AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

September 06, 2013

Ms. Candace Thorson
Deputy Executive Director
National Conference of Insurance Legislators
385 Jordan Road
Troy, NY 12180

Re: NCOIL Proposed Best Practices to Address Opioid Abuse, Misuse or Diversion

Dear Ms. Thorson:

On behalf of the nearly 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), I would like to again thank you and the National Conference of Insurance Legislators (NCOIL) for your commitment to reducing prescription narcotic abuse and for your continued receptiveness to the input and expertise of organizations like AAHPM. As you know, AAHPM is the professional organization for physicians specializing in hospice and palliative medicine, and our membership also includes nurses and other health and spiritual care providers committed to improving quality of life for patients with serious or life-threatening illness.

AAHPM's members care for the sickest and most vulnerable patients, including those at the end of life. The timely and effective management of pain and other distressing symptoms is critical to providing high-quality palliative care, and opioid analgesics are an important tool in that process. Consequently, disruptions or delays in seriously-ill patients' access to needed medications can induce pain and symptom crises. So, while there is an indisputable public health imperative to address prescription drug abuse, there is also a correlative public health imperative to ensure that our sickest, most vulnerable patients are able to get the medications necessary to treat their pain and suffering.

In its July 12, 2013 comments to NCOIL, AAHPM posed four essential considerations that should be interwoven into NCOIL's best practices to address prescription opioid abuse, misuse and diversion: (1) do the best practices encourage policies that strike an appropriate balance between reducing abuse and ensuring appropriate access to needed medications?; (2) do the best practices discourage policies that impinge on decision-making processes that should be solely within the purview of medical professionals?; (3) do the best practices encourage policies that target the actual sources and drivers of prescription drug abuse, misuse and diversion?; and (4) do the best practices encourage policymakers to actively assess the strengths and weaknesses of prior efforts? NCOIL's proposal clearly strives to incorporate these considerations and generally succeeds in constructing a thoughtful and pragmatic framework for state policy addressing opioid abuse, misuse and diversion.

Still, while AAHPM is pleased to see elements of its proposed considerations in NCOIL's guidelines, and while AAHPM recognizes that NCOIL's focus is directed at workers' compensation costs and influenced by a wide range of external advice, AAHPM sees two areas – Section 3.2 and Section 4.1 – where minor alterations could vastly improve the impact that the guidelines as a whole have on patients with serious illness and the practitioners who care for them.

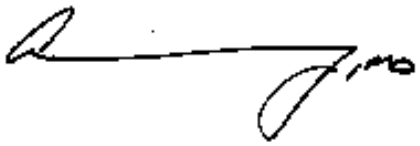
The underlying intent of Section 3.2 is extremely positive. AAHPM would particularly like to praise NCOIL's recognition that the universe of illnesses that are serious, debilitating and life-threatening extends beyond cancer. This recognition is essential if public policy is to successfully avoid limiting legitimate access to prescription opioids. That said, two details included in the section could undermine the benefits of this language. First, the section references the impact on patients with "life-threatening illnesses." AAHPM would recommend that "life-threatening" be replaced by the term "serious," as the current language is too narrow and could perpetuate the long-standing problem in which some physicians do not recognize the need to treat severe pain and symptoms associated with an illness that has not yet progressed to a terminal diagnosis.

Second, AAHPM would recommend that NCOIL's draft guidelines take an additional step and call for explicit exceptions for all patients who are on hospice or who are being actively managed by a palliative care provider. While the recognition of a broad set of illnesses with pain and symptoms necessitating use of prescription opioids is positive, a more concrete exemption is the best way to ensure that all seriously ill patients are having their treatment needs met. AAHPM members in states where such exemptions are in place alongside opioid guidelines – such as Washington State, Ohio and California – report that the exceptions are essential in allowing them to appropriately treat patients, whereas members in states where such exemptions do not accompany opioid policies – most notably Florida – report that patients suffering from serious non-cancer pain often find it difficult to secure sufficient relief.

The bedrock on which such an exemption is built is the inherent expertise in prescribing and managing opioids that hospice and palliative medicine specialists possess. Recognition of this expertise also underpins AAHPM's recommended change under Section 4.1 – the addition of language acknowledging that certain specialties require practitioners to have substantial training in opioid prescribing and should thus be excluded from any new opioid-related continuing medical education mandates beyond those encapsulated by the standards of their specialty. Generally speaking, AAHPM supports increasing prescriber expertise through CME that is incentivized, rather than mandated, but it strongly believes that additional mandates requiring redundant training would constitute an unnecessary, ineffective burden when placed upon the substantial existing continuing education requirements hospice and palliative medicine physicians currently face.

We hope the additional recommendations provided here help NCOIL refine and improve its proposed guidelines in a way that reduces the extensive health and economic toll of prescription drug abuse while still preserving the availability of much needed treatments for patients with serious or life-limiting illness. Should you need additional feedback or should you wish to speak directly with members of our physician leadership as you continue in this effort, please reach out to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



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