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National Hospice and Palliative Care Organization

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The Honorable Bernard Sanders
Chairman
U.S. Senate HELP Committee
428 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
Ranking Member
U.S. Senate HELP Committee
428 Senate Dirksen Office Building
Washington, DC 20510

Dear Chairman Sanders and Ranking Member Cassidy,

On behalf of the National Hospice and Palliative Care Organization (NHPCO), a membership organization of more than 4,000 hospice locations representing nearly 60,000 hospice professionals and hundreds of thousands of volunteers dedicated to caring for patients and families across the country, and its advocacy affiliate the Hospice Action Network (HAN), we thank you for allowing us the opportunity to provide input on the drivers and solutions of the healthcare workforce shortage. As the Senate Health, Education, Labor, and Pensions (HELP) Committee considers future legislation, we hope you keep hospice and palliative care providers in mind.

For years, hospices and palliative care facilities have experienced workforce shortages. This issue predated COVID-19 but has only been exacerbated since the pandemic began. During one of the nation's worst public health crises, hospices have struggled to keep their doors open and serve patients largely due to a shortage of healthcare workers and growing wage pressures competing with other healthcare providers for workers. As our population continues to age, the demand for hospice and palliative care services will only grow.

Palliative care, often delivered through hospice, is specialized care that focuses on preventing and treating the debilitating effects of serious illness throughout the continuum of care. Clinicians are trained to assess and manage the bothersome and challenging aspects of illnesses, as palliative care seeks to anticipate, prevent, and treat physical, emotional, social, and spiritual suffering. Most importantly, palliative care clinicians aim to facilitate and support the goals and values of patients, whatever they may be. In sum, palliative care focuses on the priorities of the patient and their families which has been demonstrated to improve both the quality of care and the quality of life for patients and their families during and after treatment.

Research[1] from the American Academy of Hospice and Palliative Medicine (AAHPM) indicates that there is a shortage of adequately trained hospice or palliative care providers. Moreover, the current rates of educating and training medical professionals in palliative care will not be sufficient to ensure all aging and seriously ill Americans have access to quality palliative care. Additionally, a 2017 study by the George Washington University Healthcare Institute estimates that there will be no more than 1% growth in the palliative care and hospice physician workforce in the next 20 years, while the number of people eligible for palliative care will increase by over 20 percent. Without a boost for palliative care education and training, there will be only one palliative physician for every 26,000 seriously ill patients by 2030.[2]

[1] https://aahpm.org/uploads/advocacy/AAHPM%20Workforce%20Flyer%20-%202018.pdf
[2] Lupu D, Quigley L, Mehfoud N, Salsberg, ES. The Growing Demand for Hospice and Palliative Medicine Physicians: Will the Supply Keep Up? J Pain Symptom Manage. 2018 Apr;55(4):1216-1223

In addition to experiencing an improved quality of life (compared to patients who don't receive palliative care), palliative care patients avoid unwanted medical treatment by spending fewer days in the hospital, less use of the emergency department and intensive care units and need fewer readmissions which ultimately free up the broader healthcare workforce to focus on other patients. Put simply, investments in palliative care have broad beneficial outcomes.

Hospices and palliative care providers are increasingly facing significant financial constraints: inflation increases the cost to provide care, wages rising rapidly, while a reimbursement structure barely covers these costs. Recruiting and retaining staff is the number one issue facing providers and we encourage the Committee to dive into our recommendations and the submissions of others in our sector to provide relief so we can focus on what's important, caring for seriously ill patients and their families.

NHPCO and HAN encourage the Committee to support the Palliative Care and Hospice Education and Training Act (PCHETA).

PCHETA would address the palliative care workforce shortage and help respond to pressing issues including addressing under-treated pain and pandemic preparedness. PCHETA will work to address the critical shortage of health professionals with knowledge and skills in palliative care, build the evidence-base for serious illness care, and educate all who care for patients. PCHETA will not only help strengthen the palliative care workforce but also help ensure that going forward, patients and providers are aware of the benefits of palliative care so that patients can receive palliative care as appropriate. According to the Institute of Medicine, there is a "need for better understanding of the role of palliative care among both the public and professionals across the continuum of care."

Congress has long worked on a bipartisan basis to support and advance PCHETA. The House has twice passed it with overwhelming bipartisan support. PCHETA is supported[3] by more than 60 national and state organizations. We urge you to ensure that all Americans facing serious illness have access to palliative care and to support the development of needed training programs in this area for our healthcare professionals.

NHPCO and HAN encourage the Committee to support the Provider Training in Palliative Care Act.

This bi-partisan legislation, introduced by Senators Rosen (D-NV) and Murkowski (R-AK), would expand the criteria for participants in the National Health Service Corps (NHSC) to defer their obligated service to receive training in palliative care services.

By allowing individuals to defer service and receive training in palliative care, this bill will expand knowledge and understanding of palliative care for those operating in other sectors of healthcare including primary care. Increased knowledge ensures patients receive timely referrals to palliative care providers to help them manage the symptoms of their serious illness as well as experience fewer hospitalizations.

NHPCO and HAN encourage the Committee to support the Travel Nursing Agency Transparency Study Act.

[3] http://patientqualityoflife.org/wp-content/uploads/2022/05/PCHETA-Senate-Support-Letter-117th-Congress_05202022-S4260-Revised.pdf

We are concerned that travel nursing agencies have exploited the pandemic and acted in anti-competitive ways. Agencies appeared to have capitalized on the desperate need for nurses by charging exorbitant rates to bring in profits for themselves without much of the actual earnings being passed on to nurses. In January 2021, wages for travel nurses were up to 3.4 times higher than full-time nurses employed in more traditional settings. Several staffing agencies have reported gross profit increases of more than 90% between 2020 and 2022. The industry's revenue also tripled to about $11.8 billion in 2021, up from $3.9 billion in 2015, according to Staffing Industry Analysts. Anecdotally, hospices have reported instances where nurses left to join a travel nursing agency, only to be placed back at the same hospice with a significantly higher wage.

Medicare fee-for-service accounts for over 90% of revenue for hospice providers making it difficult to supplement revenue from other sources to keep up with ever increasing costs for labor. Travel nursing agencies make competing with hospitals, nursing homes, and other providers even more difficult for hospices with superfluous, unsustainably high contract rates.

The Travel Nursing Agency Transparency Study act would require the Government Accountability Office (GAO) to conduct a study and report to Congress on the business practices and the effects of hiring agencies across the healthcare sector during the COVID-19 pandemic. This study includes information on practices such as any potential price gouging and taking of excessive profits, the difference between how much such agencies charged healthcare institutions and how much they paid their contracted nurses, and the extent to which travel nurse agency practices contribute to workforce shortages.

NHPCO and HAN encourage the Committee to support continued use of telehealth in hospice.

For years before the COVID-19 public health emergency, hospice providers used phone and video calls, as well as communication between a hospice nurse in the home consulting with a physician at a remote location, to supplement high-touch, in-person care which is a hallmark of high-quality hospice care. These virtual connections allow hospice providers to maintain constant contact with hospice patients and caregivers when needed, bring far-away loved ones in to end-of-life care decision making, and provide on-the-spot guidance for caretakers in the home.

While some kinds of technology have been used to supplement in-person patient care for years, data on these visits has not been collected on the hospice claims form. Data measuring these visits should be included on the form for the sake of transparency. However, we do not advocate for the inclusion of virtual visits in quality metrics.

During the PHE, CMS affirmed that hospices could continue to use telehealth for these purposes, in the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule with Comment (85 FR 19230), the regulations at 42 CFR 418.204 were amended to allow hospice providers to provide services to a Medicare patient receiving routine home care through telecommunications. Included in this interim change were details of how hospices were to document the use of these telecommunication services (e.g. they had to be included in the plan of care, tied to patient-specific needs, etc.) This reassured hospice providers who were facing the challenges of continuing to see patients and communicate with families while protecting their safety during the height of the COVID-19 pandemic and provided relief from the corresponding unprecedented workforce shortage. As such, hospices used telehealth to supplement in-person care and were able to provide high quality care to patients who were able to receive it through audiovisual technologies.

Temporary flexibility which allowed for the use of telehealth for face-to-face visits prior to recertification for the hospice benefit was also provided, initially through the CARES Act. This flexibility has since been extended, including through the *Consolidate Appropriations Act, 2023*, through CY 2024. Telehealth is appropriate for these low-touch, administrative visits, and increases provider efficiency by reducing drive time for overworked physicians and nurse practitioners.

As the COVID-19 Public Health Emergency comes to an end, clarity on the use of telehealth is needed. The hospice community needs certainty that providers can continue to use technology in the same ways they did before the PHE after May 11, 2023, and data about when telehealth is used must be collected on the Hospice Claim Form. These changes will allow the hospice workforce to proceed as always without fear of running afoul of CMS, and will allow Congress to track how telehealth impacts care as you consider future extension of telehealth flexibilities.

NHPCO and HAN encourage the Committee to support a technical fix for physician assistants in hospice.

The Medicare Patient Access to Hospice Act, included in the Bipartisan Budget Act of 2018, expanded the role for physician assistants with regard to hospice. This was an important step forward to expand the types of practitioners hospices could employ to work at the top of their licenses. Unfortunately, due to an oversight, physician assistants (PA) weren't referenced as a member of the Hospice Interdisciplinary Group in statue (Section 1861(dd)(2)(B)(i)). As a result, PAs have been excluded from the hospice Conditions of Participation (CoPs), unlike physicians and nurse practitioners, and thus their role is drastically smaller than envisioned. CMS, in the past, has cited the lack of statutory references to PAs as the basis for limiting their role.

To address this issue, we support including PAs as optional additional members of the Hospice Interdisciplinary Group as well as including them in Section 1814(a)(7)(D)(i)(I) as hospice personnel who are authorized to provide face-to-face encounters to determine continued eligibility for hospice care. This technical fix will help expand the pool of practitioners that can support hospice as originally intended by Congress.

NHPCO and HAN encourage the Committee to support the Healthcare Workforce Resilience Act.

The United States is not in a position to educate and train our way out of our workforce shortage. There are tens of thousands of trained doctors and nurses eager to immigrate to the United States and join our healthcare workforce. Immigrants are already an important aspect of our healthcare workforce. A 2018 study[4] found that 29% of U.S. physicians were born in other countries, with almost 7% of them not U.S. citizens. Foreign-born nurses account for 15%[5] of registered nurses. A study published in JAMA[6] found that non-U.S. born healthcare workers on average worked more hours, were more likely to work at night and in skilled nursing or home health settings, and reside in medically underserved areas when compared to U.S.-born healthcare workers. These attributes are especially beneficial for hospices.

[4] https://www.fiercehealthcare.com/practices/u-s-healthcare-industry-relies-foreign-born-doctors-and-other-workers

[5] https://www.gmu.edu/news/2016-06/new-study-reveals-impact-immigrant-medical-professionals-us-health-care-system

[6] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2779302

The Healthcare Workforce Resilience Act would issue 40,000 unused employment-based visas for doctors, nurses, and their families providing immediate relief for an over-stretched workforce. This short-term injection of doctors and nurses would provide instant relief.

NHPCO and HAN encourage the Committee to support the measures which address worker safety and burnout.

Hospices meet patients where they live, most often in their home at all times of the day and night. Doctors, nurses, and social workers are increasingly finding themselves in dangerous situations in homes where either their patient or members of the patient's family are suffering from substance abuse or serious mental illness. Our workers are often entering a home alone and may be exposed to a variety of threats including guns and other weapons, illegal drugs, verbal abuse, and other forms of violence. These threats can also be present in their patient's neighborhood.

These threats often mean sending more than one member of the interdisciplinary team to a home, connecting with protective services, and even requesting police escorts. These steps can help reduce the threat of harm but do not eliminate it. In the long run, they accumulate and are a significant factor in burnout rates for healthcare providers.

We encourage the Committee to investigate these risks and make investments in our communities by supporting those suffering from substance abuse and serious mental illness. In addition, we recommend creating grant programs for healthcare workers to fund additional training for ways to identify and minimize the risks in providing care in the community.

Conclusion

The workforce crisis facing hospice and palliative care providers is a serious threat to our capacity to care for those most vulnerable. Our healthcare workers are dedicated but they can only be stretched so thin. As usage of hospice and palliative care continues to grow, we need a work force that can grow with it.

Anecdotally, we had a rural hospice report to us that for the first time in almost twenty years of operation, they had to turn down a hospice referral and work with their competitors in the area to ensure the patient had a hospice. Our fear is that this type of situation is becoming all too common. We only get one chance to provide a high-quality hospice experience for a patient and their family. A delay in care is unacceptable.

We strongly encourage the HELP Committee to take the necessary next steps forward in solving this crisis before it gets out of hand. Thank you for your commitment to strengthening our healthcare workforce. Should you have any questions, please reach out to NHPCO's VP of Policy and Government Relations, Logan Hoover (lhoover@nhpco.org).

Sincerely,

Ben Marcantonio
Interim Chief Executive Officer