



National Hospice and Palliative Care
Organization



February 16, 2018

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510-6200

RE: Opioid epidemic policy recommendations inquiry

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of our nation's hospice and palliative care providers and the 1.6 million Medicare beneficiaries they serve annually, thank you for your ongoing leadership on and commitment to thwarting the nation's opioid epidemic. Opioid abuse is truly a national crisis, and one that the hospice community is dedicated to helping prevent and treat. In fact, as a key part of this nation's grief counseling safety net, hospices are acutely aware of the toll that this epidemic takes on families and communities. However, as policymakers address this challenge, **it is imperative that careful consideration be given to the unique needs of patients and families experiencing serious illness and at the end of life, so that we do not unintentionally impair the ability of hospice and palliative care providers to appropriately manage their patients' pain.**

The National Hospice and Palliative Care Organization (NHPCO) is the largest nonprofit membership organization representing hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice programs, and our members care for the vast majority of the nation's hospice patients. NHPCO is committed to improving end-of-life care and expanding access to hospice care with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so.

Palliative care applies that same philosophy for anyone with a serious or life-threatening illness. Serious illnesses may include cancer, dementia, heart and lung disease like congestive heart failure or chronic obstructive pulmonary disease, end stage renal disease, liver disease, neurological disease, HIV/AIDS and others. Palliative care can be provided to patients of any age, at any stage of their illness, and can be received in any setting – at a hospital, at home, in a community clinic, in a cancer center, or in a skilled nursing facility. A central objective of both hospice and palliative care is pain and symptom relief.

Opioids play a key role in alleviating pain and suffering for those with advanced illness and at the end of life. Patients admitted to hospice care due to advanced illness are generally older, have a high burden of comorbid conditions, and are at risk of polypharmacy and adverse drug reactions. Patients with advanced illness frequently require intensive medication management of both chronic conditions and symptoms associated with end-stage disease such as pain, shortness of breath, nausea, delirium, and depression.¹ In 2007, the International Association of Hospice and Palliative Care (IAHPC) identified opioid and non-opioid analgesics to be “essential medicines for palliative care.”²

As a precaution against potential abuse of potent prescription medication, the Medicare Hospice Conditions of Participation require hospices³ to establish policies of safe use and disposal of controlled substances. Hospices are required to share information about drug disposal with patients and their families, but are limited in their ability to destroy unused medication. In 2014, the U. S. Drug Enforcement Administration (DEA) issued a Final Rule for the Disposal of Controlled Substances⁴ that forbids hospice staff from destroying unused medications unless authorized by state law. DEA encourages hospice staff to *assist* families in destroying unused medications, but hospices are cannot actually destroy the drugs. Moreover, it is not unusual for family members to decline this assistance. In these cases, hospice staff have no choice but to leave these medications in the home. We would welcome dialogue around how hospice personnel can play a more active role in destroying unused medications.

As you know, many states are tackling these issues with more stringent prescribing and disposal laws. Fortunately, most state laws setting limits on opioid prescription include exemptions for prescribers treating patients for cancer and for hospice care. NHPCO believes that these exemptions recognize the sensitivity and vulnerability of those suffering advanced illness and at the end of life, and accommodate their needs. Federal policy changes should preserve these exemptions and other considerations.

The Committee inquired about barriers to non-pharmaceutical therapies, as well as payment incentives that could be used to remove barriers to care. In our opinion, many patients who are experiencing

¹ Sera, Leah, Mary Lynn McPherson, and Holly M. Holmes. “Commonly Prescribed Medications in a Population of Hospice Patients.” *The American journal of hospice & palliative care* 31.2 (2014): 126–131. PMC. Web. 8 Feb. 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830696/>

² IAHPC List of Essential Medicines for Palliative Care, <https://hospicecare.com/uploads/2011/8/iahpc-essential-meds-en.pdf>.

³ The Medicare Hospice Conditions of Participation, Sec. 418.106, https://www.nhpco.org/sites/default/files/public/regulatory/Drug_disposal-COPS_by_topic.pdf.

⁴ Disposal of Controlled Substances, Final Rule, https://www.deadiversion.usdoj.gov/fed_regs/rules/2014/2014-20926.pdf.

chronic and unmanaged pain may benefit from earlier access to palliative care, and when appropriate, hospice. Palliative care providers have special training and expertise in pain management and symptom control, and specialize in helping patients and their families cope with the many burdens of a serious illness, from the side-effects of a medical treatment, to caregiver stress, to issues associated with grief and loss which can begin at a patient's diagnosis, to fears about the future.

Palliative care providers employ a range of strategies to reduce pain. For example, some patients find that music, humor or distraction, spiritual support, hot or cold packs, or exercise can help relieve their pain or lessen their symptoms. Music, with its ability to transcend cultural, linguistic, and societal barriers, has the power to promote wellness for the whole person. In the hospice setting, music is one of many therapeutic modalities that are used to promote total well-being within patients, families, caregivers, and the bereaved,⁵ by helping to address pain, physical comfort, fatigue and energy, anxiety and relaxation, time and duration of treatment, mood, spirituality and quality of life.⁶ Other complementary methods include massage therapy, biofeedback, therapeutic touch, chiropractic manipulation, pet therapy, acupuncture, hypnosis, guided imagery, and cognitive and behavioral therapies.⁷

Unfortunately, Medicare does not reimburse for community based palliative care outside of the hospice benefit. While physician services can be billed under Part B, many of the ancillary services such as music or physical therapy, alternative therapies, psycho-social supports and other supports are not reimbursed. NHPCO strongly encourages the Committee to consider the Patient Choice and Quality Care Act, legislation that would create a demonstration to provide many of these services to individuals with serious and advanced illness.

The Committee also inquired about strategies to better educate health professionals who exhibit prescribing patterns for a high amount of opioids. As we noted earlier, palliative care and hospice might be an appropriate setting for many patients with significant pain. However, there is currently limited awareness about palliative care, and hospice referral is often delayed until the final weeks of life. We believe that increased provider training would improve awareness about these important care models, and offer meaningful alternatives for physicians who are unsure how to best manage their patients' pain and symptoms. The Palliative Care and Hospice Education and Training Act includes several provisions that would bolster not only the palliative and hospice workforce, but also system-wide awareness of these important services.

Finally, the committee inquired about what human service efforts might be effective in preventing or mitigating the adverse impacts of opioid or substance abuse on children and families. While not

⁵ Crossroads Hospice, Music Therapy in Hospice, <https://crhcf.org/Blog/music-therapy-in-hospice/>.

⁶ Hilliard, Russell E. "Music Therapy in Hospice and Palliative Care: A Review of the Empirical Data." Evidence-based Complementary and Alternative Medicine 2.2 (2005): 173–178. PMC. Web. 8 Feb. 2018. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1142188/>

⁷ American Academy of Hospice and Palliative Medicine, PalliativeDoctors.org, <http://palliativedoctors.org/team/complementary>

necessarily preventive, many hospices offer grief and bereavement services for families and communities experiencing loss from an opioid overdose. Hospices' skilled grief counselors can help families as they progress through the stages of grief, supporting them as they process the shock, anger, sadness, guilt, and anxiety that often accompany an opioid-related loss. Hospices are typically not reimbursed for these services, but offer them because of their experience and professional understanding that demonstrates the positive impact of grief and bereavement support services to caregivers and loved ones. Given the rising toll of opioid addiction on many communities they serve, however, hospices are increasingly stretched to deliver these services to this growing population that can benefit from the skills the hospice bereavement professionals offer⁸. NHPCO would welcome the opportunity to discuss how Congress can help hospices increase their capacity to help families and communities cope with opioid and substance-abuse related losses.

In closing, we would like to reiterate that our nation's hospice and palliative care providers can be an important part of the care continuum for people with serious pain, including those with serious illness and facing the end of life, and should be looked at as a resource for these populations. We look forward to ongoing conversations about ways our community can assure appropriate treatment, avoid drug diversion, and provide supports to communities reeling from this epidemic.

Thank you, again, for your leadership on this important issue.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Edo Banach', written in black ink.

Edo Banach, JD
President and CEO
National Hospice and Palliative Care Organization

⁸ C. Valentine, L. Bauld & T. Walter (2016) Bereavement Following Substance Misuse: A Disenfranchised Grief. OMEGA, Vol. 72(4) 283–301.