Abstract

The opioid epidemic is a serious public health problem affecting millions of people around the world. There are tools designed to identify risks for opioid misuse and improve appropriate opioid prescribing, such as the Opioid Risk Tool, Prescription Drug Monitoring Program, urine drug screens, and opioid treatment agreements. The DHMC inpatient consult service uses these tools variably. Palliative care has particular indications for using opioids in the care of patients with chronic and terminal illnesses, rendering some of these tools less necessary than in patients without terminal diseases.

Methods and Materials

After obtaining IRB approval, we analyzed data from 463 patients seen by the palliative care inpatient consult service over a 6-month period. Data collected included:
1) Whether prescribed opioids
2) Prescription drug monitoring check
3) Completion of Opioid Risk Tool
4) Completion of opioid treatment agreement
5) Completion of urine drug screen

Results

The inpatient service of the palliative care department saw 463 patients during the survey period. 175 (37.8%) of these patients were prescribed opioids. Of the patients who were prescribed opioids:
• 23.4% had completed the Opioid Risk Tool during their care
• 49.1% of these patients’ prescribers checked the Prescription Drug Monitoring (PDMP) program
• 48.0% completed an opioid treatment agreement
• 12% completed a urine drug screen at some point during their care.

Discussion

Healthcare providers and systems have a responsibility to safely prescribe opioids. In this study, many patients seen by the palliative care inpatient team were prescribed opioids and may have received opioids after discharge. Thus, the increased use of the ORT, PDMP, and use of treatment agreements may be warranted. The challenge in palliative care is that patients are very seriously, if not terminally, ill. Many of these patients do not have life expectancies that may even warrant going through the administrative steps of doing the ORT, checking a PDMP, and signing an opioid treatment agreement in order to reduce risk of opioid use disorder. Patients receiving end-of-life care and their families are more concerned with quality of life at the end of their life rather than risk of developing an addiction they might not even have time to develop.

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References

3. McAuliffe KL, Reiter LV, Quandt SA, Thadani A. Opioid use disorder. Patients receiving end-of-life care and their families are more concerned with quality of life at the end of their life rather than risk of developing an addiction they might not even have time to develop.

Contact

Madeleine Blythe
Geisel School of Medicine
Madeleine.blythe@dartmouth.edu
(757) 309-5876