



Feb 16, 2018

**TO: Senate Committee on Finance
Chairman Orrin G. Hatch
Ranking Member Ron Wyden**
**FROM: Ohio's Hospice, Inc.
Palliative & Hospice Physicians**

RE: Comments - Relief from the Scourge of Opioid Epidemic

Dear Chairman Hatch and Ranking Member Wyden,

Thank you for the opportunity to make comments and recommendations to address the opioid epidemic that is devastating lives and communities in Ohio and throughout the country. Obviously the issue is tearing apart the fabric of our communities. We appreciate the understanding of the importance that we also carefully consider the impact related to efforts to eradicate this plague has on our Medicare and Medicaid populations. As healthcare providers address medical issues for individuals needing palliative and end of life care, we believe in balance between treatment and opioid controls.

It is important to recognize the unique role that palliative care and hospice physicians play in chronic disease management. As hospice has been recognized as a pioneer in end-of-life (EOL) care and pain management, Hospice & Palliative Medicine (HPM) practitioners are seen as leaders in pain management, goal setting, resource allocation, global care management, and conservation of resources. Our recommendations reflect the commitment we make to improve the health care of Americans, improve the quality of life for our patients and their families, and the unwavering vigilance to safely prescribe with no tolerance for abuse and diversion. Innovative Care Solutions, Hospice of Dayton, Hospice of Central Ohio, work under Ohio's Hospice corporate umbrella and has become a leader in developing policies and programs with these goals in mind.

As opioid utilization becomes hyper-regulated, it is clear that education and higher practice standards are needed. There is also a need to delineate between the types of patients that require opioids. Providers should understand the risk individuals face for OUD/SUD when battling pain, whether it is non-malignant, malignant, chronic, as well as pain and suffering from a progressive serious illness and conditions with a high risk of morbidity or mortality. Identifying where an individual falls in the progression of their illness is paramount just as much so as appreciating the progression of an aging population where many have serious chronic conditions that contribute to a lessening of functionality and at some point contributes to dying. Our hope is that the Congress recognizes the inherent differences in these patient populations and appreciates the unique needs that palliative care and hospice patients present with along with the need for these patients to be protected as hyper-regulation evolves.

Lastly, it appears that many providers and patients have believed that the act of prescribing opioids would amazingly achieve an intended curing effect. Many practices fail to tie symptom assessment and pain score monitoring tools with accurately measured functional status. Answering the question, did we improve or return functional status, can provide more objective data to show how opioids use can improve a person's function, and overall quality of life.

Our recommendations and comments to the questions that were posed follow:

1. How can Medicare and payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing opioid use disorder (OUD) or other substance use disorders (SUD)?
 - a. Monitoring of function to justify the use of opioids would be beneficial. Clearly the regulators, payors, and enforcement bodies want to see justification (patients continue to

- work/maintain independent living) for interventions and are satisfied when adequate documentation is in place. Utilizing function scales in place of or in combination with pain scales in the palliative setting (upstream from the hospice patient, where the function may no longer be possible) is externally important.
- b. The importance of utilizing nonopioid pain adjuvants and multimodal therapy should align with reimbursement policies to help deemphasize opioid use in chronic pain. The use of a biopsychosocial approach to pain (which is the backbone of the palliative care philosophy) has been shown to improve outcomes in pain management.
 - c. Reimbursement or funding support for specialty training in palliative medicine and end of life care often is focused in the acute care arena and large educational health systems and doesn't reach into the post-acute - community arena, where much of the palliative care support, training, and education occurs.
 - d. Improving payment models for supportive resources and addressing social determinants needs (i.e., chaplains, SW), for individuals with palliative care needs or with life-limiting illness would:
 - i. Prevent OUD by identifying and addressing spiritual pain/mental/psychosocial pain; and
 - ii. Recognize SUD and then improve engagement with community resources. Some programs are just not large enough to offset the costs of having these talented individuals on their multidisciplinary team.
 - e. Having a better understanding of the use technology brings to this area, especially to see the benefit of opioids therapy. Often providers just prescribe opioids and assume that the intended effect will be achieved. Using remote symptom assessment tools along with monitoring the pain score and functional status (using step counters/sleep monitoring devices, functional measurement tools) can provide more objective data to show that opioids can improve a person's function and overall quality of life.
2. What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilization of those non-pharmaceutical therapies when clinically appropriate?
 - a. CMS should create more palliative care support and reimbursement codes for the use and inclusion of appropriate referrals to community palliative care practices. Promoting the benefit of the community palliative medicine providers as a collaborator in the care of individuals with serious illness, identifying those who would benefit from opioids as an adjunct to their treatment, is a strong example of where this expertise would improve patient outcomes.
 - b. Improved access and coverage for compounded topical therapies.
 - c. Improved access and coverage for the continuing use of non-pharmaceutical therapies.
 - i. Implement changes in contracting with payors to shorten pre-authorization periods. Long pre-authorization periods and complicated documentation requirements often complicate the healing process by disrupting the treatment plan and require huge time and resource commitments to meet eligibility criteria.
 3. How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?
 - a. First, agree on what is "evidence-based." While many non-pharmaceutical therapies have shown positive outcomes and improved functioning, these therapies are often not approved for reimbursement or treatment choices.
 - b. If non-pharmaceutical therapies are approved the sequence of services are limited without continuing to show a high degree of need. Just as the treatment is beginning to improve function and reduce pain, the individual doesn't meet the "initial" criteria because they aren't

- “as sick” as they were originally. Yet, they haven’t reached their full potential recovery, and the lack of ongoing therapy degrades earlier successes and slows healing.
- c. Allow less restrictive access and coverage for primary functional treatments to include physical/occupational therapy, osteopathic manipulative therapy, massage therapy, music therapy, and therapeutic exercise.
4. Are there changes to Medicare and Medicaid prescription drug program rules that can minimize the risk of developing OUD and SUDs while promoting efficient access to appropriate prescriptions?
 - a. CMS should support the funding for initiatives to encourage states to develop interactive and functional Prescription Drug Monitoring Programs, like Ohio’s.
 - b. Identify basic parameters around what data elements Prescription Drug Monitoring Programs should collect, would help create the interoperability standards between state programs.
 - c. Identify and determine what data elements should be shared on a national, regional, and state basis. Open the data to researchers who could assist in educating providers on utilization and improved use.
 - d. Promote collaborative practices of sharing data between states, particularly between those states that border one another, if not already occurring.
 - e. Improving payment models for supportive resources (i.e., chaplains, social workers) for individuals with life-limiting illness and on opioids in our opinion would:
 - i. Prevent OUD if possible (spiritual pain/mental/psychosocial pain identification), and
 - ii. Recognize SUD and then improve engagement with community resources. Some programs are just not large enough to offset the costs of having these talented individuals on their multidisciplinary team.
 5. How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?
 - a. There needs to be better ways to identify the practice setting and what patients are being served and why. This would lead to better identification of related issues and what education is needed around high patterns of prescribing. For example, patients with serious illnesses that have a high morbidity or mortality risk describe palliative care and hospice type patients, as well as cancer patients. These types of patients often use controlled substance in some situations that are not prescribed in the same manner as in other patient populations. It is important for policymakers, CMS, and others to determine how to define a palliative care patient and assuring that Hospice & Palliative Medicine practitioners can prescribe for that patient without overly burdensome scrutiny regardless of where the patient is on the trajectory of their illness, therefore improving access to good pain management.
 - i. For example, in regards to end of life narcotic use - not only are opioids used for pain but also for shortness of breath. It’s not uncommon to see uncontrolled shortness of breath with end-stage cancer, COPD, heart disease, muscular disorders (ALS, muscular dystrophy, etc.), patients with aspiration (CVA, dementia, Parkinson’s), patients with ES CAD having acute MI, and heart failure patients. This list covers the majority of terminal patients. It’s not just a pain issue, but Morphine is also helping symptom management with shortness of breath.
 - ii. Additionally, as patients are dying, they often lose the ability to swallow. When patients have trouble swallowing they can’t take their nonnarcotic pain and comfort medications by mouth. At this time Roxanol or Methadone are easily given sublingual to control symptoms and allow patients the ability to be comfortable and be cared for at home. When patients are no longer tolerating oral medications, there are limited options to provide comfort. They cannot continue their non-narcotic medications since they can’t swallow. IV medication administration would require an increased level of care, increased number of caregivers and increased education of caregivers. Ease of administration allows for lower levels and lower cost of care.

- b. Incentivize earlier and clearer pathways to palliative care with improved funding for palliative care services for inpatient, facility and home care. These services have demonstrated lower ER visits and reduced hospital admissions, lowering cost and improving quality of life.
 - c. Provide, develop, and implement more opportunities and support to improve and demonstrate the value of pain and palliative medicine education at the undergraduate and post-graduate level as well as for community prescribers in making physicians better pain managers.
 - d. There are needs for physicians and payors to understand the physiology of pain and its effect on the patient and family unit.
 - e. There are needs to improve funding for specialty training in palliative medicine and the current workforce shortage in our field which may limit access to care.
 - f. As the health care system addresses social determinant needs as well as treating the patient and family as a unit of care, it is critical to understand the importance of an interdisciplinary team approach to pain management including team access to and funding for specialty level psychological and PharmD expertise on the team.
 - g. It is important for all healthcare providers if prescribing controlled substances, to educate the patient and family on their need to be a partner and identify their responsibility for medication safety and stewardship to the community.
 - h. Pain management is critical to keep members of society participating in the workforce and community. More work needs to occur to demonstrate support for identifying the value of utilizing measurement tools that focus on improving function rather than just reducing a number on the pain scale for upstream patients.
- 6. What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?
 - a. There should be support for state initiatives to develop and enhance interactive functionality between Prescription Drug Monitoring Programs.
 - b. There should be some central mechanism to identify basic parameters around what data elements Prescription Drug Monitoring Programs should collect.
 - c. Promote collaborative practices of sharing data between states, particularly those that border one another, if not already occurring.
- 7. What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?
 - a. Addressing pain and suffering through a comprehensive program has many benefits. Using an opioid risk assessment, a medication agreement, an OARRS (Ohio's Prescription Drug Monitoring Tool) review, as well as an agreement with the patient to initially accept lower potent prescriptions, allows for closer evaluations to document efficacy and/or aberrant behavior. This also provides more time to implement a clear and easy to follow disposal policy when care is completed. These actions help to ideally shift some of the responsibility and incentives, as well as consequences to the patient.
 - b. Promote the development of well-designed organizational policies and procedures on medication management and drug disposal which enable staff to work effectively and with more job satisfaction.
 - c. It is important for all healthcare providers to educate the patient and family on their need to be a partner and identify their responsibility for medication safety and stewardship to the community.
 - d. Support the relaxation of laws that govern the direction of medications moving into a patient's estate when that individual dies and support more drug disposal drop-off sites and other mechanisms of disposal. Encourage similar programs in other states that allow oversight of the destruction of medications through appropriate mechanisms, similar to the practice of hospices in Ohio and a 2018 state law taking effect in Kentucky.

- e. These types of programs should be explored to supplement other efforts to destroy dangerous medications in the home. For example, other healthcare providers that work in the patient's home environment could educate and assist clients in the destruction of dangerous medications in the home. Additionally, primary physicians should routinely educate patient and families on their responsibility to destroy medications that are no longer used.
 - f. The responsibility of prescribers and healthcare providers to take an active voice in national and state opioid policy should be addressed in basic education and training.
8. What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?
- a. One response we are seeing in Ohio, to address issues related to treating adults and children affected by an unintended overdose death, is the utilization of grief and bereavement counseling and support by community-based not-for-profit hospices.
 - b. Many of our legacy hospice providers, who have developed strong community support programs in Ohio, report a growing population of participants seeking grief and bereavement services, both children and adults. Grief and bereavement services in hospice are unfunded. These efforts are stretching the abilities of the hospice programs to continue these services and the impact is causing many to discuss the viability of the maintaining services at this level. These services give tremendous support and guidance for individuals, many that already live in destructive environments.
 - c. Many other behavioral health services are being provided on this issue in Ohio. One may look at this as both a negative and positive, in the sense that services are being provided. Unfortunately, in this document, we are only addressing what has now become a much larger issue than just opioid abuse.

Again, thank you for the opportunity to make recommendations. We are happy to answer any questions or give further input if requested.

Sincerely submitted by,



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