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Fashioning Appropriate Regulation of Opioids for Palliative Care

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Palliative care specialists, who care for patients with serious, life-limiting illnesses such as cancer, are experts in evaluating and managing acute pain. They do this through comprehensive patient evaluation; use of non-pharmacological treatments such as physical therapy; and careful selection and rotation of opioids and non-opioids. Palliative care experts at VCU and UVA have written articles about the challenges of managing pain and opioids in cancer and palliative care. As the workgroup mandated by **S1179/H2161 (2017 session)** and focused on standards for training health care providers reports back, and the Boards of Medicine and Dentistry adopt regulations mandated by **S1180 (2017 session)** related to prescribing opioids, the lessons learned by these experts about opioid management could be a resource for lawmakers and policymakers.

Key recommendation – Amid concerns of substance abuse and diversion in patients with cancer, including those near the end of life, regulations and training for providers should encourage the development and use of distinct assessment and management guidelines for palliative care situations.

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Key findings

1. Screening and urine drug screens from five National Cancer Institute Centers indicate at least one in five patients may be at risk of "opioid-use disorder."[i]
2. A survey of palliative care programs in the U.S. found that less than 50% had policies for screening patients or family members for possible abuse of opioids.[ii] Professional organizations have no standing guidelines for assessment and management of opioid-use disorder in cancer patients.
3. A recent review by VCU researchers on ways to assess opioid abuse risks among patients concluded that prescription drug monitoring programs are relatively inexpensive and low-risk ways to prevent doctor-shopping, though the impact of such programs varies. The review recommends guidelines for risk assessment be paired with good clinical practice.

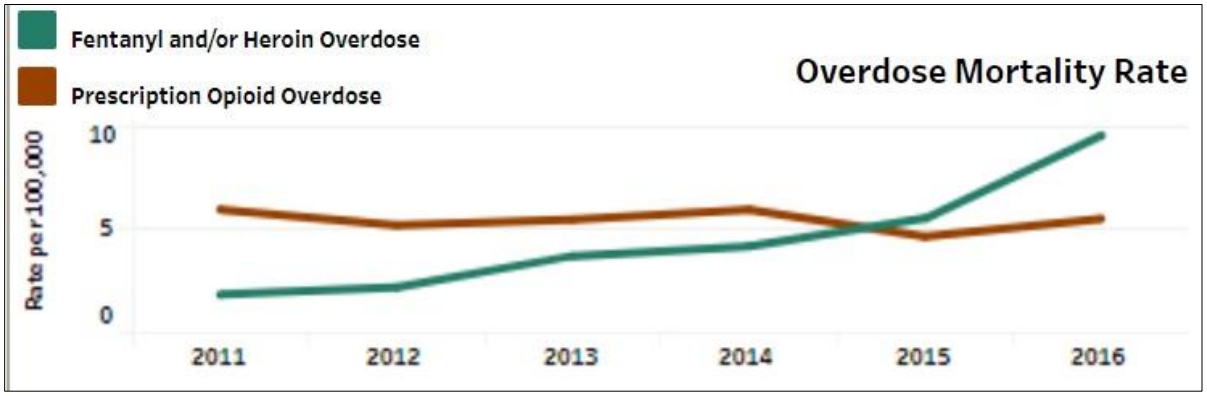
Background

In 2016, Virginia Governor Terry McAuliffe declared the opioid crisis a public health emergency. During the 2017 General Assembly session, policymakers approved bills responding to the crisis, including:

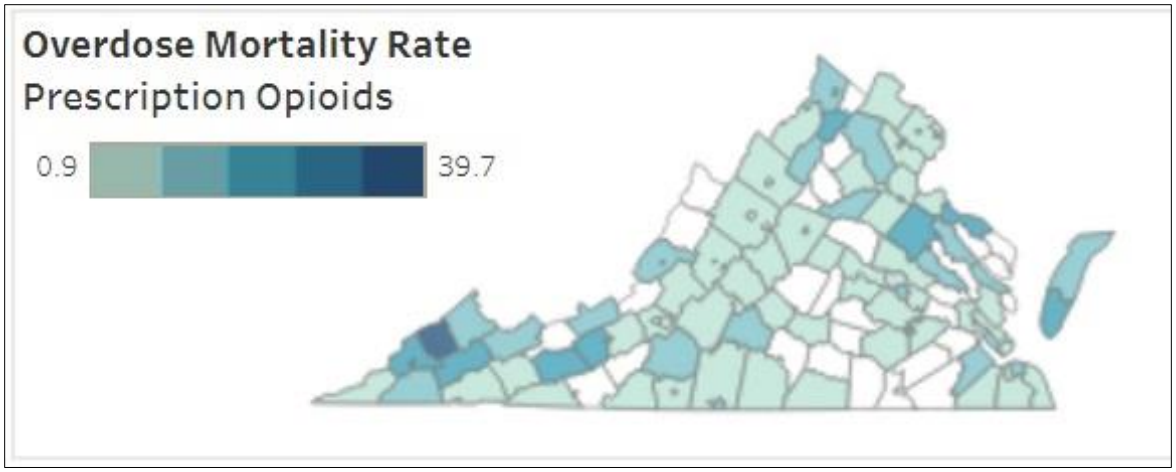
- S1179 (mandates creation of a workgroup to develop educational standards and curricula regarding training for the safe and appropriate use of opioids)
- S1180 (mandates boards of Dentistry and Medicine to adopt regulations for prescribing opioids.)

Data on Prescription Overdose fatalities

Final 2016 data (from Virginia Department of Health Opioid Addiction data dashboard showed 465 deaths state-wide due to prescription opioid overdose. The mortality rate of 5.5 per 100,000 residents represented a slight increase from 2015 (see brown line in chart below).



The mortality rate due to prescription opioid overdose varied significantly by locality, ranging from .9 per 100,000 residents to 39.7 per 100,000 residents.



Data on Opioids Dispensed

According to the 2017 Annual Report of the Prescription Monitoring Program (required by S1180 (2017)), the number of Virginians receiving more than 100 morphine milligram equivalents (MME) dropped by nearly 32,000 from Quarter 4 of 2016 to Quarter 3 of 2017, and 18.6% decline in the number of individuals.

The decline in pain reliever doses over the same time period was 40.15%. Other states have seen highly variable impacts from the implementation of prescription drug monitoring programs – ranging from a 66% decrease in Colorado to a 61% increase in Connecticut.[iii]

[i] Passik SD, Portenoy RK, Ricketts PL. Substance abuse issues in cancer patients. Part 1: Prevalence and diagnosis. *Oncology (Williston Park)*. 1998;12(4):517–521, 524.

[ii] Tan PD, Barclay JS, Blackhall LJ. Do palliative care clinics screen for substance abuse and diversion? Results of a national survey. *J Palliat Med*. 2015;18(9):752–757.

[iii] Brady JE, Wunsch H, DiMaggio C, Lang BH, Giglio J, Li G. Prescription drug monitoring and dispensing of prescription opioids. Public Health Rep. 2014;129(2):139–147.