a palliative care service, experiencing a valuable facet of health care while gaining key skills in patient communication and symptom management. At the end of the rotation, these clinicians may elect to continue their career in the palliative care specialty; or they may return to their prior field, albeit with additional skills that can help them find more meaning and satisfaction in their future patient encounters.

There are promising models that the HELP Committee can examine to inform the development of such a program. In 2019, the University of Pennsylvania began piloting a part-time, competency-based, and time-variable fellowship program for mid-career professionals with board certification in internal medicine or a medical subspecialty. And in the summer of 2020, the University of Colorado School of Medicine began offering a non-residential HPM fellowship that allows clinicians to stay and train in their communities.

Note that this national mid-career palliative care rotation, while built on the experiences of medical residents rotating on the palliative care service, will require careful planning to ensure sufficient supervision and professional career development for the participants. Therefore, we recommend that the Department of Health and Human Services develop an implementation plan that includes a three-to-five year pilot program before any national effort is launched. We also recommend that this work begin with an analysis of existing models, including those listed above.

Attending to the Holistic Needs of the Current Health Care Workforce

While we are certain that the HELP Committee is familiar with the Surgeon General's Advisory on Health Worker Burnout, as well as the National Academy of Medicine's National Plan for Health Workforce Well-Being, we would like to reiterate the recommendations therein as part of this conversation. Clinician burnout reflects a longstanding, multi-system failure; therefore, efforts to stabilize the workforce must address issues like administrative burden; violence against health care workers; systemic racism; and stigma associated with mental health needs; etc. Furthermore, this work must be undertaken by powerful stakeholders at all levels, including health care organizations; federal, state, local, and tribal governments; health insurers and payers; health care technology companies; academic institutions, clinical training programs, and accreditation bodies; and researchers, as well as clinicians and community members.

Future Workforce Capacity

Beyond protecting the current workforce, it is also essential that the HELP Committee pass legislation to grow the future pipeline of palliative care professionals. In particular, **we urge the passage of the Palliative Care and Hospice Education and Training Act** (**PCHETA**, S. 4260 in the 117th Congress). This bipartisan legislation, introduced by Senators Tammy Baldwin and Shelley Moore Capito seeks to address interdisciplinary workforce shortages for the care of patients with serious illness. PCHETA would:

- Expand opportunities for interdisciplinary education and training in palliative care and end-of-life care through the establishment of education centers and career incentive awards for physicians, nurses, advanced practice nurses, and social workers, and other health professionals.
- Enhance existing health professions education programs by providing incentives to incorporate palliative care and hospice training.

In addition, **we strongly recommend a further increase the number of residency slots** funded by Medicare and ensure distribution of these positions address specialty shortages, as provided in the bipartisan *Resident Physician Shortage Reduction Act of 2021* (H.R. 2256/S. 834, 117th Congress). HPM fellowship training programs are not eligible to receive federal funds since, HPM was recognized as a formal subspecialty in 2006, and Medicare GME funding was capped in 1997. This cap should be updated to address evolutions in medicine and patient needs, especially given the current demographics and demands. While we recognize that this might not fall under the jurisdiction of the HELP Committee, we urge members of this body to consider ways to partner with colleagues to advance this bill, and/or identify alternative strategies to expand training slots for new clinicians (ideally beyond physicians to encompass the full interdisciplinary team).

Finally, we recommend that the HELP Committee consider loan repayment vehicles such as the *Provider Training in Palliative Care Act* (S. 2890, 117th Congress) and S.705 (118th Congress). Both introduced by Senator Jacky Rosen, the former would modestly expand the criteria for participants in the National Health Service Corps (NHSC) to defer their obligated service to receive training in palliative care services. Meanwhile, the latter would authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage; it would also include loan forgiveness for certain urgently needed specialists, including hospice and palliative medicine.

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Thank you for the opportunity to submit these comments. Please do not hesitate to contact me or Stacie Sinclair, Associate Director for Policy (stacie.sinclair@mssm.edu), if we can provider further assistance.

Sincerely,

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