AAHPM

American Academy of Hospice and Palliative Medicine

RECOMMENDATIONS FOR HEALTH CARE REFORM

The **American Academy of Hospice and Palliative Medicine** (AAHPM) represents more than 3700 physicians and providers caring for patients with life-threatening or serious conditions and their families. These professionals come from many medical specialties, such as internal medicine, family medicine, pediatrics, surgery, neurology and psychiatry, anesthesiology, physical medicine and rehabilitation, radiology and emergency medicine. Hospice and Palliative Medicine (HPM) is a newly recognized medical subspecialty that focuses on relieving pain and suffering, improving communication with patients and families, and informed decision-making regardless of prognosis or eligibility for hospice care.

Despite enormous expenditures, studies demonstrate that patients with serious illness and their families receive poor quality medical care, characterized by untreated symptoms, high caregiver burden, and low patient and family satisfaction. The rapid growth of hospice and palliative care has been a response to the unmet needs of these patients.

Many of the problems of our health care system – high costs, over-utilization, lack of coordination, preventable transitions between health care institutions, and poor quality – become particularly evident in the last years of life[1]. We can help. A growing evidence base has demonstrated the potential of palliative care to control costs, improve quality and enhance patient and family satisfaction for a rapidly expanding population of patients with serious and life-threatening illness[2].

The National Quality Forum and the National Priorities Partnership[3] have identified "Palliative and End-of-Life Care" as one of six national priorities in health care reform. The National Institutes of Health (NIH)[4] and the Institute of Medicine[5] have both recommended substantial investment in hospice and palliative care. Barriers to assuring access to quality palliative care for all Americans with advanced or serious illness include lack of physician and nursing education; financial disincentives discouraging workforce development (palliative medicine training programs competing with high-revenue generating specialties in academic centers) and organizational commitment; lack of regulatory and accreditation requirements for quality palliative care across health care settings; lack of an evidence base guiding quality care; and need for adequate compensation to attract young professionals into the field.

As policymakers consider options for health care reform, AAHPM suggests the following targeted steps to strengthen workforce, research and care delivery, including for the growing population of Medicare beneficiaries, in the last years of life.

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Summary

- **Support efforts to increase the number of hospice and palliative medicine (HPM) specialists through increased funding for graduate medical education (GME) and faculty development.**

  - Assure GME payments for FTE (vs. 0.5) for HPM training programs
  - Allow GME payments for community-based training programs and sites of service
  - Create HPM Academic Career Awards and Education Centers

- **Support increased funding for palliative care research to strengthen clinical practice and improve health care delivery for patients living with multiple chronic conditions or life-threatening or serious illness, as well as their families.**

  - Direct NIH funding to focus on HPM research in pain, other symptoms, shared-decision making and care delivery
  - Conduct HHS Demonstration and pilot projects in hospital-based and out-patient based palliative care programs

- **Support efforts to improve access to and delivery of HPM services for patients with life-threatening or serious illness in all clinical settings.**

  - Ensure access to HPM in all clinical settings
  - Enhance reimbursement for HPM consultation
  - Provide reimbursement for consultation for family meetings and shared decision-making, training and resources to support caregivers

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[1]Tracking the Care of patients with Severe Chronic Illness, The Dartmouth Health Atlas 2008, http://www.dartmouthatlas.org/atlases/2008_Chronic_Care_Atlas.pdf

[2] Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE. Cost savings associated with US hospital palliative care consultation programs. Arch Intern Med 2008;168:1783-90

[3] National Priorities Partnership: http://www.qualityforum.org/about/NPP/

[4] National Institutes of Health, National Institutes of Health State-of-the-Science Conference Statement on Improving End-of-Life Care, State-of-the-Science Conference Statement. December 6–8, 2004. http://consensus.nih.gov/2004/2004EndOfLifeCareSOS024html.htm

[5] Field MJ, Cassel CK, eds. *Approaching death: improving care at the end of life*. Washington, D.C.: National Academy Press; 1997.

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RECOMMENDATIONS FOR HEALTH CARE REFORM

I. The Academy of Hospice and Palliative Medicine supports efforts to increase the number of hospice and palliative medicine (HPM) specialists through increased funding for graduate medical education (GME) and faculty development.

A growing evidence base has demonstrated the value of HPM to enhance quality and control costs for a rapidly expanding population of patients with multiple chronic conditions or life-threatening or serious illness, as well as their families[1],[2]. The Accreditation Council for Graduate Medical Education (ACGME) has now accredited 48 graduate training fellowship programs in HPM, but many are in jeopardy due to current funding mechanisms. Support for these programs is critical to assure an adequate workforce to meet the needs of these complex patients and to train the next generation of physicians. Targeting funds to support the growth and development of clinical faculty in HPM is essential as fellowship programs are forced to compete with subspecialties (i.e. cardiology, oncology, etc) that have greater revenue generating potential.

AAHPM looks to policymakers to:

- Assure GME payments for HPM fellows pay for full-time equivalent (FTE) --rather than 0.5 -- for palliative medicine fellowship training programs. This is needed due to workforce shortages in these areas and is similar to existing GME funding provisions for Geriatric Medicine and Pediatric Neurology fellowship programs.
- Support extension of GME to allow payments to community-based training programs and sites of service
- Lift the cap on residency position funding for ACGME-accredited training programs for HPM.
- Create a Palliative Care Academic Career Award and Palliative Care Education Centers through Health Resources and Services Administration (similar to Title VII Geriatric Health Professions Training Programs)

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[1] Morrison R, Perod J, Cassel J et al. Cost savings associated with US hospital palliative care consultation programs . Arch Int Med 168 (2008) 1783-1780.

[2] Taylor D, Osterman O, Van Houtven C et al. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? Soc Sci Med. 65 (2007) 1466-1478.

II. The Academy of Hospice and Palliative Medicine supports increased funding for palliative care research to strengthen clinical practice and improve health care delivery for patients living with multiple chronic conditions or life-threatening or serious illness, as well as their families.

The National Institutes of Health [3] and the Institute of Medicine[4] have called for substantial investments in palliative care research. While the growth of our field has been remarkable, the knowledge base to support basic elements of clinical practice, communication (shared decision-making) and care delivery still remains small. Specific focus areas and funding mechanisms for HPM research should be developed in several NIH centers (National Cancer Institute, National Institute on Aging, National Heart, Lung and Blood Institute, National Center for Nursing Research).

AAHPM looks to policymakers to:

- Direct the National Institutes of Health (NIH) to conduct research on relief and prevention of symptoms and communication in advanced illness.
- Direct the NIH to develop a Career Development Award in Hospice and Palliative Medicine
- Direct the NIH to develop Centers of Excellence in Hospice and Palliative Care
- Direct the Secretary of Health and Human Services to conduct Medicare and Medicaid demonstration projects/pilot programs to evaluate hospital-based, nursing-home based and community-based non-hospice palliative care programs for patients with multiple diseases or life-threatening or serious conditions.
- Direct "Comparative Effectiveness" research funding to evaluate palliative care delivery models, alternative approaches to pain and symptom management, communication and care coordination for seriously ill patient populations and their families

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[3] National Institutes of Health, **National Institutes of Health State-of-the-Science Conference Statement on Improving End-of-Life Care** State-of-the-Science Conference Statement. December 6–8, 2004. http://consensus.nih.gov/2004/2004EndOfLifeCareSOS024html.htm

[2] *Marilyn J. Field and Christine K. Cassel, Editors; Committee on Care at the End of Life, Institute of Medicine* . **Approaching Death: Improving Care at the End of Life. 1997**
www.iom.edu/CMS/3809/12687.aspx

III. The Academy of Hospice and Palliative Medicine supports efforts to improve access to and delivery of HPM services for patients with life-threatening or serious illness in all clinical settings.

HPM embraces a model of care that is essential to the creation of an efficient, high quality and patient-centered health care system. The National Quality Forum and the National Priorities Partnership[5] have identified "Palliative and End-of-Life Care" as one of 6 national priorities in health care reform. Many of the problems of our health care system: over-utilization, lack of coordination, preventable transitions between health care institutions and poor quality become particularly focused in the last years of life[6],[7]. HPM must be a central component of any successful national health care delivery and payment reform effort.

AAHPM looks to policymakers to:

- Require access to hospice and non-hospice palliative care services for eligible beneficiaries in all models of payment reform (including medical home, bundled payment plans or accountable care organizations)
- Provide reimbursement for physician consultation to determine goals and medical orders for care (POLST)
- Define a "Never Event" for health care transitions, limiting reimbursement for transferring institutions who fail to address and communicate goals of care for qualified patients.
- Allow for comprehensive/bundled payments for interdisciplinary palliative care consultations under the new CMS hospice and palliative medicine specialty code
- Reform payments under the Medicare Hospice Benefit so as to encourage admission to hospice care earlier in the course of illness
- Ensure access to Medicare hospice services for all appropriate patients in any clinical setting
- Provide for the development and testing of hospice and palliative care quality measures
- Develop supports (training, resources, tax credits) for caregivers of patients with serious illness
- Fund measures to support family caregivers, including reimbursement for provider time spent in family conferences focused on achievable care goals and transition planning

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[5] National Priorities Partnership: http://www.qualityforum.org/about/NPP/
[6] Fisher E, Bynum J and Skinner, J Slowing the growth of health care costs- the lessons of regional variation. NEJM 360 (2009) 849-852.
[7] http://www.dartmouthatlas.org/atlases/2008_Chronic_Care_Atlas.pdf