

**REPORT OF
THE JOINT SUBCOMMITTEE**

**TO STUDY THE COMMONWEALTH'S
CURRENT LAWS AND POLICIES
RELATED TO CHRONIC, ACUTE,
AND CANCER PAIN MANAGEMENT**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



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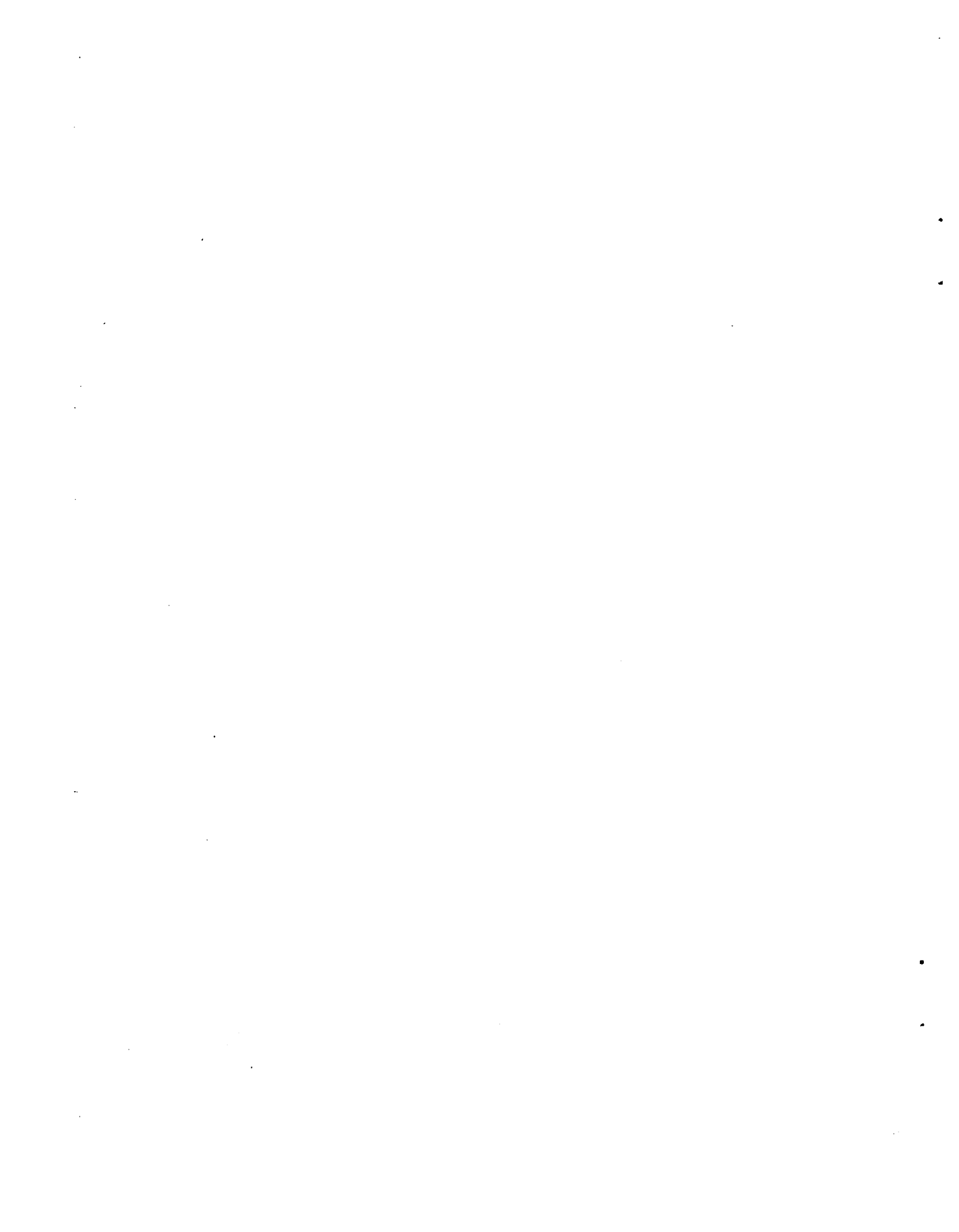
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PURSUANT TO
SJR 72, 1994
HJR 583, 1995
HJR 256, 1996
and HJR 565, 1997



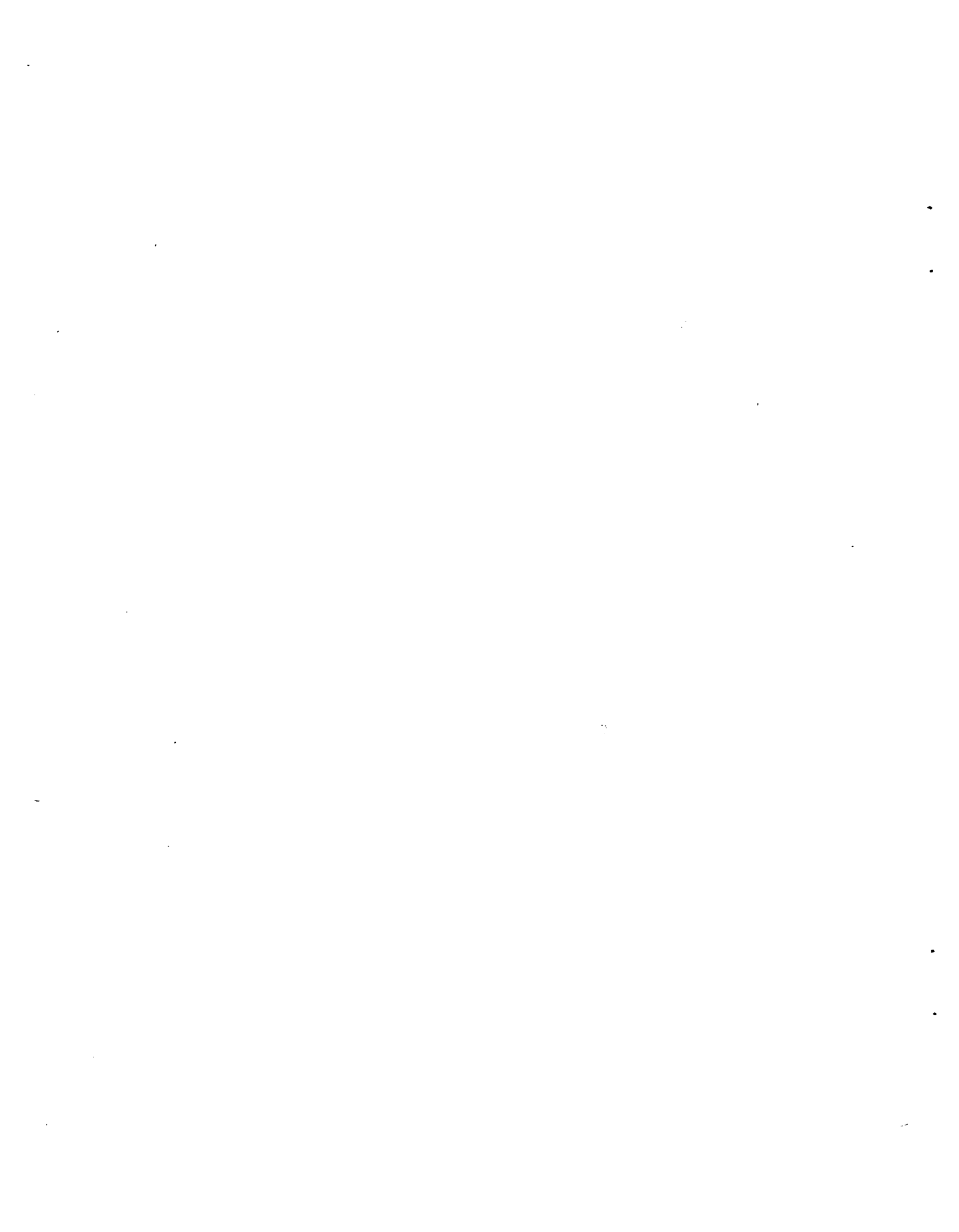


TABLE OF CONTENTS

I.	STUDY ORIGIN	Page 1
II.	ANALYSIS OF THE ISSUES	Page 2
III.	THE JOINT SUBCOMMITTEE'S WORK	Page 7
IV.	RECOMMENDATIONS	Page 18
V.	CONCLUSION	Page 23

APPENDICES

Appendix A: Enabling resolutions

SJR 72, 1994
HJR 583, 1995
HJR 256, 1996
HJR 565, 1997
HJR 172, 1998

Appendix B: Legislation to Implement Recommendations

1995 Legislation
1996 Legislation
1997 Legislation
1998 Legislation

Appendix C: Symposium Materials

I. STUDY ORIGIN

Originally established pursuant to SJR 72 in 1994, the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute and Cancer Pain Management was continued in 1995 by HJR 583, in 1996 by HJR 256, and in 1997 by HJR 565.

The initial enabling resolution, SJR 72, focused solely on issues relating to acute and cancer pain. This resolution noted that primary care is often sought because of acute pain, and that at least 80 percent of injuries result in acute pain. Senate Joint Resolution 72 also explained that there have been great advances in pain management techniques in recent years, specifically recognizing work done by the Agency for Health Care Policy and Research in the U.S. Department of Health and Human Services in developing the national acute and cancer pain guidelines. Conventional treatments, the resolution averred, do not provide relief in approximately 50 percent of patients, and 25 percent of cancer patients die without experiencing relief from severe pain.

The initial enabling resolution (SJR 72 of 1994) also detailed that unrelieved pain can contribute to delays in return of normal stomach and bowel functions following surgical procedures, thereby delaying hospital discharges. Further, inadequate pain management may cause physiological and psychological effects and increased morbidity, for example, pneumonia and infections. The preambles also described effective acute and cancer pain management as including pharmacologic treatment, including opioids and nonsteroidal anti-inflammatory drugs (NSAIDs), as well as nonpharmacologic strategies, such as transcutaneous electrical nerve stimulation (TENS), biofeedback, relaxation, and massage.

The 1994 resolution directed the joint subcommittee to examine the following matters: current acute and cancer pain management efforts in the Commonwealth; the effectiveness of acute and cancer pain management provided by the Commonwealth's medical schools, health care providers, and acute and cancer pain management clinics; Virginia's current law and public policy related to acute and cancer pain management; current Virginia training, including continuing education, in acute pain management; the special pain management needs of infants, children, and adolescents; and the impact of inadequate pain management on resource utilization and costs.

The primary objective of the 1995 continuing resolution—HJR 583—was to educate the medical and health care community on appropriate and effective acute and cancer pain management by holding a pain management summit.

In 1996, the focus of the subcommittee evolved via HJR 256 to include consideration of issues related to chronic pain management.

The eleven-member joint subcommittee consists of three senators, four Delegates, and five citizens, of whom three are physicians with expertise in the areas of pain management and complementary care.

II. ANALYSIS OF THE ISSUES

Acute and Cancer Pain Issues

Among surgery innovators of the late nineteenth century and the twentieth century, combinations of local, regional, and general anesthetics were considered appropriate for management of acute postoperative pain. Some of these early investigators used preoperative medication in combination with regional and general anesthetics to provide a "balanced anesthesia" approach to postoperative pain.

The twentieth century brought with it the development of a standard or conventional approach to alleviation of pain which concentrated on fixed schedules, recognized dosages, and injections of opiates. Various factors have motivated anesthesiologists to examine this conventional treatment for postoperative pain. For example, opiates have frequent unpleasant side effects, such as nausea, vomiting and respiratory depression. Further, opioids given on a fixed schedule do not provide consistent pain relief. Medical advances have made the use of continuous infusion of various medications in smaller doses at more frequent intervals safer and more effective. Finally, according to recent investigations, preoperative and postoperative improvements in analgesia can significantly reduce morbidity (infections, relapses, etc.) and length of hospitalization, and can, thereby, reduce the costs of surgery and postoperative care.

For these reasons, the currently recommended management of acute pain focuses on analgesic combinations of opioids and nonsteroidal anti-inflammatory drugs (NSAIDs) on (i) a scheduled regimen with additional or supplemental doses for breakthrough pain or (ii) continuous dosing or (iii) patient-controlled analgesia (PCA). The use of oral NSAIDs may allow for lower opioid doses and fewer side effects; however, it must be noted that NSAIDs have side effects (for example, gastric disturbances and bleeding).

The purpose of pain management vis-a-vis surgery is to reduce postoperative stress—lung complications, cardiac complications, water retention, salt retention, hypertension, skeletal muscle tension, nausea, etc. The patient's comfort is the goal of acute pain management, through the use of the best relief which can safely be provided under the circumstances. Some of the identified issues in accomplishing this goal are:

1. Attitudes towards pain: Many practitioners become desensitized to patients' complaints about pain. Perhaps some health care providers expect stoical

acceptance. Perhaps some health care providers view the pain as inevitable under some circumstances, such as following surgery. One common misperception among health care providers is that those who complain about pain are whiners, when the real problem is a failure to recognize the differences among patients and patient conditions. The first fact that must be recognized is that pain levels vary widely from one person to the next and from one time to the next in the same individual. Further, treatment of adults is quite different than treatment of children (children metabolize substances more quickly than adults and have developing systems, i.e., immune, endocrine, etc.).

2. Effect on health care costs. The ability of aggressive pain management to influence health care costs by reducing side effects, morbidity, and the duration of treatment in the hospital has had the unexpected effect of creating difficulties with third-party payments. Aggressive pain management can mean the use of preoperative doses of analgesics through infusion. Third-party payors want the reductions in hospital stays/costs, but often don't want to pay the smaller costs of the preoperative, postoperative, and other pain management care.

3. Patient understanding/knowledge. Patients should be informed about what kind of pain to expect from surgery or illness. Patients need to be educated on how to use analgesics, whether administered orally or through infusion or injection. All patients need to know the possible side effects and interactions of the medications. They also need to know how to achieve the optimum pain relief from the smallest doses of the drugs; in other words, how and when to self-administer the medications. Patients may also need to learn to trust their perceptions.

4. Lack of knowledge of or anxiety about current pain management strategies among health care providers. Health care providers may not be receiving adequate training in acute pain management, particularly those health care providers, including primary care physicians, who commonly relate to surgery and postpartum patients and minor or major emergent conditions.

5. Regulatory/malpractice concerns. Some physicians may be hesitant to provide adequate pain management for patients with acute pain because of defensive practice habits (avoidance of possible malpractice suits) or because of fear of regulatory agencies at the state and federal levels.

6. Measurement of pain. There are various instruments for pain assessment, e.g., Simple Descriptive Pain Intensity Scale, Numeric Pain Intensity Scale, and the Visual Analog Scale (considered by some experts as the best clinical instrument). None of these instruments can take the place of personal description, however, and some experts believe that self-reporting is the most important tool for assessing pain.

7. Nonpharmacologic methods of acute pain management or complementary care. The various methods of nonpharmacologic pain management—often referred to as complementary care—may be helpful, in combination with medications, in managing acute pain. These methods include such procedures as homeopathy, transcutaneous electrical nerve stimulation (TENS), hypnosis, biofeedback, water therapy, massage, thermal therapy, chiropractic manipulation, and acupuncture. These pain management tools are usually not reimbursed by third-party payors.

8. Fear of addiction. Many physicians may have concerns about patients becoming addicted to pain medications (opioids) and concerns about the patient who is, may already be or may become addicted. These concerns may be alleviated with appropriate education on addiction.

9. Low Priority of Pain Treatment. Among many practitioners, pain management is not considered “real” treatment or care. This attitude is carried over strongly in the third-party payor systems.

10. Reimbursement. Third-party payor systems do not, at this time, consider many pain management techniques as separately reimbursable.

11. Institutional rules. Hospital and nursing home administrative rules appear to affect the adequacy of pain management.

The increasing importance of pain management as a means of improving outcomes in acute and cancer pain areas has motivated the Joint Commission on Accreditation of Healthcare Organizations to require pain management as a component of hospital accreditation and the Agency for Health Care Policy and Research to issue clinical practice guidelines on management of acute and cancer pain.

Chronic Pain Issues

People have recognized pain from the origin of the human race—in ancient times, many cultures believed that pain was inflicted because the individual had, in some way, offended the gods. Pain can warn of the onset of disease or injury and frequently serves the useful purpose of preventing the organism from suffering greater damage, for example, when the hand is quickly removed from a hot object.

Interpretations of the meaning of pain have undergone considerable evolution over the centuries. Modern medical findings note that acute pain can emanate from injury of the skin, subcutaneous tissues or deeper structures or from muscular spasms or orthopedic injuries. Cancer pain may come from the tumor itself or from bones or nerves affected by the abnormal cells or may be caused by chemotherapy, radiation therapy or surgery.

Opioids and anti-inflammatories may be used to relieve acute pain, and opioids are considered the gold standard for treatment of cancer pain. The definition, the causes and the proper, effective treatment of chronic pain continue, however, to be debated as understanding and measurement of chronic pain are still being researched. At present, chronic pain might be defined as that pain which persists longer than one month or beyond the normal course of the event, disease, trauma or surgical procedure which initially caused the pain. Chronic pain recurs over time.

There are no definitive therapies for chronic pain, although there are different theories about chronic pain. Chronic pain serves no useful physiological purpose such as preventing further injury. Further, chronic pain does considerable damage to the patient, causing great stress, emotional turmoil, psychological symptoms, and dysfunction in everyday life. The patient frequently suffers financially and socially.

Several theories of pain have been put forth. The gate-control theory, for example, avers that pain is modulated by a gating mechanism in the spinal cord and activity in structures of the higher central nervous system. This theory is consistent with the endogenous-opioid theory, i.e., that endogenous opioids have receptors throughout the central nervous system and may bond with these receptors to prevent pain. The sensory-pathway theory relates to the conveyance through various chemical changes and electrical impulses of sensory stimuli from sense organs or receptors to the sensory or reflex centers of the central nervous system.

The pathophysiology of chronic pain may be caused by disease processes or by malfunctioning of otherwise normal nerves. Three primary types of chronic pain syndromes are myofascial dysfunctional pain, i.e., inflammation of muscles and surrounding tissue; neuropathic pain, i.e., injury or dysfunction of nerves; and central pain, i.e., pain as a result of amputation, stroke, or spinal cord injury.

In treating chronic pain, the practitioner is advised to conduct a comprehensive patient evaluation through patient interviews; in-depth past medical history; assessment of symptoms such as range of motion, tender spots, and pain trigger points; and appraisal of the psychological effects of the pain. An accurate diagnosis should be determined and a treatment protocol or plan developed. The patient may require psychological or complementary interventions as well as oral or injection medications, which can include anti-inflammatories and analgesics. Patients should be educated in the proper use of medications.

Practitioners are also counseled to consider requiring written agreements with their patients for the use of medications, with some flexibility built in for break-through pain or unusually high levels of pain. Practitioners are also advised to start with simple treatments and move to more draconian measures as and if necessary. Opioids are not the first mode of treatment for chronic pain, but should

be considered after other treatment modalities have failed. Proper drug treatment is that which provides minimum side effects, increases the patient's level of functioning, and increases the patient's social viability.

Monthly visits, unscheduled drug and alcohol testing, and development of cooperative, participatory relationships with patients should be used along with common sense and regular reevaluations of the patient's condition and of the practitioner/patient agreements.

Issues related to chronic pain treatment are similar to those identified in the treatment of acute and cancer pain, for example, drug tolerance, physical dependence, addiction, pseudo-addiction, undertreatment, drug diversion, and appropriate choices of medications, nonpharmaceutical pain therapies (e.g., transcutaneous electrical nerve stimulation (TENS), hypnosis, biofeedback, acupuncture, and homeopathy), and other complementary care (e.g., massage, whirlpools, heat, and cold).

One increasingly important issue in relationship to chronic pain is the concern about regulatory and law-enforcement investigations when prescribing narcotics to individuals with chronic pain. This concern was magnified in Virginia and nationally in 1996 because of two highly publicized regulatory cases involving a physician and a pharmacist which had the same origin.

Relevant State Law Related to Pain Management Issues

The Drug Control Act is set forth in Chapter 34 of Title 54.1 (Professions and Occupations) of the Code of Virginia. Although the Drug Control Act is administered by the Virginia Board of Pharmacy, the Schedules included in the Virginia Code are recapitulations of federal law and each time the Federal Drug Administration makes changes or the federal law is revised, Virginia law must follow suit.

Three statutes are important to this study—§§ 54.1-2971.01, 54.1-3307.1 and 54.1-3408.1. Section 54.1-3307.1 was enacted with the most sincere of motives to provide physicians with a procedure for registering to obtain, dispense, and administer diacetylmorphine (heroin) for the purpose of relieving the pain of terminally ill cancer patients. This act never became effective because its second enactment clause called for it to become "effective upon notification of the Board of Pharmacy by the Governor that the Congress of the United States has approved appropriate legislation." Federal law never allowed for state registration to dispense heroin. In 1997, this provision was repealed.

Section 54.1-3408.1 was enacted in 1988 as § 54-524.65:1, with the support of physicians and others. Section 54.1-2971.01 was enacted as a first-year recommendation of this study. Both statutes authorize physicians to prescribe excess dosages of pain-relieving agents "if such excess dosage is prescribed,

dispensed or administered in good faith for recognized medicinal or therapeutic purposes.” The physician is also required to certify the “medical necessity for the excess dosage in the patient’s medical record.” Although the authority is clearly given to prescribe the so-called “excess” dosage, many physicians remain reluctant to do so and many pharmacists are reluctant to fill such prescriptions.

Professional Education

An ongoing problem in achieving adequate and effective treatment of pain, whether cancer, acute or chronic, is the inadequacy of provider education in pain management at all levels—undergraduate medical education, internships, residencies, and continuing medical education. The breadth and depth of scientific knowledge has increased to such an extent over the last century that medical schools and other professional schools across the country feel the necessity of prioritizing their curricula content. Unfortunately, little of this content related to pain management before the trend to revise curricula began, and few units of any kind are being added to the already overburdened study years. Further, the quality of the pain management training received by interns and residents varies widely. This hands-on training is traditionally conducted in the mentor/student model through verbal instruction which may not include any pain management instruction or may include out-dated or inaccurate pain management instruction, depending on the knowledge and understanding of the mentor.

Once the provider has gone into practice, there is little in the way of continuing education on pain management. Further, there are few incentives to become knowledgeable since reimbursement does not relate to pain and regulatory and law-enforcement agencies monitor prescribing habits with zeal. Even those physicians who understand that pain management is a multifaceted discipline in which all varieties of treatment from the complementary to the use of opioids must be considered may be hesitant to manage pain properly for fear of disciplinary involvement.

III. THE JOINT SUBCOMMITTEE’S WORK

The First Year: 1994

The joint subcommittee spent the first months of its study (1994) conducting site visits, viewing demonstrations and video tapes, hearing presentations on pain management, and becoming familiar with the issues. Among the issues identified for continuing study were outmoded attitudes towards pain as something that simply must be endured; the effect on health care costs of aggressive pain management in reducing hospital stays and surgery side effects; patient understanding and knowledge concerning pain medications and their side effects and interactions; lack of knowledge and anxiety about current pain management strategies among health care providers; fear of regulatory, police and malpractice actions against practitioners in relation to excess dosages; the lack of knowledge about how to measure or gauge pain; nonpharmacologic methods of pain

management such as hypnosis and biofeedback; and the fear of addiction to pain medications.

The Second Year: 1995

To implement HJR 583's objective relating to holding a pain management summit, a steering group was appointed by the chairman. This steering group included representatives of the three medical schools, various relevant organizations and insurers, nurses, and cancer treatment centers. Under the chairman's leadership, the steering group began meeting in May and continued monthly meetings and correspondence with staff into the fall of 1995. The date, location, and structure of the conference were established, and speakers and panelists identified. Support was solicited from various companies and organizations. Brochures were designed, printed, and mailed to thousands of Virginia practitioners—physicians, nurses, pharmacists, and institutions.

The conference—Pain Management: Attitudes, Obstacles and Issues—was held on December 6, 1995, at the Richmond Marriott. This symposium was presented by the joint subcommittee in cooperation with the Medical Society of Virginia and was financed with unrestricted educational grants from various sponsors. Over 200 practitioners and other interested parties attended the symposium which focused on provider education and offered four different kinds of continuing education credit.

The symposium was structured to provide an overview of pain management treatment—particularly keyed to the pain guidelines—followed by panel discussions of various issues in pain management. Following opening remarks and introductions by the chairman, Senator Woods, and the vice chairman, Delegate Behm, the first keynote address was presented by Dr. Michael H. Levy, Director, Supportive Oncology Program, Fox Chase Cancer Center. The objectives of this address were to enable the participants to utilize a pain rating scale in the assessment of cancer pain; select an appropriate analgesic, based upon a patient's level of pain and response to prior therapy; delineate alternative routes of opioid administration and indications for their usage; describe the role for nonpharmacologic interventions in the management of cancer pain; and list three ways in which clinicians and institutions can implement the Agency for Health Care Policy and Research (AHCPR) guidelines.

Subsequent to this first keynote address, the Lieutenant Governor of Virginia, Donald S. Beyer, Jr., delivered a welcome and presented Governor George F. Allen's Freedom From Cancer Pain Week Proclamation.

Dr. Ada Jacox, R.N., Ph.D., Professor and Independence Foundation Chair in Health Policy, Johns Hopkins University, presented the second keynote address on issues in acute and cancer pain management. The objectives of this presentation were to enable the participants to identify the scope of acute and cancer pain

undermanagement, identify the barriers to effective pain management, describe the process used and issues addressed in the development of the AHCPR guidelines for the management of acute and cancer pain, and describe the evidence underlying acute and cancer pain management.

Following the keynote presentations, the symposium shifted its approach to a moderator/panel format. The first of these panels focused on implementing the guidelines in everyday practice. Dr. Stephen P. Long, a joint subcommittee member, was the moderator. The distinguished panel consisted of Patrick J. Coyne, R.N., M.S.N., C.S., C.R.N.H., of Virginia Commonwealth University's the Medical College of Virginia and ; the two keynoters—Drs. Ada Jacox and Michael H. Levy; Dr. Michelle Whitehurst-Cook, then president-elect of the Virginia Academy of Family Physicians; and Dr. Renee A. Woodford of Virginia Beach General Hospital. This panel's objectives focused on enabling the participants to understand the basic principles, pathophysiology, pharmacology, and modern treatment options for the effective treatment of acute postoperative and cancer pain; understanding and discussing the benefits of proper and aggressive management of acute postoperative, procedure-related, and cancer pain vis-a-vis local, regional and national influences, and the legislative efforts and barriers to such treatment; and gaining a prospective on initiating, developing, and implementing a comprehensive, multidisciplinary pain service.

Lunch was designed to promote additional discussion and interaction with the faculty. The objectives were to enable the participants to engage in an interactive dialogue on the principles set forth in the acute and cancer pain treatment guidelines and to address technical, medical and administrative questions about acute and cancer pain management in the everyday practice environment.

The panel on ethical, legal and regulatory issues was conducted with Dr. Warren W. Koontz of the Virginia Board of Medicine serving as moderator. This panel consisted of Dr. Edward M. Spencer of the Center for Biomedical Ethics at the University of Virginia (substituting for Dr. John C. Fletcher, who was ill), Dr. James L. Levenson of Virginia Commonwealth University's Medical College of Virginia, Dr. Joseph P. McMenamain of McGuire, Woods, Battle and Boothe, and Dr. Thomas R. Pellegrino of Eastern Virginia Medical School. This highly expert panel was focused on enabling the participants to examine the ethical considerations of pain management, specifically as related to parameters of pain endurance, narcotic treatment of pain, and differences between treatment of cancer pain versus acute pain of short duration; identify and understand the legal considerations of pain treatment in Virginia, including the requirements in Virginia law and regulations for prescribing excess dosages; and identify regulatory agencies and clarify the regulatory environment in Virginia, including the government entities involved.

Mr. Jim G. Weeks of Provider Business Services, Inc., moderated a panel on cost and reimbursement issues. This panel's impressive membership included Dr. Francis J. Balestrieri of the Woodburn Surgery Center, Dr. J. Lawrence Colley of Trigon Blue Cross Blue Shield, Ms. Carolyn H. Ray of the Virginia Department of Personnel and Training, and Mr. Joseph M. Teefey of the Virginia Department of Medical Assistance Services. This panel was designed to enable the participants to examine various third-party reimbursement patterns for pain management and the effects of these patterns on patient care and medical practice; examine the issues related to the increasing reliance on managed care and its potential effects on effective pain management, particularly in relation to referrals for specialty care, the discharge of cancer and acute pain patients back to the communities, and the role of primary care practitioners in handling acute and cancer pain; and understand and discuss the effects on health care costs of aggressive pain management, including side effects, morbidity and length of hospital stays.

The final panel of the day addressed treatment issues related to extremes in age, i.e., young children and older adults. This outstanding panel was moderated by Dr. Thomas J. Smith of Virginia Commonwealth University's Medical College of Virginia and included Dr. Richard W. Lindsay of the University of Virginia, Dr. Edward Clifton Russell of Virginia Commonwealth University's Medical College of Virginia, Dr. Navil F. Sethna of Harvard Medical School, and Dr. Holly Lyn Stanley of St. Mary's Hospital. This panel's focus was to enable the participants to understand differences in palliative care in children and the elderly, to know standard approaches to pain management in children and the elderly, and to identify resources for help in treating pain in children and the elderly.

Dr. John C. Rowlingson of the University of Virginia School of Medicine provided a comprehensive and insightful summation of the symposium while including examples of patient situations and treatment issues from his practice experience.

Upon conclusion of the symposium, evaluations were collected for submission to the four accrediting agencies and a reception was held for all participants.

A review of the evaluations substantiated an overwhelmingly positive response to the symposium. Participants expressed support with comments such as "Thank you for the fine symposium!" "An excellent program!" "My practice will be considerably enlightened by this very interesting discussion." "This session was the best CE I have ever taken. Thank you." "I thoroughly appreciated the opportunity to attend this excellent symposium." "To be together in a room with such educated, knowledgeable persons made me feel part of a health care team with common interest." "Great conference."

The forum-type presentations were well-received and appreciated as were the conventional lectures. The use of well-respected, i.e., "big-name," individuals added

to the credibility of the proceedings and drew some participants. The attendance and presentation by Lt. Governor Donald S. Beyer was a special key feature and lent even more prestige to the meeting. The one-day format was exceptionally short for the symposium objectives, however, and more time for discussion would have permitted more consensus building and, perhaps, legislative recommendations.

The consensus appeared to be that the joint subcommittee had brought together a variety of experienced practitioners for enthusiastic, open collaboration which provided a comprehensive overview of acute and cancer pain treatment issues and should benefit all of the participants' patients.

The symposium was accomplished without expense to the Commonwealth and with the joint subcommittee's expenses limited to the actual day of the event. Private companies and organizations provided generous grants to support the symposium, thus enabling the agenda to include the outstanding national and Virginia faculty and to obtain accreditation for continuing medical education and continuing education for nurses, pharmacists, and others.

The Third Year: 1996

The first 1996 meeting of the pain management study committee focused on reviewing the study committee's previous work and launching its 1996 examination of issues related to the economic effects of chronic pain and third-party coverage of pain management. Dr. Stephen P. Long of Virginia Commonwealth University's Medical College of Virginia, a citizen member of the joint subcommittee, delivered a lecture on chronic pain. His most impressive message was that pain can warn of the onset of disease or injury and frequently serves the useful purpose of preventing the organism from suffering greater damage, for example, when the hand is quickly removed from a hot object. Chronic pain, however, serves no useful physiological purposes such as preventing further injury. Further, chronic pain does considerable damage to the patient, causing great stress, emotional turmoil, psychological symptoms, and dysfunction in everyday life. The patient frequently suffers financially and socially.

Dr. Vincent J. Speckhart, also a citizen member of the joint subcommittee, and a medical practitioner who advocates alternative medicine and complementary care, noted that most of the discussion had been concerned with the abuse potential of narcotics use. Dr. Speckhart pointed out that alternative and complementary care produces no psychic or physical dependence and has no abuse potential. The Commonwealth of Virginia, he stated, should make every effort to encourage the use of alternative methods of therapy and to foster research in, and teaching of, these methods. He also observed that state regulatory agencies should allow greater freedom in making these therapies available to the citizens of the Commonwealth. Dr. Speckhart mentioned that there is a very large demand for such services and for trained practitioners in these techniques.

The 1996 study included presentations from Lawrence D. Tarr, Chairman of the Worker's Compensation Commission, who noted that chronic pain is not a separate category within the worker's compensation system and that specific statistics on the effects of chronic pain are not available.

Worker's compensation, which began in 1918, is a system focused on quick, fair, and medically efficient resolution of injuries incurred in the workplace or illnesses caused by working conditions. This system, a public/private partnership, is founded on compromise between employees and employers, i.e., the employees give up the right to sue the employer for the employers' assumption of responsibility for medical treatment which is reasonable, necessary and causally related to the injuries or illnesses. The benefits are tax free wage loss and medical coverage. Doctors' opinions are crucial in determining whether the worker is unable to perform the preinjury job and each case is unique. Cases involving complaints of pain but no evidence of injury are especially difficult. The Worker's Compensation Commission is a quasi-judicial body which administers a peer review system and hearing process. Appeals from the peer review program (a panel of physicians) are heard by the Commission.

Other matters covered by the joint subcommittee during the 1996 interim study included a short literature review. Three papers on the socioeconomic impact of pain were reviewed—two related to chronic pain and one related to acute and cancer pain. One chronic-pain paper described a study of 107 chronic pain patients who were enrolled in a pain management program, and the other paper was a review of the literature related to socioeconomic statistics, pain prevalence in the community, and quality of life. The acute and cancer pain paper described the familiar issues of undermedication, attitude, patient education, public perception, etc., and provided some data to support improved outcomes from effective pain treatment.¹

Some of the pertinent data on the chronic pain patients are:

¹ The two papers on chronic pain were:

Latham, J. And B.D. Davis. The Socioeconomic Impact of Chronic Pain. *Disability and Rehabilitation*, 1994, Vol. 16, No. 1, 39-44.

Richardson, I.H., P. H. Richardson, A.D. deC. Williams, J. Featherstone and V.R. Harding. The Effects of a Cognitive-Behavioural Pain Management Programme on the Quality of Work and Employment Status of Severely Impaired Chronic Pain Patients. *Disability and Rehabilitation*, 1994; Vol. 16, No. 1, 26-34.

The paper related to acute and cancer pain was: Ferrell, Betty R., Grace E. Dean, Marcia Grant, and Paul Coluzzi. An Institutional Commitment to Pain Management. *Journal of Clinical Oncology*. 1995, Vol. 13, No. 9 (September), 2158-2165.

An early and much-referenced study documenting undertreatment of pain was: Marks, R.M. and E.J. Sacher. Undertreatment of Medical Inpatients with Narcotic Analgesics. *Ann. Internal Medicine*, 1973, Vol. 38, 173-181.

- Chronic pain is thought to be the third largest health problem in the world.
- Chronic pain has been estimated over the last decade to affect approximately 40 to 70 million Americans.
- One authority estimated that 50 million Americans are disabled, partly or completely, for a period of time (days, weeks, months) or permanently.
- Loss of work productivity and time and increased health-care charges cost billions of dollars annually—from back and head pain alone.
- Some kinds of chronic pain for which some data exists are back pain and headache.
- Twenty-three million Americans have back pain.
- Twenty-four million Americans have debilitating headaches.
- Some experts estimate that 80 percent of physician visits are for pain complaints.
- A Canadian workers' compensation board documented 20,126 low back pain injuries in 1981, with a claims paid totaling \$44,319,000.
- Enormous amounts of money are spent on over-the-counter analgesics per year.
- Pain behavior—depression, poor mobility, lack of self-sufficiency, lack of life control, and other negative lifestyle and psychological functioning—results in missed work, reduced productivity, and unemployment for more than half of the people suffering chronic pain.
- The more time spent away from work because of chronic pain, the less likely the individual is to return to work.
- Older workers with chronic pain are less likely to return to work than younger workers.
- The chronic pain patient is less likely to improve if one or more of the following conditions exists: compensation is being provided, the spouse is highly sympathetic and supportive, the pain role provides protection from conflicts or provides some other advantage or litigation is pending.

Studies of chronic pain patients enrolled in pain management programs provided some insights:

- Quality of work can be improved in a significant number of patients (35 percent in one study).
- Employment status may continue to fluctuate even with the pain management treatment.
- Long-term pain causes negative lifestyle and psychological functioning such as inappropriate activities of daily life (in bed or immobile), excessive medication intake, depression and other forms of affective distress, maladaptive cognitions, muscle wasting, more pain with any subsequent activity, more anxiety, fear of activity, tension, loss of self-esteem, helplessness, hopelessness, loss of control of life, relationship problems, marriage problems, dysfunctional families, and unemployment.
- Components of chronic pain management must include exercise, scheduling of activity, education of the patient on how to avoid pain, relaxation therapy, and

cognitive therapy. Thus, chronic pain management programs appear to be handled best by multidisciplinary teams.

- Primary aims of chronic pain management are reduction of medications, better quality of life, and return to work.
- The economic climate of the time may affect the patient's ability to return to work, i.e., the patient may be receiving benefits or work may not be available because of high unemployment or because of the patient's past history of sickness and work loss.

Some other points of interest are:

- Few hospitals have pain management services.
- Physicians are still taught to view pain as an incidental product of disease.
- Patients still fear the use of narcotics.
- If intense pain can be blocked before it begins, through a combination of topical analgesics, nonsteroidal anti-inflammatory drugs, and, if necessary, narcotics, the patient is predicted to have shorter hospital stays, shorter periods of disability, fewer visits to the health care system, less metastases, and less cost for care.

The joint subcommittee also heard presentations on Board of Medicine regulatory/disciplinary activities, the State Police Pharmaceutical Diversion Investigative Unit, and treatment of chronic pain in the rural primary care setting. Investigations and complaints before the Board of Medicine are confidential and no information on specific investigations and complaints can be released by law (see § 54.1-108). Voluntary testimony was, however, given by a primary care physician who treats chronic pain patients in his rural practice and had been investigated for his prescribing practices by the Board of Medicine, but had no violations identified. This physician's testimony and a very valuable question and answer session were only possible through the courage of the presenter.

The Board's activities are reported, along with data from other health regulatory boards, to the public in statistical, cumulative form which does not identify any practitioner by name. If a practitioner is disciplined, the Board's action on the case is published and available to the public. Documentation of the medical efficacy of opioid treatment in the patient's record was repeatedly cited as the appropriate and efficient way of avoiding disciplinary consequences. There is no way, however, for a practitioner to insulate himself from the potential of investigation. Due to the threat of regulatory or law-enforcement action, the legal expenses, and the very public nature of the process, such investigations are frequently costly and always stressful for the subject.

The State Police's drug diversion activities were described in detail, and the joint subcommittee also viewed a video of two real defendants who had used various scams to procure prescriptions for controlled substances. Some of the scams

described were to fake illnesses or injuries, such as migraine headaches, burns (using mild caustics and dyes), dental problems, and skiing injuries. The individual may also go to several physicians or hospital emergency rooms with the same complaint, perhaps claiming to be new in town or a current patient with a very common name (such as Smith or Jones).

Among the concerns of the State Police Pharmaceutical Diversion Investigative Unit's personnel were the abundance of prescription drugs available on the streets (because they are safer than other drugs and relatively cheap for the individual); consistency of the definitions in Title 18.2 and the Drug Control Act (Chapter 34 of Title 54.1 of the Code of Virginia); and the low misdemeanor penalties for violations involving Schedules III, IV, and V drugs.

The joint subcommittee also considered the issue of off-label drug reimbursement by insurers. When the federal Food and Drug Administration (FDA) approves drugs for distribution, every drug is accorded at least one "indication." Today, with so many prescription drugs available, many medicines can be used effectively on illnesses or symptoms other than those indicated on the label by the FDA. For example, some drugs specifically developed for one kind of cancer may be useful in treating another form of cancer.

Most insurance companies, managed-care plans, and other third-party payment systems deny reimbursement for uses other than the indications stated on the label by the FDA unless state law requires otherwise. Virginia has had an off-label law for reimbursement of cancer drugs for some years. However, reimbursement for other types of off-label drugs had continued to be denied in Virginia. Many of these prescriptions are very expensive and denial of payment can, therefore, be denial of access to the treatment, including pain management. This controversy was addressed in the 1996 study of the joint subcommittee.

The Fourth Year: 1997

As provided in the continuing resolution, the fourth year of the study was primarily focused on the development of guidelines for the use of opioids in the treatment of chronic pain in cooperation with a special committee of the Medical Society of Virginia. Dr. Stephen P. Long, a subcommittee member, served as the chair of the special subcommittee, with the chairman, Senator Jane H. Woods, and the subcommittee's legal counsel, Norma E. Szakal, also serving as members. The special committee met a number of times to revise the work of a drafting committee. The Board of Medicine also played an important role in this effort. Following development of the final draft, the guidelines were accepted by the 1997 Medical Society of Virginia House of Delegates in November, 1997. The surplus funds from the symposium were transferred to the Medical Society to support the development of regional forums to disseminate information on the use of opiates in the treatment of chronic pain guidelines and the implementation of educational programs, particularly those related to pain management and the new guidelines.

The joint subcommittee also considered the issues relating to the use of marijuana as medicine, specifically whether the long-standing Virginia law which permits the prescribing and use of marijuana in the treatment of cancer and glaucoma (see § 18.2-251.1), should remain on the books. Presently, this law is not operational, being in effect overridden by the threat of sanctions pursuant to the strong federal policy opposing medicinal marijuana laws. During the 1997 Session, the Senate Committee on Education and Health considered and defeated a house bill which would have repealed Virginia's medicinal marijuana law. The motion not to report the bill included a commitment that the Senate Committee would study the issues relating to marijuana as medicine during the 1997 interim. Thus, because of the similarities in the issues relating to pain management and the issues relating to marijuana as medicine, the joint subcommittee was asked to conduct the study for the Senate Committee on Education and Health.

As part of its consideration of medicinal marijuana issues, the joint subcommittee heard presentations from patients who had obtained legitimate prescriptions for the alleviation of pain and nausea; Mary Lynn Mathre, R.N. of the University of Virginia Medical Center; and Dr. Billy Martin, Harris Professor of Pharmacology of Virginia Commonwealth University's Medical College of Virginia. Dr. Martin is the recipient of a merit award from the National Institutes of Health to conduct research on marijuana. This research grant is part of a national effort to resolve the controversy initiated by the passage of California's Proposition 215 and Arizona's Proposition 200.

The joint subcommittee also reviewed the *Report to the Director, National Institutes of Health by the Ad Hoc Group of Experts Workshop on the Medical Utility of Marijuana*. This report recommended more research to bridge the gap from basic science animal studies to human clinical studies. The experts suggested that NIH support the scientific evaluation of the therapeutic effects of marijuana for various disorders outside the social debate, with the usefulness of marijuana as a medical intervention evaluated on a benefit/risk basis. The Expert Group noted the special issues related to clinical trials using marijuana, e.g., the health risks of smoking; the difficulties in assessing the advantages and disadvantages of dosage by smoking; and the issues surrounding dosage variations and dosage control administration (inhalation frequency, environmental problems, developing effective controls, and Drug Enforcement Administration special handling registration).

Testimony to the joint subcommittee noted that previous studies on smoked marijuana did not include patients with acute, cancer or chronic pain. Further, most of the subjects in the previous studies were young, healthy male volunteers, with few, if any, women included. Thus the effects of marijuana on sick, older or immunocompromised patients are not clear. There is, indeed, some evidence for use of marijuana to treat certain neurological and movement disorders, such as multiple sclerosis, Parkinson's disease, and Huntington's Chorea; to control nausea

and vomiting caused by chemotherapy; to simulate appetite in AIDS-wasting syndrome; and to reduce intraocular pressure in glaucoma. The report noted that other effective treatments are, however, readily available for many of the diseases/conditions which may benefit from the therapeutic effects of marijuana.

As required by SJR 366 of 1997 (a 1996 recommendation), the joint subcommittee received a report on the pain management instruction in the Commonwealth's three medical schools. This report, published as Senate Document 3 of 1998, was entitled, *An Inventory of the Pain Management Curricula Offered in the Commonwealth of Virginia's Three Medical Schools*. The report covered undergraduate, graduate, and continuing medical education pain management instruction. This report noted that "[m]any patients do not receive adequate treatment for their pain. This is due to many reasons: failure to diagnose pain properly, lack of education about treatment modalities, lack of research into the effectiveness of pain treatment options, fear of addiction to narcotics, and problems with laws and regulations surrounding prescription drugs and reimbursement."²

The report concluded that the three medical schools are making improvements in pain management instruction. Testimony on the research for the report indicated the development of a collegial atmosphere of interaction and exchange on the issues relating to pain management instruction.

Pursuant to SJR 368 of 1996, the joint subcommittee received from the Department of Medical Assistance Services its report on the *Study of the Effects on Medicaid Costs and Services of Chronic Pain and Pain Management*. This report, published as Senate Document No. 29 of 1998, focused on analyses of Medicaid claims data for chronic low back pain and chronic headache and included hospital admissions and lengths of stay, physician office visits, prescriptions, and rehabilitation treatment. The study data examined claims for 18,935 patients with a principal diagnosis of back pain, receiving care costing \$25.9 million over a twelve-month period. Prescription drugs accounted for approximately \$16 million of this cost; the remaining \$9.9 million reimbursed physicians' office visits and inpatient and outpatient hospital treatment, including rehabilitation. The study data also examined claims for 19,751 patients with a principal diagnosis of headache, with an approximate twelve-month cost of \$18.3 million, i.e., prescriptions totaling more than \$13.3 million and physician and inpatient and outpatient hospital care of approximately \$5 million. The data indicated that patients initially given opioids "consumed more resources than patients who did not." The additional costs may be the result of better quality care or because the

² Report of the University of Virginia Health Sciences Center on *An Inventory of the Pain Management Curricula Offered in the Commonwealth of Virginia's Three Medical Schools*, Senate Document No. 3, 1998, p. 3.

patients were more seriously ill. Further, the data also demonstrated “substantial and significant” regional variations in treatment patterns and costs.³

Senate Document 29 noted some “limitations inherent in large-scale data sets. For example, total drug costs were most likely overestimated because it was impossible to differentiate which pharmaceuticals were prescribed to treat only the back pain or headache diagnoses followed in this study. However, despite this limitation, we did find that most patients with diagnoses of back pain or headache seemed to respond fairly promptly to treatment (because the utilization slowed or stopped), but that the care for a small group of patients is long and expensive.”⁴

A survey of 798 practitioners was also conducted in conjunction with the analysis of the Medicaid claims data. A majority of those surveyed indicated that the patient’s insurance, or lack thereof, “sometimes or always affects their ability to use certain treatment modalities, especially psychiatric services and interventional procedures.”⁵

This report recommended (i) closer management of high utilizing patients to reduce costs of treatment for back pain and headache; (ii) examination of the causes of the regional variations in treatment patterns and costs; (iii) more professional education in pain management; (iv) more education of patients and caregivers about pain management; and (v) examination of the restrictions in current laws and regulations concerning opioid prescriptions and reimbursement for pain management.

The joint subcommittee also continued to cooperate and seek input from the State Police Drug Diversion Unit, including discussions on the current trends and activities in this area.

IV. RECOMMENDATIONS

The joint subcommittee’s work was intensive and productive, i.e., reinforcing the excess dosage law; requiring the Board of Medicine to inform its regulated professions of the excess dosage law; successfully implementing the symposium without obtaining any state support; successfully supporting passage of a general off-label drug reimbursement bill; examining such controversial and difficult issues as regulatory and law-enforcement actions related to pain management and medical marijuana; and developing guidelines for the use of opioids in the treatment of chronic pain. These recommendations were often accomplished through legislative action; however, in the case of the symposium and the chronic pain guidelines, the

³ Report of the Department of Medical Assistance Services, Study of the Effects on Medicaid Costs and Services of Chronic Pain and Pain Management, Senate Document No. 29, 1998, p. 2.

⁴ Senate Document No. 29, 1998, p. 3.

⁵ Senate Document No. 29, 1998, p.3.

partnership with the Medical Society of Virginia and the cooperation with the Board of Medicine were essential and much appreciated.

Recommendations: 1994

At the conclusion of the 1994 study interim, the joint subcommittee recommended three legislative actions—all of which passed. The intractable pain law was strengthened by mirroring the Drug Control Act (see § 54.1-3408.1) in the Board of Medicine's statutes and requiring the Board to advise its licensees of its provisions. This bill—SB 1085 of 1995 (see Appendix B)—confirmed and clarified a physician's authority to prescribe extraordinary doses of pain-relieving agents in cases of intractable pain in new § 54.1-2971.01. Both §§ 54.1-3408.1 and 54.1-2971.01 authorize physicians to prescribe excess dosages of pain-relieving agents "if such excess dosage is prescribed, dispensed or administered in good faith for recognized medicinal or therapeutic purposes." The physician is also required to certify the "medical necessity for the excess dosage in the patient's medical record."

The other 1994 recommendations were (i) to continue the study and to hold a pain management summit (see HJR 583 of 1995 in Appendix A) and (ii) to request the Commonwealth's medical schools, health care professionals, professional associations, health-related agencies, and health regulatory boards to assist in educating the public and practitioners on acute and cancer pain management (see SJR 368 of 1995 in Appendix B).

Recommendations: 1995

No public moneys were appropriated for the symposium which was a public/private partnership in cooperation with the Medical Society of Virginia. Although the cost projections for the symposium were designed to "break even," unexpected grants, received after the brochure was published and distributed, and the registration fees resulted in excess balances in the symposium funds after all expenses were paid.

Many agencies became partners with the joint subcommittee in producing the symposium. The Medical Society of Virginia acted as the fiscal agent for the purpose of receiving the educational grants, and the Senate Clerk's Office acted as the fiscal agent for the purpose of receiving and processing the registration fees (special credit union account). Because the registration fees for the symposium had to be calculated to cover the costs (no state money having been appropriated), the receipt shortly before the symposium date of unexpected educational grants created an excess in the funds. Therefore, balances remained in both funds, i.e., \$ 3,101.63 in the Medical Society Foundation and \$8,263.97 in the account handled by the Senate Clerk's Office.

At the end of the second year of this study, the consensus was that the study should be continued for a third year, partly to determine the appropriate and proper use of the excess funds from the symposium.

House Joint Resolution 256 of 1996 (see Appendix A) revised the mission of the joint subcommittee from focusing solely on acute and cancer pain to focusing on chronic, acute, and cancer pain management. The resolution noted the intensity of the joint subcommittee's study during its first year (1994) and the successful completion of the 1995 objective through the holding of the conference on December 6, 1995, known as the Pain Management Symposium: Attitudes, Obstacles and Issues. Further, the joint subcommittee was also directed to:

- Examine the issues related to pain management, particularly the economic effects of chronic pain.
- Examine the issues set forth in SJR No. 72 of 1994 (the initial enabling resolution).
- Conduct an in-depth assessment of third-party reimbursement for pain treatment.

The 1996 continuing resolution authorized, as recommended in 1995, the joint subcommittee to seek the assistance of an additional pain management expert, chosen from among the steering group which served for the symposium. Dr. John Rowlingson of the University of Virginia School of Medicine was so appointed.

Recommendations: 1996

The joint subcommittee's 1996 recommendations were many and all resulted in legislative initiatives during the 1997 Session. Of these recommendations, three study resolutions, SJR 366, SJR 368, and HJR 565, and one bill, SB 1164, were approved.

Senate Joint Resolution 366 provided for a joint study among the three medical schools (the Medical College at Hampton Roads, Virginia Commonwealth University's Medical College of Virginia, and the University of Virginia School of Medicine) of the inclusion of pain management in the medical school curricula. This curricula study was directed to recommend possible ways to include more comprehensive instruction on chronic, acute, and cancer pain management within the curricula.

Senate Joint Resolution 368 called for the Department of Medical Assistance Services to conduct a study to determine how pain resulting from illness or injury affects Medicaid costs and services. This study was to include data on hospital admissions and lengths of stay, physician visits including specialists, pharmacy usage, and rehabilitation therapies. The Department was required to seek assistance from providers and was authorized to design its study to cover one diagnosis or injury or a group of diagnoses or injuries. The study was to identify any patterns of treatment, treatment that appeared to shorten the duration of pain, and which treatments had the best outcomes.

House Joint Resolution No. 565 continued the joint subcommittee's work to cooperate with the Medical Society of Virginia to develop chronic pain guidelines for Virginia. The continuing resolution specifically noted that the surplus funds from the symposium would be offered to the Medical Society. The resolution noted that there are no national guidelines for chronic pain and that the development of chronic pain guidelines for Virginia could well provide a vehicle for Virginia to set the standard for the rest of the country.

Senate Bill 1164 implemented the joint subcommittee's recommendation that insurers be required to reimburse for certain off-label drug use. This bill required reimbursement for off-label drug use for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. This provision applies to insurers proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis; corporations providing individual or group accident and sickness subscription contracts; and health maintenance organizations providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both. The insurer-related provisions will apply to policies, contracts and plans issued after July 1, 1997. The state employees' benefits plan was also amended to provide coverage for off-label use of cancer drugs and drugs approved for at least one indication.

Senate Joint Resolution 367 which requested the Virginia Workers' Compensation Commission to conduct a pilot study on the effects of pain management was not approved. In conducting this study, the Commission would have been directed to seek the assistance of various insurance companies and employers and to design its study to cover one kind of injury or a group of injuries, for example, lower back injuries or back injuries in general. The Commission would have been required to include in its pilot study the following issues: (i) whether loss of work productivity and time can be reduced through appropriate pain management; (ii) whether appropriate pain management can reduce hospital stays and/or physician visits; (iii) whether appropriate pain management can improve behavior, e.g., depression, poor mobility, lack of self-sufficiency, lack of life control, and other negative lifestyle and psychological functions which result from pain; and (iv) a comparison of the duration of intense pain to the length of time away from work or the likelihood of returning to work. The General Assembly was informed that none of this data was available to the Commission as it would be maintained, if at all, by the insurers and that the Commission had no authority to order insurance companies to provide them with this information.

Two other recommendations that were not approved in 1997 were SB 704 and SB 743. Senate Bill 704 would have increased the penalties for violations involving Schedule III controlled substances from a Class 1 misdemeanor to a Class 5 felony and the penalties for violations involving Schedule IV controlled substances from a Class 1 misdemeanor to a Class 6 felony. These provisions had a delayed effective date of July 1, 1998. An issue receiving significant attention during the 1997 Session which was related to this bill was the rehabilitation of impaired practitioners. The increased penalties would mean the loss of the individual's license because of any felony conviction.

Senate Bill 743 would have conformed the references in the criminal code to terms used or defined in the Drug Control Act (§ 54.1-3400 et seq.). In the present law, only certain terms used in Title 18.2 are said to be synonymous with the uses and definitions in the Drug Control Act, e.g., marijuana. Recently, interpretations by the courts of terms such as "dispense" and "prescribe" have been inconsistent with the law as set forth in the Drug Control Act. This bill may have been perceived as interacting with other bills having to do with the drug violation laws, although it would not have had the effect of increasing any penalties.

Recommendations: 1997

To ensure the implementation and effectiveness of the guidelines for opioid use in the treatment of chronic pain which were developed in a cooperative effort by the Medical Society of Virginia, the Board of Medicine, and the joint subcommittee, several legislative initiatives were recommended for the 1998 Session. The Board of Medicine was authorized, through the passage of SB 549, to endorse, in the furtherance of its responsibility to ensure continued practitioner competency, the Medical Society of Virginia's Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain. The term "endorse" is defined in this new law as "to publicize and distribute such guidelines as providing an appropriate standard of care; however, the Board's endorsement shall not be construed to mean that the guidelines must be followed or are regulations or are in any way intended to be enforceable law."

In addition to the law authorizing the Board of Medicine's endorsement of the new guidelines, the subcommittee recommended that the guidelines be conveyed through a resolution to the General Assembly, the practitioners, and the public. Senate Joint Resolution 165 accomplished this objective, stating that Virginia's guidelines are "unique in the nation as a bell weather development accomplished through cooperation among a legislative group, the regulatory agency, and the professional association." Since the full report and the guidelines are set forth in this legislation, this resolution served the dual purpose of publishing and conveying the guidelines.

House Joint Resolution 318 implemented the joint subcommittee's recommendation to commend the Medical Society of Virginia for developing the

Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain. This resolution noted that “the guidelines are a first in the nation—assisting Virginia physicians in making tough decisions in palliative care.”

Senate Joint Resolution 102 implemented the joint subcommittee’s recommendation that the efforts of the three medical schools, initiated as a result of the SJR 366 study (SD No. 3, 1998), to cooperate in their approach to curricula content and instruction be continued. This resolution noted the unique working relationship developed by the three medical schools as a result of the study and encourages the Virginia medical schools “to lead the country in an innovative approach to integrating instruction in pain management.”

The joint subcommittee made no formal recommendation on the issue of medical marijuana, believing that the research initiated by the National Institutes of Health may resolve the issues.

As in 1996, the joint subcommittee recommended a stronger approach to violations of Schedules III, IV and V of the Drug Control Act. Senate Bill 127, continued to 1999 in the Senate Committee on Finance, would have increased the penalty for second and subsequent controlled substance violations involving Schedule III drugs from a Class 1 misdemeanor to a Class 6 felony. First offenses would remain Class 1 misdemeanors in this bill.

The joint subcommittee also recommended continuation of the study, with the subcommittee metamorphosing from the Joint Subcommittee Studying the Commonwealth’s Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management to the Joint Subcommittee to Monitor the Implementation of Certain Guidelines for Use of Opioids. The joint subcommittee is authorized to hold one meeting and will monitor the implementation of the chronic pain guidelines and continue to examine issues relating to third-party reimbursement for pain management. The joint subcommittee has plans to continue its cooperation with the Medical Society of Virginia’s Ad Hoc Pain Management Committee and the Board of Medicine.

V. CONCLUSIONS

The joint subcommittee believes that its recommendations and educational activities have raised the awareness of the provider community about pain and its management. There are still many concerns—including physician reluctance to prescribe properly, third-party reimbursement issues, and the lack of knowledge of pain management methods—both pharmacological and nonpharmacological. The joint subcommittee now believes that, with the development of the chronic pain guidelines for Virginia, the health care community needs to rally around pain management issues.

The General Assembly cannot legislate away pain and disease. The General Assembly can, however, help make effective pain management more accessible to the citizens of the Commonwealth and take steps to ensure that they are cared for by practitioners who endorse contemporary effective methods of pain therapy.

The joint subcommittee has worked to create an environment in which the therapies will be assessed objectively and promising new and innovative therapies will be allowed, e.g., off-label drug use and reimbursement, complementary care, and the proper and effective prescribing of opioids in the treatment of pain.

The joint subcommittee asks the Board of Medicine and the Medical Society of Virginia to work with all professions involved in pain management, particularly nurses, pharmacists, physician assistants and physicians, to create reliable techniques for disseminating and implementing new developments in pain therapy.

Finally, the joint subcommittee exhorts the General Assembly and its members to continue to monitor the developments in this area and to remember always that one of humanity's universal concerns is the alleviation of pain—we are all subject to it.

Respectfully Submitted,

Senator Jane H. Woods, *Chairman*
Delegate I. Vincent Behm, Jr., *Vice Chairman*
Delegate David G. Brickley
Delegate Jerrauld C. Jones
Delegate Gladys B. Keating
Senator Benjamin J. Lambert III
Stephen P. Long, M.D.
John C. Rowlingson, M.D.
Senator Richard L. Saslaw
Betsy H. Schofield
Vincent Speckhart, M.D.
Mildred M Torian

Appendix A: Enabling Resolutions

SJR 72, 1994

HJR 583, 1995

HJR 256, 1996

HJR 565, 1997

HJR 172, 1998

SENATE JOINT RESOLUTION NO. 72

Establishing a joint subcommittee to study the Commonwealth's current laws and policies relating to acute and cancer pain management.

Agreed to by the Senate, February 14, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, the most common reason for seeking primary care is acute pain, and among the millions of injuries suffered annually in the United States, 80 percent involve acute pain; and

WHEREAS, although there have been vast improvements in pain management techniques in recent years, in 1992 the Agency for Health Care Policy and Research within the United States Department of Health and Human Services recognized the "inadequacy of traditional pain management" when issuing a clinical practice guideline for acute pain management following surgery and trauma; and

WHEREAS, experts acknowledge that conventional postoperative pain treatment, intramuscular injections of opioid "as needed," does not relieve pain in approximately 50 percent of patients and that, in children, pain is managed even less well than in adults; and

WHEREAS, traditional attitudes about patients' pain concerns, i.e., that these patients are complainers, must be dispelled, because unrelieved pain contributes to "patient discomfort, longer recovery periods, and greater use of scarce health care resources and may compromise patient outcomes"; and

WHEREAS, unrelieved pain may delay the return of normal stomach and bowel functions, important indicators for hospital discharge; and

WHEREAS, inadequate pain management may cause physiological and psychological sequelae, resulting in increased morbidity; for example, immune system impairment and increased likelihood of pneumonia, postoperative complications, cardiovascular failures, and infectious complications; and

WHEREAS, estimates that 25 percent of all cancer patients are dying without relief of severe pain dramatically demonstrate the need for ethical, aggressive, and effective pain management, including pharmacologic treatment, such as opioids and nonsteroidal anti-inflammatory drugs (NSAIDs), and nonpharmacologic strategies, such as transcutaneous electrical nerve stimulation (TENS), biofeedback, relaxation, and massage; and

WHEREAS, state law and policy could play a role in facilitating effective pain management, thereby serving the medical needs of the Commonwealth's citizens in the safest and most efficacious manner; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be established to study the Commonwealth's current laws and policies related to acute and cancer pain management. The joint subcommittee shall be composed of 11 members as follows: three members of the Senate to be appointed by the Senate Committee on Privileges and Elections; four members of the House of Delegates to be appointed by the Speaker of the House; and four citizens of the Commonwealth to be appointed by the Governor. Of the four citizen members, two shall be physicians who are experts in pain management and two shall be patients or the relatives of patients who have some experience with pain management.

In its deliberations, the joint subcommittee shall examine (i) current acute and cancer pain management efforts in the Commonwealth; (ii) the effectiveness of acute and cancer pain management provided by the Commonwealth's medical schools, health care providers, and acute and cancer pain management clinics; (iii) Virginia's current law and public policy related to acute and cancer pain management; (iv) current Virginia training, including continuing education, in acute pain management; (v) the pain treatment needs of acute and cancer patients; (vi) the special pain management needs of infants, children, and adolescents; and (vii) the impact of inadequate pain management on resource utilization and costs.

The joint subcommittee shall determine (i) statewide needs related to inadequate acute and cancer pain management and any appropriate corrective actions; (ii) any law and public policy revisions needed to facilitate the utilization of effective acute and cancer pain management; and (iii) the potential cost avoidance through aggressive acute and cancer pain management.

The direct costs of this study shall not exceed \$6,250.

interdisciplinary approaches to pain management, reimbursement for nonpharmacological treatments, promotion of understanding and cooperation between law enforcement and practitioners, issues related to health care facilities such as hospitals, nursing homes, and adult care residences, and the appropriate roles in pain management of various sectors of the health care industry.

The direct costs of this study shall not exceed \$6,750.

All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall be continued for one year only and shall submit its final findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

GENERAL ASSEMBLY OF VIRGINIA -- 1995 SESSION

HOUSE JOINT RESOLUTION NO. 583

Continuing the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management.

Agreed to by the House of Delegates, February 4, 1995

Agreed to by the Senate, February 21, 1995

WHEREAS, established to examine the policy and laws relating to pain management, the joint subcommittee established by Senate Joint Resolution No. 72 (1994) has conducted site visits, viewed demonstrations and video tapes, and heard many presentations on the issues related to pain management; and

WHEREAS, severe pain, such as acute postoperative pain, is the result of complex physiologic reactions to tissue injury and disease; and

WHEREAS, among the many principles that the joint subcommittee has learned is that pain is an expensive and frustrating phenomena and that, unless it is properly treated, pain results in physical debilitation and increased morbidity; and

WHEREAS, in this era of managed care health care plans, many experts are concerned about improving the quality of pain management; and

WHEREAS, with an estimated \$70 million spent annually on medical visits, lost work days, and workers' compensation, all thoughtful people concerned about accessible and affordable health care must realize that pain management is an essential service that contains costs and is not a frivolous expenditure to silence complaining patients; and

WHEREAS, in this year of its study, the joint subcommittee has identified issues related to pain management including outmoded attitudes towards pain as something that simply must be endured; the effect on health costs of aggressive pain management in reducing hospital stays and surgery side effects; patient understanding and knowledge concerning pain medications, their side effects and interactions; lack of knowledge and anxiety about current pain management strategies among health care providers; fear of regulatory, police and malpractice actions against practitioners in relation to excess dosages; the lack of knowledge about how to measure or gauge pain; nonpharmacologic methods of pain management such as hypnosis and biofeedback; and the fear of addiction to pain medications; and

WHEREAS, the joint subcommittee has recommended a bill to confirm and clarify physicians' authority to prescribe extraordinary doses of pain-relieving agents in cases of intractable pain; and

WHEREAS, the joint subcommittee will also be asking for various health care providers to cooperate with each other and to assist in this study; and

WHEREAS, in the coming year, the joint subcommittee will be examining those issues that were not fully explored during 1994 and seeking cooperative efforts and private assistance in conducting a pain management summit; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management be hereby continued. The members duly appointed pursuant to SJR No. 72 of 1994 shall continue to serve, except that any vacancies shall be filled as provided in the enabling resolution. Staffing shall continue to be provided by the Division of Legislative Services.

The joint subcommittee shall, in the coming year, be seeking to involve a broad spectrum of health professionals in efforts to enhance understanding and implementation of effective, up-to-date pain management techniques, both pharmacological and nonpharmacological. In this regard, the joint subcommittee will be seeking private cooperation and support to hold a pain management summit and will be inviting the cosponsorship of various other government officials. The joint subcommittee will seek the cooperation and participation of all sectors of the private health care community and the Board of Medicine as well as the Boards of Dentistry and Nursing and other health regulatory boards in assisting with the planning and implementation of a pain management summit, upon obtaining private cooperation and support.

In its deliberations, the joint subcommittee will also examine the issues set forth in SJR 72 of 1994 and will do an in-depth assessment of third party reimbursement for pain treatment,

GENERAL ASSEMBLY OF VIRGINIA -- 1996 SESSION

HOUSE JOINT RESOLUTION NO. 256

Continuing the Joint Subcommittee studying the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management as the Joint Subcommittee studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management.

Agreed to by the House of Delegates, February 8, 1996

Agreed to by the Senate, February 21, 1996

WHEREAS, the joint subcommittee was established by Senate Joint Resolution No. 72 (1994) and continued by House Joint Resolution No. 583 (1995), providing the bases for many explanations, presentations, and demonstrations on pain management modalities; and

WHEREAS, specifically, the study committee was continued in 1995 to seek cooperative efforts and private assistance in conducting a pain management summit; and

WHEREAS, beginning in May 1995, a steering group met regularly and planned the agenda and particulars of the conference; and

WHEREAS, private companies and organizations provided generous grants to support the symposium, thus enabling the agenda to include outstanding national and Virginia faculty and to obtain accreditation for continuing medical education and continuing education for nurses, pharmacists, and others; and

WHEREAS, on December 6, 1995, the Pain Management Symposium: Attitudes, Obstacles and Issues was held with great success, having over two hundred health care providers in attendance; and

WHEREAS, the symposium was accomplished without expense to the Commonwealth and with the joint subcommittee's expenses limited to the actual day of the event; and

WHEREAS, the hope of the joint subcommittee is that this educational effort will assist the patients of the Commonwealth, and, in fact, appears to have had remarkable effects, with several pain management efforts underway in rural areas; and

WHEREAS, the joint subcommittee has not examined the many issues related to chronic pain, such as back pain and knee pain; and

WHEREAS, chronic pain may be the most economically significant symptom in terms of lost employment days, disabling conditions, and long-term human suffering; and

WHEREAS, in addition to examining chronic pain issues, the joint subcommittee will oversee the publication of several medical articles, reflecting the proceedings of the symposium, and will develop a report to chronicle its work; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee studying the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management be continued for one more year as the Joint Subcommittee studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management. The members duly appointed pursuant to SJR No. 72 (1994) shall continue to serve, except that any vacancies shall be filled as provided in the enabling resolution. Staffing shall continue to be provided by the Division of Legislative Services.

The joint subcommittee shall examine the issues related to pain management, particularly the economic effect of chronic pain and may, in this regard, seek the assistance of an additional pain management expert, chosen from among the steering group which served for the symposium.

In its deliberations, the joint subcommittee will also examine the issues set forth in SJR No. 72 (1994), and will do an in-depth assessment of third party reimbursement for pain treatment which had been planned for 1995, but was not completed.

The direct costs of this study shall not exceed \$4,350.

All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall be continued for one year to examine the issues related to chronic pain and insurance coverage and shall submit its final findings and recommendations on all aspects of pain management to the Governor and the 1997 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

GENERAL ASSEMBLY OF VIRGINIA -- 1997 SESSION

HOUSE JOINT RESOLUTION NO. 565

Continuing the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management.

Agreed to by the House of Delegates, February 4, 1997

Agreed to by the Senate, February 19, 1997

WHEREAS, the joint subcommittee was established by Senate Joint Resolution No. 72 (1994), continued by House Joint Resolution No. 583 (1995), and revised by House Joint Resolution No. 256 (1996), providing the bases for many explanations, presentations, and demonstrations on pain management modalities; and

WHEREAS, specifically, the study committee was continued in 1995 to seek cooperative efforts and private assistance in conducting a pain management summit; and

WHEREAS, on December 6, 1995, the Pain Management Symposium: Attitudes, Obstacles and Issues was held, without expense to the Commonwealth, with great success, having over 200 health care providers in attendance; and

WHEREAS, in 1996 the joint subcommittee was continued to examine the issue of chronic pain as the most economically significant symptom in terms of lost employment days, disabling conditions, and long-term human suffering and to close out the work required for the symposium; and

WHEREAS, during the 1996 interim, the joint subcommittee earnestly sought data from various entities on the economic implications of chronic pain management; and

WHEREAS, such data was not forthcoming; and

WHEREAS, the joint subcommittee is requesting, through other resolutions, that the Virginia Workers' Compensation Commission and the Department of Medical Assistance Services conduct, during the 1997 interim, pilot studies on the effects of pain management; and

WHEREAS, the joint subcommittee was also directed to examine issues related to off-label drug use in 1996 and did, after discussing other states' laws on this subject as well as various models, recommend amendments to the Code of Virginia to accommodate these issues; and

WHEREAS, the joint subcommittee also studied issues in 1996 concerning drug diversion and provider fear of investigations by regulatory and law-enforcement agencies; and

WHEREAS, several amendments to the drug laws are being proposed by the joint subcommittee as a result of this study; and

WHEREAS, the joint subcommittee discovered in the course of examining drug diversion issues and their relationship to chronic pain management that no national guidelines exist for chronic pain management; and

WHEREAS, the joint subcommittee has determined that the surplus funds from the symposium must be used to educate the medical community in pain management; and

WHEREAS, the joint subcommittee has requested the Medical Society of Virginia to accept these funds and to cooperate with the joint subcommittee by developing chronic pain guidelines for Virginia; and

WHEREAS, the development of these guidelines may well provide a vehicle for Virginia to set the standard for the rest of the country; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management be continued for another year in order to receive data on the economic effects of pain management which is to be collected through pilot studies and to cooperate with the Medical Society of Virginia in supporting the development of chronic pain guidelines for Virginia. The members duly appointed pursuant to SJR No. 72 (1994) shall continue to serve, except that any vacancies shall be filled as provided in the enabling resolution. Staffing shall continue to be provided by the Division of Legislative Services. The additional pain management expert, chosen from among the members of the steering group which served for the symposium, will also continue to serve as provided in HJR No. 256 (1996).

In its deliberations, the joint subcommittee shall continue to examine third party reimbursement for pain treatment, as well as the issues set forth in SJR No. 72 (1994).

GENERAL ASSEMBLY OF VIRGINIA -- 1998 SESSION

HOUSE JOINT RESOLUTION NO. 172

Continuing the Joint Subcommittee Studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management as the Joint Subcommittee Monitoring the Implementation of Certain Guidelines for Use of Opioids in Chronic Pain.

Agreed to by the House of Delegates, March 12, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, the Joint Subcommittee Studying the Commonwealth's Current Laws and Policies Relating to Acute and Cancer Pain Management was established pursuant to Senate Joint Resolution No. 72 (1994), continued by House Joint Resolution No. 583 (1995), and revised by House Joint Resolutions No. 256 (1996) and No. 565 (1997); and

WHEREAS, the joint subcommittee has been very active, conducting an intensive study of pain management in 1994, conducting a symposium on pain management in 1995 without the use of state funds, bringing together law-enforcement and medical experts to discuss pain management issues in 1996, and supporting, in 1997, in cooperation with the Medical Society of Virginia, the development of chronic pain guidelines; and

WHEREAS, in 1996 the joint subcommittee sought data from various entities on the economic implications of chronic pain management; and

WHEREAS, because of the scarcity of any data, the joint subcommittee initiated a Medicaid study of the effects of chronic pain management in certain conditions, e.g., lower back pain; and

WHEREAS, the Medicaid study provided some interesting, but inconclusive, results; and

WHEREAS, the joint subcommittee also requested a study of medical school curricula in 1997 that has resulted in a new attitude of cooperation; and

WHEREAS, the publication in October 1997 of the Report of the Medical Society of Virginia Pain Management Subcommittee conveyed the chronic pain guidelines to physicians across Virginia; and

WHEREAS, the joint subcommittee has granted the excess funds from the 1995 symposium to the Medical Society of Virginia to conduct educational programs or otherwise promote awareness of the need for pain management instruction; and

WHEREAS, the Board of Medicine has been an active participant in these educational activities and will publish the chronic pain guidelines in its newsletter; and

WHEREAS, although the joint subcommittee has accomplished much, the attitudes of fear and avoidance which so often result in undertreatment of chronic, acute, and cancer pain still abound; and

WHEREAS, in the coming year, the effects of the newly developed chronic pain guidelines will be important to monitor; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management be continued for another year as the Joint Subcommittee Monitoring the Implementation of Certain Guidelines for Use of Opioids in Chronic Pain. The total membership of the joint subcommittee shall be 15 members and shall include 4 new members as provided for in this resolution. The members duly appointed pursuant to SJR No. 72 (1994) shall continue to serve. Any vacancies shall be filled as provided in the enabling resolution, except that appointments of the members of the House of Delegates to fill vacancies shall also be in accordance with the principles of Rule 16 of the House Rules. The four additional members of the joint subcommittee shall be appointed as follows: two members of the House of Delegates to be appointed by the Speaker of the House in accordance with the principles of Rule 16 of the House Rules; and two members of the Senate to be appointed by the Senate Committee on Privileges and Elections. The additional pain management expert, chosen from among the members of the steering group which served for the symposium, will also continue to serve as provided in HJR No. 256 (1996).

In its deliberations the joint subcommittee shall monitor the implementation of the chronic pain guidelines and shall continue to examine third party reimbursement for pain treatment, as well as the issues set forth in SJR No. 72 (1994). The joint subcommittee shall limit its meetings to one in the

coming year.

The direct costs of this study shall not exceed \$1,950.

All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall submit its findings and recommendations on all aspects of pain management to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Appendix B: Legislation to Implement Recommendations

1995 Legislation

SJR 368

HJR 583

Chapter 277: SB 1085

1996 Legislation

HJR 256

1997 Legislation

APPROVED

SJR 366

SJR 368

HJR 565

Chapter 656: SB 1164

FAILED

SJR 367

SB 704

SB 743

1998 Legislation

APPROVED

SJR 102

SJR 165

HJR 172

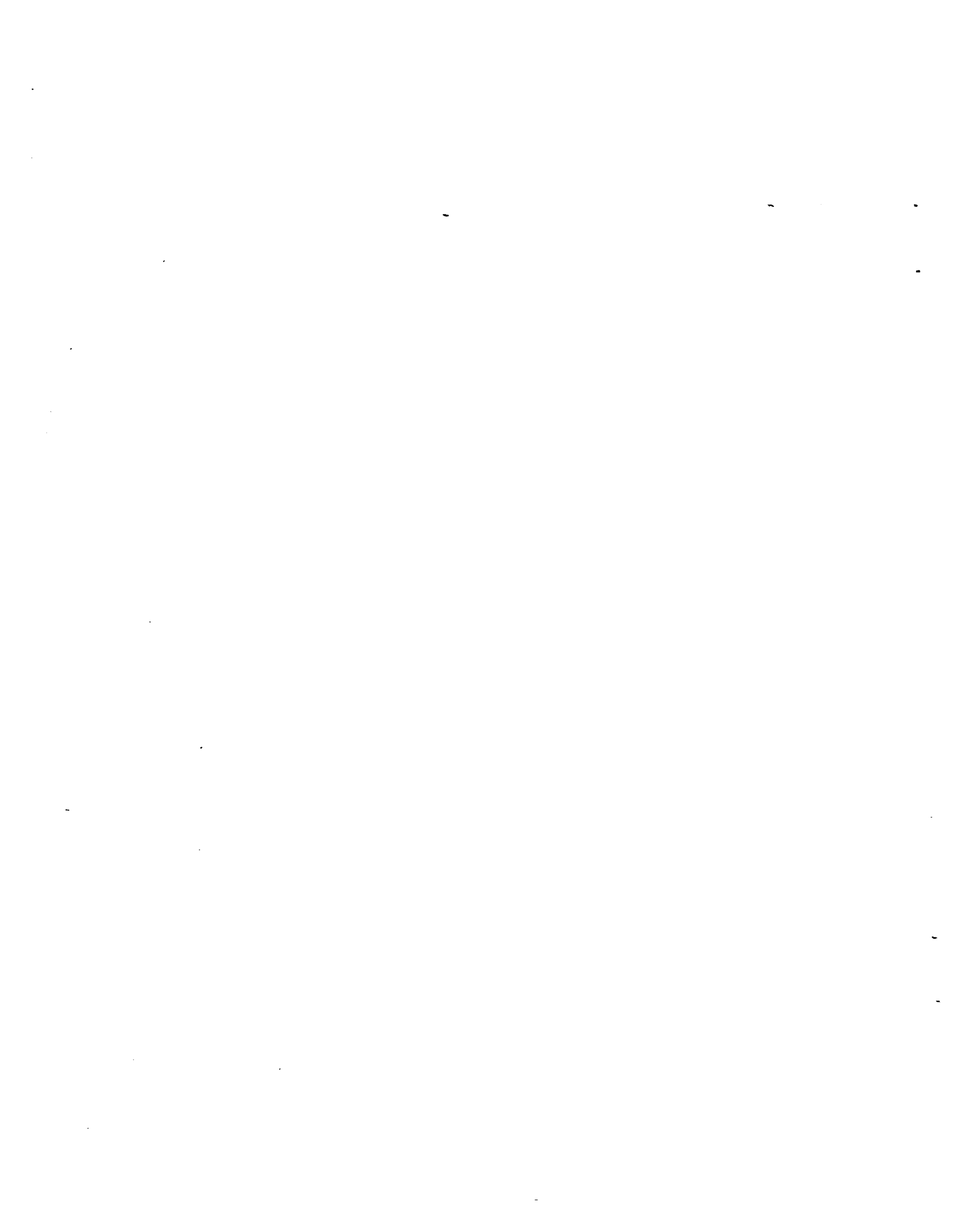
HJR 318

Chapter 496: SB 549

CONTINUED

SB 127

1995 Legislation
SJR 368
HJR 583
Chapter 277: SB 1085



SENATE JOINT RESOLUTION NO. 368

Requesting that the Commonwealth's medical schools, health care professionals, professional associations, health-related agencies, and health regulatory boards assist in educating the public and practitioners on acute and cancer pain management.

Agreed to by the Senate, February 7, 1995

Agreed to by the House of Delegates, February 22, 1995

WHEREAS, the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management was established pursuant to SJR 72 of 1994 and has completed a demanding study schedule during the 1994 interim; and

WHEREAS, the complexities of the issues related to pain management have surprised and interested the members; and

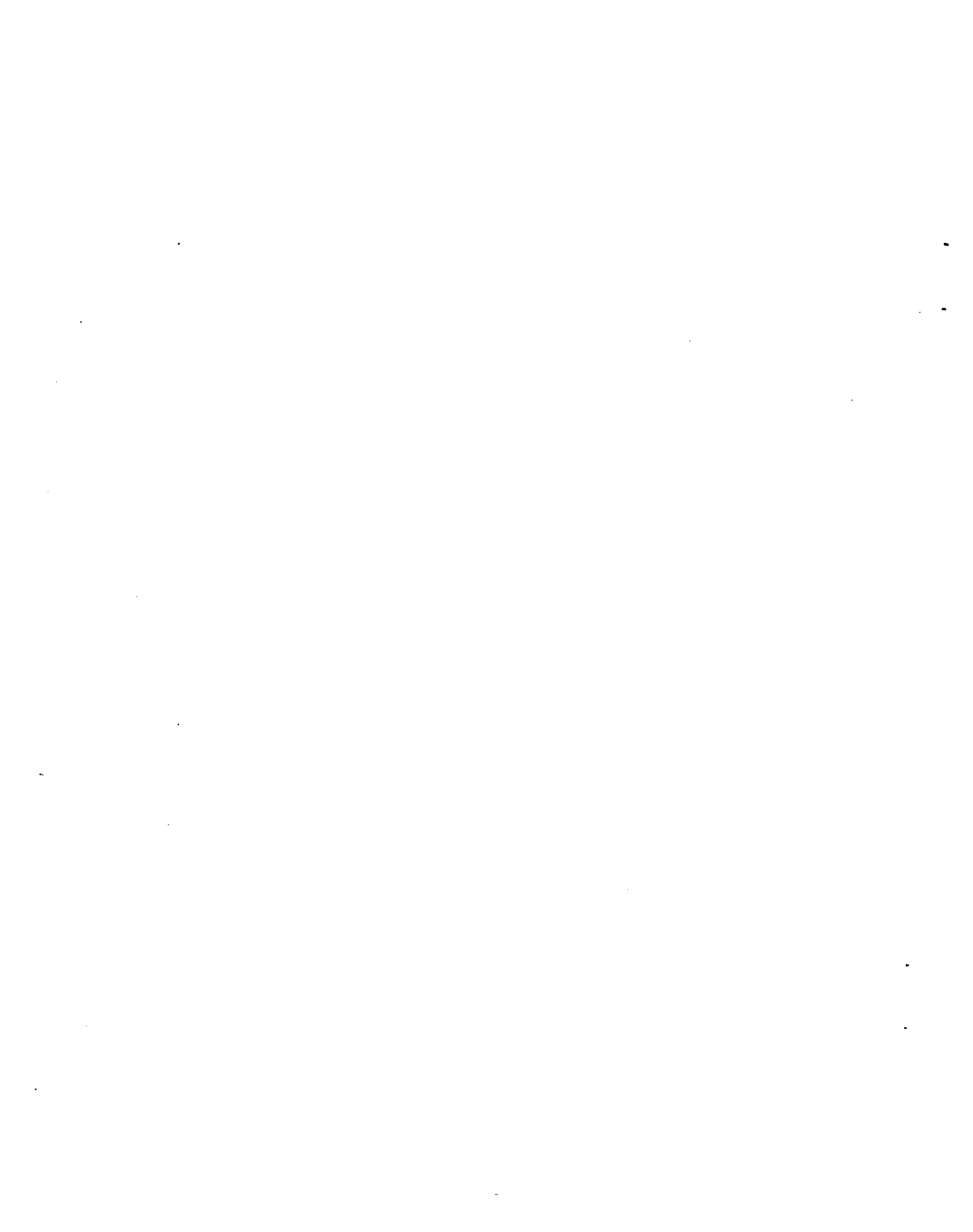
WHEREAS, among the issues before the joint subcommittee is the lack of understanding and knowledge among health care providers about the laws related to this subject and about the current state of pain management practice; and

WHEREAS, the welfare of patients who live with unceasing severe pain must be considered and, in the interest of preventing future patients from experiencing the suffering that many have known, the joint subcommittee hopes to initiate educational initiatives by existing organizations and agencies; and

WHEREAS, although the joint subcommittee knows that fiscal constraints will not allow any new initiatives among relevant state agencies, the joint subcommittee wishes to urge the health regulatory boards, the Board of Health, and the medical schools to use existing newsletters or other publications to assist in promoting knowledge of appropriate pain management; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the University of Virginia School of Medicine; the Medical College of Virginia; all private professional associations, particularly the Medical Society of Virginia; all private practitioners of medicine, dentistry, nursing, psychology, podiatry, professional counseling, and physical therapy; all health care institutions and their associations, including the Virginia Hospital Association and the Virginia Health Care Association; and all relevant state agencies, including the Departments of Health and Medical Assistance Services and the Boards of Medicine and Dentistry as well as the Boards of Nursing, Psychology, and Professional Counseling cooperate and participate with the joint subcommittee in this educational effort.

The General Assembly also admonishes all of the above entities and any other interested parties to participate in the development and implementation of a pain management summit to be conducted if private cooperation and support can be obtained.



GENERAL ASSEMBLY OF VIRGINIA -- 1995 SESSION

HOUSE JOINT RESOLUTION NO. 583

Continuing the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management.

Agreed to by the House of Delegates, February 4, 1995

Agreed to by the Senate, February 21, 1995

WHEREAS, established to examine the policy and laws relating to pain management, the joint subcommittee established by Senate Joint Resolution No. 72 (1994) has conducted site visits, viewed demonstrations and video tapes, and heard many presentations on the issues related to pain management; and

WHEREAS, severe pain, such as acute postoperative pain, is the result of complex physiologic reactions to tissue injury and disease; and

WHEREAS, among the many principles that the joint subcommittee has learned is that pain is an expensive and frustrating phenomena and that, unless it is properly treated, pain results in physical debilitation and increased morbidity; and

WHEREAS, in this era of managed care health care plans, many experts are concerned about improving the quality of pain management; and

WHEREAS, with an estimated \$70 million spent annually on medical visits, lost work days, and workers' compensation, all thoughtful people concerned about accessible and affordable health care must realize that pain management is an essential service that contains costs and is not a frivolous expenditure to silence complaining patients; and

WHEREAS, in this year of its study, the joint subcommittee has identified issues related to pain management including outmoded attitudes towards pain as something that simply must be endured; the effect on health costs of aggressive pain management in reducing hospital stays and surgery side effects; patient understanding and knowledge concerning pain medications, their side effects and interactions; lack of knowledge and anxiety about current pain management strategies among health care providers; fear of regulatory, police and malpractice actions against practitioners in relation to excess dosages; the lack of knowledge about how to measure or gauge pain; nonpharmacologic methods of pain management such as hypnosis and biofeedback; and the fear of addiction to pain medications; and

WHEREAS, the joint subcommittee has recommended a bill to confirm and clarify physicians' authority to prescribe extraordinary doses of pain-relieving agents in cases of intractable pain; and

WHEREAS, the joint subcommittee will also be asking for various health care providers to cooperate with each other and to assist in this study; and

WHEREAS, in the coming year, the joint subcommittee will be examining those issues that were not fully explored during 1994 and seeking cooperative efforts and private assistance in conducting a pain management summit; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management be hereby continued. The members duly appointed pursuant to SJR No. 72 of 1994 shall continue to serve, except that any vacancies shall be filled as provided in the enabling resolution. Staffing shall continue to be provided by the Division of Legislative Services.

The joint subcommittee shall, in the coming year, be seeking to involve a broad spectrum of health professionals in efforts to enhance understanding and implementation of effective, up-to-date pain management techniques, both pharmacological and nonpharmacological. In this regard, the joint subcommittee will be seeking private cooperation and support to hold a pain management summit and will be inviting the cosponsorship of various other government officials. The joint subcommittee will seek the cooperation and participation of all sectors of the private health care community and the Board of Medicine as well as the Boards of Dentistry and Nursing and other health regulatory boards in assisting with the planning and implementation of a pain management summit, upon obtaining private cooperation and support.

In its deliberations, the joint subcommittee will also examine the issues set forth in SJR 72 of 1994 and will do an in-depth assessment of third party reimbursement for pain treatment,

interdisciplinary approaches to pain management, reimbursement for nonpharmacological treatments, promotion of understanding and cooperation between law enforcement and practitioners, issues related to health care facilities such as hospitals, nursing homes, and adult care residences, and the appropriate roles in pain management of various sectors of the health care industry.

The direct costs of this study shall not exceed \$6,750.

All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall be continued for one year only and shall submit its final findings and recommendations to the Governor and the 1996 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

VIRGINIA ACTS OF ASSEMBLY -- 1995 SESSION

CHAPTER 277

An Act to amend and reenact § 54.1-3408.1 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 54.1-2971.01, relating to prescriptions in excess of recommended dosage; pain management.

[S 1085]

Approved March 16, 1995

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-3408.1 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 54.1-2971.01 as follows:

§ 54.1-2971.01. Prescription in excess of recommended dosage in certain cases.

A. Consistent with § 54.1-3408.1, a physician may prescribe a dosage of a pain-relieving agent in excess of the recommended dosage upon certifying the medical necessity for the excess dosage in the patient's medical record. Any practitioner who prescribes, dispenses or administers an excess dosage in accordance with this section and § 54.1-3408.1 shall not be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for recognized medicinal or therapeutic purposes.

B. The Board of Medicine shall advise physicians of the provisions of this section and § 54.1-3408.1.

§ 54.1-3408.1. Prescription in excess of recommended dosage in certain cases.

In the case of a patient with intractable pain, ~~an attending~~ a physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient's medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be ~~deemed to be~~ in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes.

Nothing in this section shall be construed to grant any person immunity from investigation or disciplinary action based on the prescription, dispensing or administration of an excess dosage in violation of this ~~section~~ title.

1996 Legislation
HJR 256

GENERAL ASSEMBLY OF VIRGINIA -- 1996 SESSION

HOUSE JOINT RESOLUTION NO. 256

Continuing the Joint Subcommittee studying the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management as the Joint Subcommittee studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management.

Agreed to by the House of Delegates, February 8, 1996

Agreed to by the Senate, February 21, 1996

WHEREAS, the joint subcommittee was established by Senate Joint Resolution No. 72 (1994) and continued by House Joint Resolution No. 583 (1995), providing the bases for many explanations, presentations, and demonstrations on pain management modalities; and

WHEREAS, specifically, the study committee was continued in 1995 to seek cooperative efforts and private assistance in conducting a pain management summit; and

WHEREAS, beginning in May 1995, a steering group met regularly and planned the agenda and particulars of the conference; and

WHEREAS, private companies and organizations provided generous grants to support the symposium, thus enabling the agenda to include outstanding national and Virginia faculty and to obtain accreditation for continuing medical education and continuing education for nurses, pharmacists, and others; and

WHEREAS, on December 6, 1995, the Pain Management Symposium: Attitudes, Obstacles and Issues was held with great success, having over two hundred health care providers in attendance; and

WHEREAS, the symposium was accomplished without expense to the Commonwealth and with the joint subcommittee's expenses limited to the actual day of the event; and

WHEREAS, the hope of the joint subcommittee is that this educational effort will assist the patients of the Commonwealth, and, in fact, appears to have had remarkable effects, with several pain management efforts underway in rural areas; and

WHEREAS, the joint subcommittee has not examined the many issues related to chronic pain, such as back pain and knee pain; and

WHEREAS, chronic pain may be the most economically significant symptom in terms of lost employment days, disabling conditions, and long-term human suffering; and

WHEREAS, in addition to examining chronic pain issues, the joint subcommittee will oversee the publication of several medical articles, reflecting the proceedings of the symposium, and will develop a report to chronicle its work; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee studying the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain Management be continued for one more year as the Joint Subcommittee studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management. The members duly appointed pursuant to SJR No. 72 (1994) shall continue to serve, except that any vacancies shall be filled as provided in the enabling resolution. Staffing shall continue to be provided by the Division of Legislative Services.

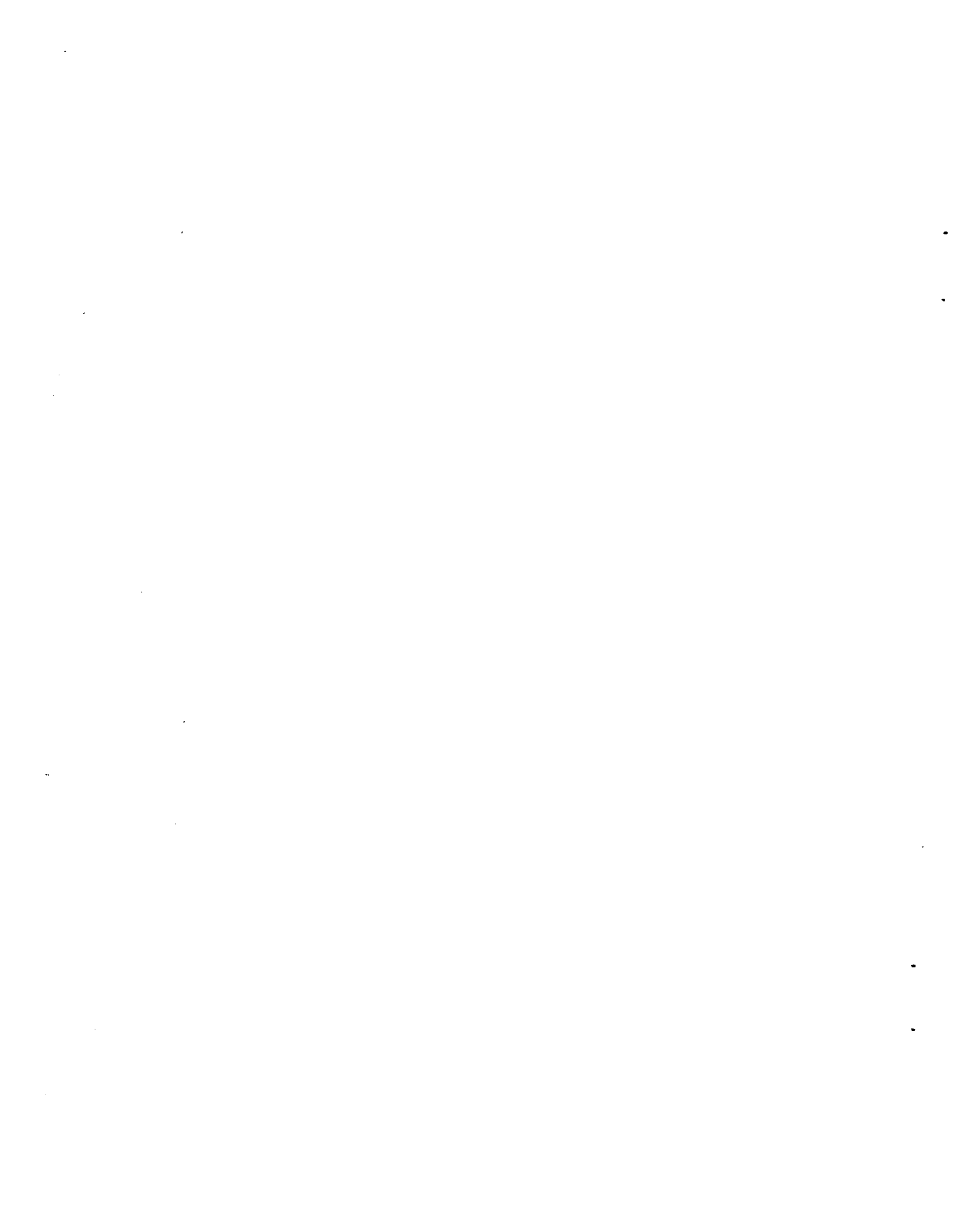
The joint subcommittee shall examine the issues related to pain management, particularly the economic effect of chronic pain and may, in this regard, seek the assistance of an additional pain management expert, chosen from among the steering group which served for the symposium.

In its deliberations, the joint subcommittee will also examine the issues set forth in SJR No. 72 (1994), and will do an in-depth assessment of third party reimbursement for pain treatment which had been planned for 1995, but was not completed.

The direct costs of this study shall not exceed \$4,350.

All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall be continued for one year to examine the issues related to chronic pain and insurance coverage and shall submit its final findings and recommendations on all aspects of pain management to the Governor and the 1997 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.



1997 Legislation

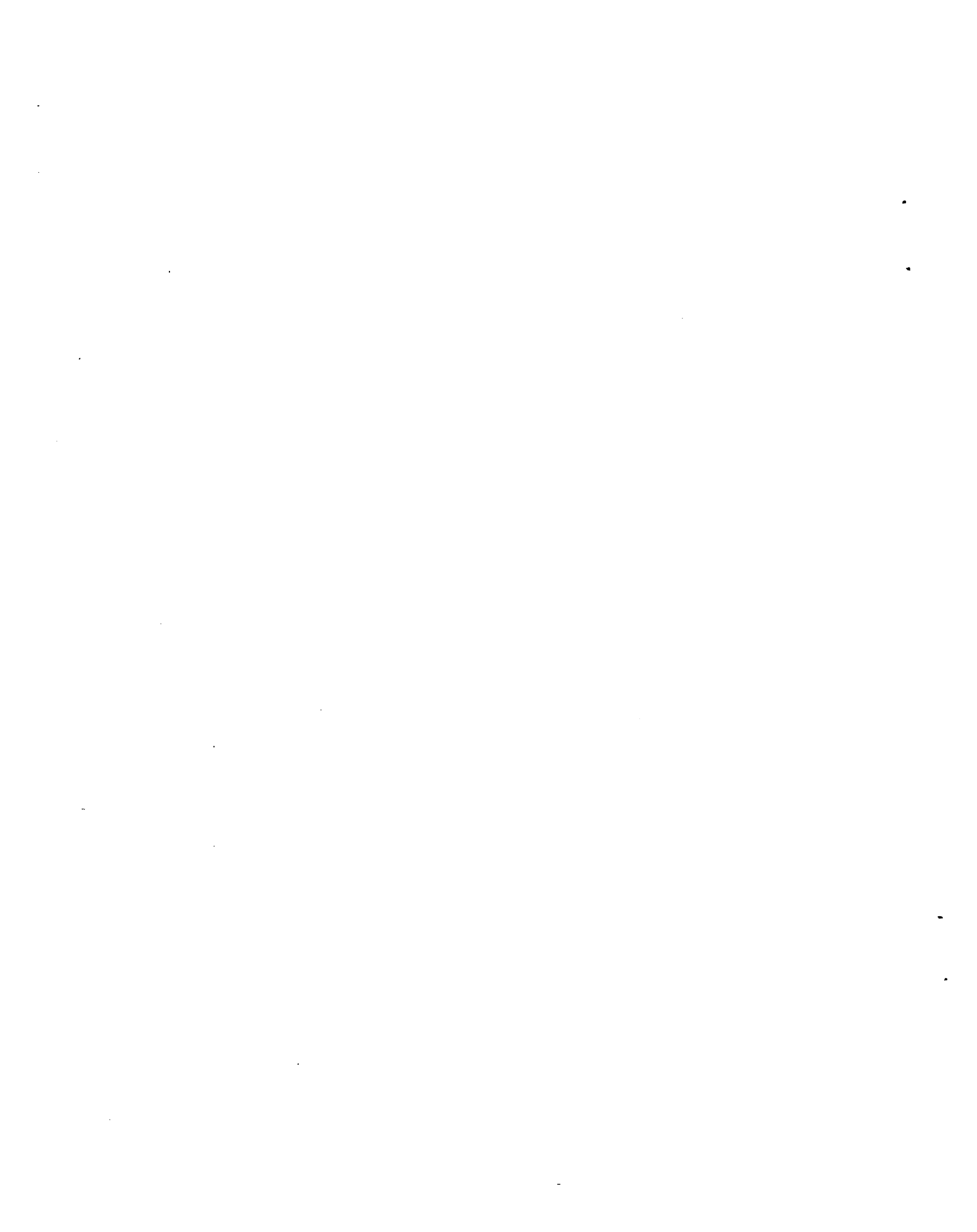
APPROVED

SJR 366

SJR 368

HJR 565

Chapter 656: SB 1164



SENATE JOINT RESOLUTION NO. 366

Requesting the Medical College at Hampton Roads, the Medical College of Virginia of Virginia Commonwealth University and the University of Virginia Medical Center to study the inclusion of pain management in their curricula.

Agreed to by the Senate, January 30, 1997

Agreed to by the House of Delegates, February 13, 1997

WHEREAS, the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute and Cancer Pain has worked hard over the past three years to improve the knowledge and attitudes among Virginia's health professionals on the relief of pain; and

WHEREAS, although common sense would indicate that a primary function of medical and other health practitioners is to relieve pain, many practitioners still view pain as a natural and unavoidable, incidental product of disease and injury; and

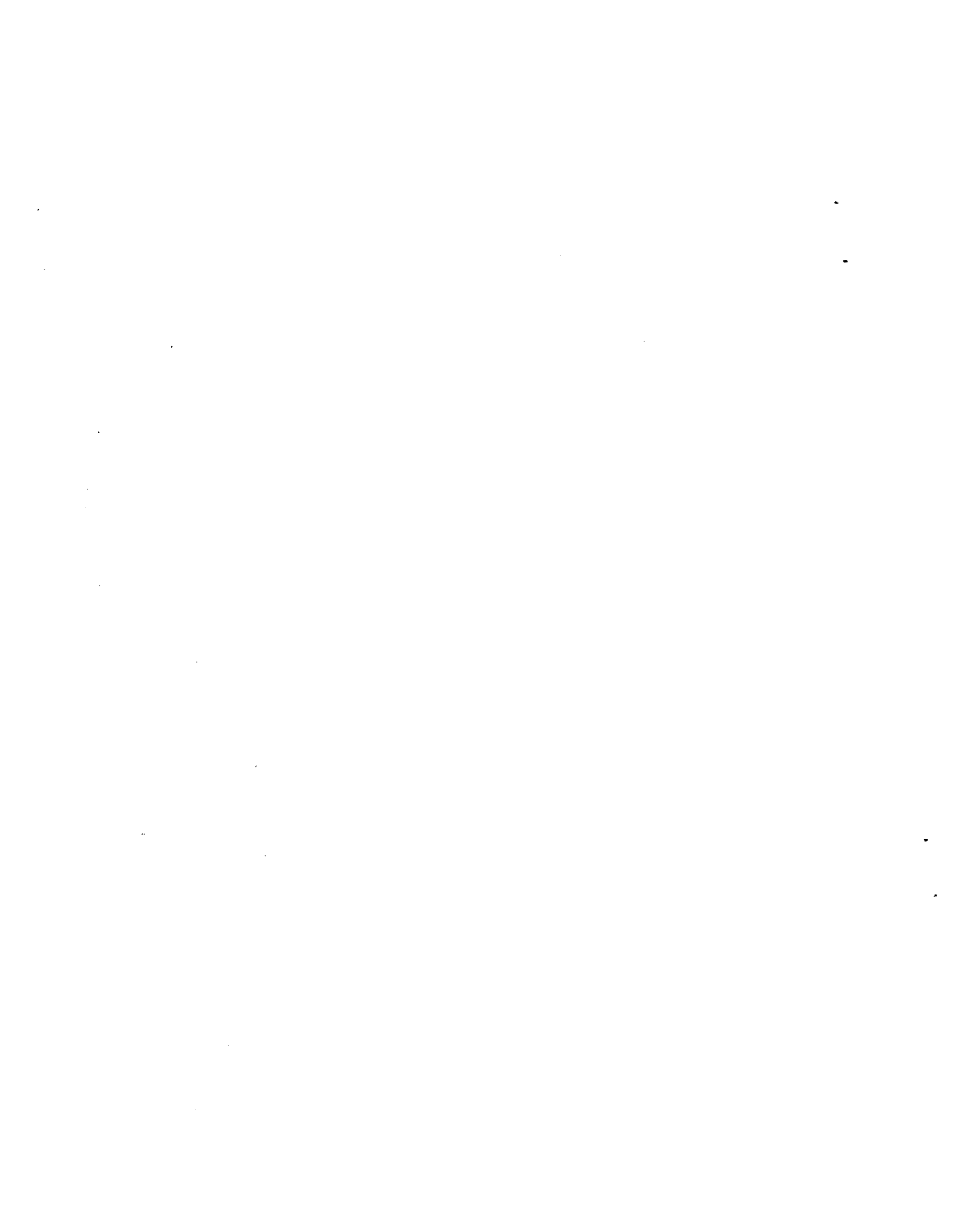
WHEREAS, many health practitioners are still unaware of the existence of the national pain guidelines for acute and cancer pain that were developed by the Agency for Health Care Policy and Research in the United States Department of Health and Human Services; and

WHEREAS, many prescribers are unaware of the benefits of pain management on the patient's overall condition and quality of life, e.g., shorter stays in acute facilities, quicker return to work, expanded activities, better social relationships, and less stress and anxiety; and

WHEREAS, anecdotal information presented to the joint subcommittee concerning instruction in pain management indicates that little, if any, time is dedicated to this subject and that many medical students, interns, and residents—even those practitioners whose patients are beset with great pain—may be receiving insufficient guidance in this very important area; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Medical College at Hampton Roads, the Medical College of Virginia of Virginia Commonwealth University and the University of Virginia Medical Center be requested to study the inclusion of pain management in their curricula. The three medical schools shall jointly provide a preliminary report to the joint subcommittee to study the Commonwealth's current laws and policies related to chronic, acute, and cancer pain on their study and on possible ways to include more comprehensive instruction on chronic, acute, and cancer pain management within their curricula by November 1, 1997.

The three medical schools shall complete their work in time to submit their joint findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.



SENATE JOINT RESOLUTION NO. 368

Requesting the Department of Medical Assistance Services to conduct a study to determine how pain resulting from illness or injury affects Medicaid costs and services.

Agreed to by the Senate, January 30, 1997

Agreed to by the House of Delegates, February 13, 1997

WHEREAS, in the continuing resolution for the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute and Cancer Pain Management, House Joint Resolution No. 256 (1996), one of the stated objectives of the joint subcommittee was to evaluate the economic effects of pain management, particularly as related to chronic pain; and

WHEREAS, during the 1996 interim study, the joint subcommittee earnestly sought data from several sources on the economic benefits of proper management of chronic pain on various benefits programs, but was unsuccessful; and

WHEREAS, studies of chronic pain patients enrolled in pain management programs indicate that 80 percent of physician visits are for pain complaints, that 23 million Americans have back pain, and that 24 million Americans have debilitating headaches; and

WHEREAS, various studies have found that pain management for acute and cancer pain can shorten hospital stays, improve outcomes, and reduce physician visits; and

WHEREAS, the aforementioned study results indicate that use of pain management would be of benefit to the Commonwealth in reducing the costs of medical assistance; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Medical Assistance Services be requested to conduct a study to determine the effects on Medicaid costs and services of pain resulting from an illness or injury. Data studied should include, but not be limited to, hospital admissions and length of stay, physician visits including specialists, pharmacy usage, and rehabilitation therapies. In conducting its study, the department shall seek the assistance of various participating providers and may design its study to cover one diagnosis or injury or a group of diagnoses or injuries. The study report should identify any patterns of treatment, treatment that appeared to shorten the duration of pain, and best outcomes.

All agencies of the Commonwealth shall provide assistance to the department for this study, upon request. The department shall present a preliminary report to the Joint Subcommittee Studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management by November 1, 1997.

The Department of Medical Assistance Services shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.



GENERAL ASSEMBLY OF VIRGINIA -- 1997 SESSION

HOUSE JOINT RESOLUTION NO. 565

Continuing the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management.

Agreed to by the House of Delegates, February 4, 1997

Agreed to by the Senate, February 19, 1997

WHEREAS, the joint subcommittee was established by Senate Joint Resolution No. 72 (1994), continued by House Joint Resolution No. 583 (1995), and revised by House Joint Resolution No. 256 (1996), providing the bases for many explanations, presentations, and demonstrations on pain management modalities; and

WHEREAS, specifically, the study committee was continued in 1995 to seek cooperative efforts and private assistance in conducting a pain management summit; and

WHEREAS, on December 6, 1995, the Pain Management Symposium: Attitudes, Obstacles and Issues was held, without expense to the Commonwealth, with great success, having over 200 health care providers in attendance; and

WHEREAS, in 1996 the joint subcommittee was continued to examine the issue of chronic pain as the most economically significant symptom in terms of lost employment days, disabling conditions, and long-term human suffering and to close out the work required for the symposium; and

WHEREAS, during the 1996 interim, the joint subcommittee earnestly sought data from various entities on the economic implications of chronic pain management; and

WHEREAS, such data was not forthcoming; and

WHEREAS, the joint subcommittee is requesting, through other resolutions, that the Virginia Workers' Compensation Commission and the Department of Medical Assistance Services conduct, during the 1997 interim, pilot studies on the effects of pain management; and

WHEREAS, the joint subcommittee was also directed to examine issues related to off-label drug use in 1996 and did, after discussing other states' laws on this subject as well as various models, recommend amendments to the Code of Virginia to accommodate these issues; and

WHEREAS, the joint subcommittee also studied issues in 1996 concerning drug diversion and provider fear of investigations by regulatory and law-enforcement agencies; and

WHEREAS, several amendments to the drug laws are being proposed by the joint subcommittee as a result of this study; and

WHEREAS, the joint subcommittee discovered in the course of examining drug diversion issues and their relationship to chronic pain management that no national guidelines exist for chronic pain management; and

WHEREAS, the joint subcommittee has determined that the surplus funds from the symposium must be used to educate the medical community in pain management; and

WHEREAS, the joint subcommittee has requested the Medical Society of Virginia to accept these funds and to cooperate with the joint subcommittee by developing chronic pain guidelines for Virginia; and

WHEREAS, the development of these guidelines may well provide a vehicle for Virginia to set the standard for the rest of the country; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management be continued for another year in order to receive data on the economic effects of pain management which is to be collected through pilot studies and to cooperate with the Medical Society of Virginia in supporting the development of chronic pain guidelines for Virginia. The members duly appointed pursuant to SJR No. 72 (1994) shall continue to serve, except that any vacancies shall be filled as provided in the enabling resolution. Staffing shall continue to be provided by the Division of Legislative Services. The additional pain management expert, chosen from among the members of the steering group which served for the symposium, will also continue to serve as provided in HJR No. 256 (1996).

In its deliberations, the joint subcommittee shall continue to examine third party reimbursement for pain treatment, as well as the issues set forth in SJR No. 72 (1994).

VIRGINIA ACTS OF ASSEMBLY -- 1997 SESSION

CHAPTER 656

An Act to amend and reenact §§ 2.1-20.1, as it is currently effective and as it may become effective, and 38.2-3407.5 of the Code of Virginia, relating to off-label drug use.

[S 1164]

Approved March 21, 1997

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-20.1, as it is currently effective and as it may become effective, and 38.2-3407.5 of the Code of Virginia are amended and reenacted as follows:

§ 2.1-20.1. Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. ~~1.~~ The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

2. ~~The plan shall~~ Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. ~~The plan shall~~ Include coverage for postpartum services providing inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. *Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.*

5. *Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.*

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from

such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The assets of the fund shall be held for the sole benefit of the employee health insurance program. The fund shall be held in the state treasury. Any interest on unused balances in the fund shall revert back to the credit of the fund.

D. For the purposes of this section, ~~the term:~~

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Personnel and Training which utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

§ 2.1-20.1. (Delayed effective date) Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. ~~1.~~ The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

2. ~~The plan shall~~ Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. ~~The plan shall~~ Include coverage for postpartum services providing inpatient care and a home

visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. *Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.*

5. *Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.*

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The assets of the fund shall be held for the sole benefit of the employee health insurance program. The fund shall be held in the state treasury. Any interest on unused balances in the fund shall revert back to the credit of the fund.

D. For the purposes of this section, ~~the term:~~

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.15:25.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Personnel and Training which utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

§ 38.2-3407.5. Denial of benefits for certain prescription drugs prohibited.

A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits will not be denied for any drug approved by the United States Food and Drug

Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopoeia Dispensing Information.

B. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, (ii) corporation providing individual or group accident and sickness subscription contracts, and (iii) health maintenance organization providing a health care plan for health care services, whose policy, contract or plan, including any certificate or evidence of coverage issued in connection with such policy, contract or plan, includes coverage for prescription drugs, whether on an inpatient basis, outpatient basis, or both, shall provide in each such policy, contract, plan, certificate, and evidence of coverage that such benefits will not be denied for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

C. For the purposes of subsections A and B:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

D. Coverage, as described in ~~subsection~~ subsections A and B, includes medically necessary services associated with the administration of the drug.

~~E.~~ E. Subsections A and B shall not be construed to do any of the following:

1. Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the specific type of cancer or indication for which the drug has been prescribed;
2. Require coverage for experimental drugs not otherwise approved for any indication by the United States Food and Drug Administration;
3. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration;
4. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition; or
5. Require coverage for prescription drugs in any contract, policy or plan that does not otherwise provide such coverage.

~~D.~~ F. The provisions of this section shall not apply to short-term travel, or accident-only policies, or to short-term nonrenewable policies of not more than six months' duration.

~~E.~~ G. The provisions of ~~this section~~ subsection A are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1994, and the provisions of subsection B are applicable to contracts, policies or plans delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1997.

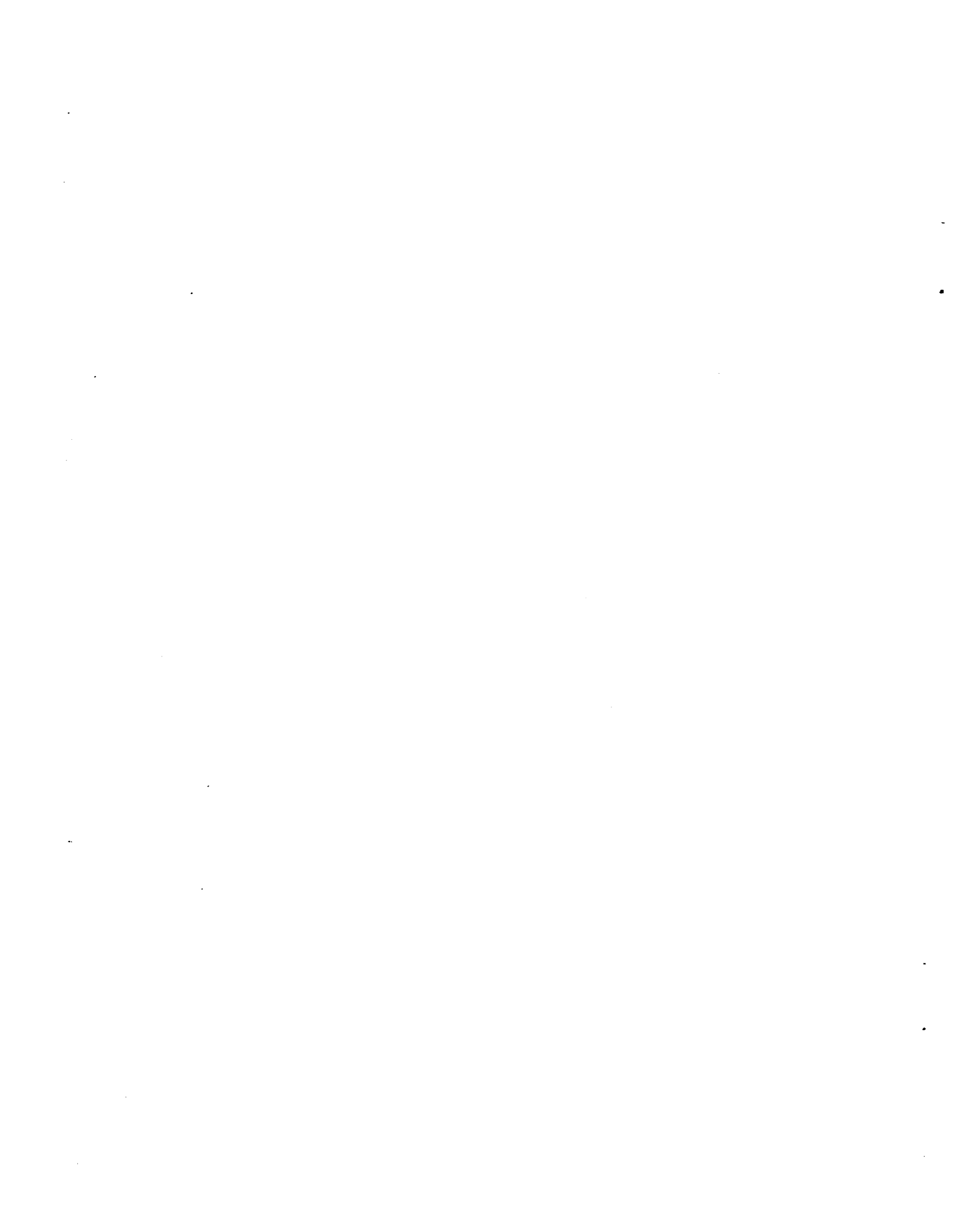
1997 Legislation

FAILED

SJR 367

SB 704

SB 743



SJ367 Study; effects of pain management.

977723760

SENATE JOINT RESOLUTION NO. 367
Offered January 20, 1997

Requesting the Virginia Workers' Compensation Commission to conduct a pilot study on the effects of pain management.

Patrons-- Woods, Lambert and Saslaw; Delegate: Behm

Referred to the Committee on Rules

WHEREAS, the continuing resolution of the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute and Cancer Pain Management, House Joint Resolution 256 of 1996, stated, as one of the 1996 objectives of the joint subcommittee, an evaluation of the economic effects of pain management, particularly as related to chronic pain; and

WHEREAS, during the 1996 interim study, the joint subcommittee has earnestly sought data from several sources on the economic benefits of proper management of chronic pain on various benefits programs; and

WHEREAS, studies of chronic pain patients enrolled in pain management programs indicated that the quality of work can be improved through pain management, that medication dependency can be reduced, and that time away from work can be shortened; and

WHEREAS, pain management for acute and cancer pain have been found, by various studies, to decrease hospital stays and to improve outcomes; and

WHEREAS, the aforementioned study results indicated that pain management would be of benefit to employers in reducing the costs of workers' compensation; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Virginia Workers' Compensation Commission be requested to conduct a pilot study on the effects of pain management. In conducting this study, the Commission shall seek the assistance of various insurance companies and employers and shall design its study to cover one kind of injury or a group of injuries, for example, lower back injuries or back injuries in general. The Commission shall include in its pilot study the following issues: (i) whether loss of work productivity and time can be reduced through appropriate pain management; (ii) whether appropriate pain management can reduce hospital stays and/or physician visits; (iii) whether appropriate pain management can improve behavior--depression, poor mobility, lack of self-sufficiency, lack of life control, and other negative lifestyle and psychological functioning

which result from pain; (iv) a comparison of the duration of intense pain to the length of time away from work or the likelihood of returning to work; and (v) such other issues as the Commission deems proper.

All agencies of the Commonwealth shall provide assistance to the Commission for this study, upon request.

The Virginia Workers' Compensation Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

977710760

SENATE BILL NO. 704

Offered January 8, 1997

A BILL to amend and reenact § 18.2-248 of the Code of Virginia, relating to violations of the Drug Control Act; penalties.

 Patrons-- Lambert, Saslaw and Woods; Delegate: Behm

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §18.2-248 of the Code of Virginia is amended and reenacted as follows:

§18.2-248. Manufacturing, selling, giving, distributing or possessing with intent to manufacture, sell, give or distribute a controlled substance or an imitation controlled substance prohibited; penalties.

A. Except as authorized in the Drug Control Act (§54.1-3400 et seq.), it shall be unlawful for any person to manufacture, sell, give, distribute, or possess with intent to manufacture, sell, give or distribute a controlled substance or an imitation controlled substance.

B. In determining whether any person intends to manufacture, sell, give or distribute an imitation controlled substance, the court may consider, in addition to all other relevant evidence, whether any distribution or attempted distribution of such pill, capsule or tablet included an exchange of or a demand for money or other property as consideration, and, if so, whether the amount of such consideration was substantially greater than the reasonable value of such pill, capsule or tablet, considering the actual chemical composition of such pill, capsule or tablet and, where applicable, the price at which over-the-counter substances of like chemical composition sell.

C. Any person who violates this section with respect to a controlled substance classified in Schedule I or II shall upon conviction be imprisoned for not less than five nor more than forty years and fined not more than \$500,000. Upon a second or subsequent conviction of such a violation, any such person may, in the discretion of the court or jury imposing the sentence, be sentenced to imprisonment for life or for any period not less than five years and be fined not more than \$500,000.

D. If such person proves that he gave, distributed or possessed with intent to give or distribute a controlled substance classified in Schedule I or II only as an accommodation to another individual who is not an inmate in a community correctional facility, local correctional facility or state correctional facility as defined in §53.1-1 or in the custody of an employee thereof, and not with intent to profit thereby from any consideration received or expected nor to induce the recipient or intended recipient of the controlled substance to use or become addicted to or dependent upon such controlled substance, he shall be guilty of a Class 5 felony.

E. If the violation of the provisions of this article consists of the filling by a pharmacist of the prescription of a person authorized under this article to issue the same, which prescription has not been received in writing by the pharmacist prior to the filling thereof, and such written prescription is in fact received by the pharmacist within one week of the time of filling the same, or if such violation consists of a request by such authorized person for the filling by a pharmacist of a prescription which has not been received in writing by the pharmacist and such prescription is, in fact, written at the time of such request and delivered to the pharmacist within one week thereof, either such offense shall constitute a Class 4 misdemeanor.

F. Any person who violates this section with respect to a controlled substance *shall be guilty of (i) a Class 5 felony if the violation involves a drug classified in Schedule III; (ii) a Class 6 felony if the violation involves a drug classified in Schedule IV; or (iii) a Class 1 misdemeanor if the violation involves a drug classified in Schedule V or an imitation controlled substance which imitates a controlled*

substance classified in Schedule III, IV, or V, except for an anabolic steroid classified in Schedule III constituting a violation of ~~§18.2-248.5, shall be guilty of a Class 1 misdemeanor.~~

G. Any person who violates this section with respect to an imitation controlled substance which imitates a controlled substance classified in Schedule I or II shall be guilty of a Class 6 felony. In any prosecution brought under this subsection, it is not a defense to a violation of this subsection that the defendant believed the imitation controlled substance to actually be a controlled substance.

H. "Drug kingpin" means a person who was the principal or one of several principal administrators, organizers or leaders of a continuing criminal enterprise if (i) the enterprise received at least \$500,000 in gross receipts during any twelve-month period of its existence from the manufacture, importation, or distribution of heroin or cocaine or ecgonine or the derivatives, salts, isomers, or salts of isomers thereof or (ii) the person engaged in the enterprise to manufacture, sell, give, distribute or possess with the intent to manufacture, sell, give or distribute the following:

1. 100 kilograms or more of a mixture or substance containing a detectable amount of heroin;
2. 500 kilograms or more of a mixture or substance containing a detectable amount of:
 - a. Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed;
 - b. Cocaine, its salts, optical and geometric isomers, and salts of isomers;
 - c. Ecgonine, its derivatives, their salts, isomers, and salts of isomers; or
 - d. Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in subdivisions a through c; or
3. 1.5 kilograms or more of a mixture or substance described in subdivision 2 which contains cocaine base.

Any person who is found to be a drug kingpin shall upon conviction be guilty of a felony punishable by a fine of not more than one million dollars and imprisonment for twenty years to life, twenty years of which shall be a mandatory, minimum sentence which shall be served with no suspension in whole or in part, nor shall anyone convicted hereunder be placed on probation or parole.

I. For purposes of subsection H of this section, a person is engaged in a continuing criminal enterprise if (i) he violates any provision of this section, the punishment for which is a felony and (ii) such violation is a part of a continuing series of violations of this section which are undertaken by such person in concert with five or more other persons with respect to whom such person occupies a position of organizer, a supervisory position, or any other position of management, and from which such person obtains substantial income or resources.

2. That the provisions of this act may result in a net increase in periods of imprisonment in state correctional facilities. Pursuant to §30-19.1:4, the estimated amount of the necessary appropriation is \$375,000.

3. That this act shall become effective on July 1, 1998.



Go to ([General Assembly Home](#))

977708760

SENATE BILL NO. 743

Offered January 8, 1997

A BILL to amend and reenact §§18.2-247 and 18.2-248 of the Code of Virginia, relating to violations of the Drug Control Act.

Patrons-- Woods, Lambert and Saslaw; Delegates: Behm and Keating

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §§18.2-247 and 18.2-248 of the Code of Virginia are amended and reenacted as follows:

§18.2-247. Use of terms defined in the Drug Control Act in Title 18.2.

A. Wherever the terms used or defined in the Drug Control Act, (§§54.1-3400 et seq.), including, but not limited to, "controlled substances," *dispense*, *prescribe*, "marijuana" and "Schedules I, II, III, IV, V and VI" are used in Title 18.2, such terms shall refer to those terms as they are used or defined in ~~the such~~ Drug Control Act, ~~Chapter 34 of Title 54.1.~~

B. The term "imitation controlled substance" when used in this article means a pill, capsule, tablet, or substance in any form whatsoever which is not a controlled substance subject to abuse, and:

1. Which by overall dosage unit appearance, including color, shape, size, marking and packaging or by representations made, would cause the likelihood that such a pill, capsule, or tablet will be mistaken for a controlled substance unless such substance was introduced into commerce prior to the initial introduction into commerce of the controlled substance which it is alleged to imitate; or

2. Which by express or implied representations purports to act like a controlled substance as a stimulant or depressant of the central nervous system and which is not commonly used or recognized for use in that particular formulation for any purpose other than for such stimulant or depressant effect, unless marketed, promoted, or sold as permitted by the United States Food and Drug Administration.

C. In determining whether a pill, capsule, tablet, or substance in any other form whatsoever, is an "imitation controlled substance," there shall be considered, in addition to all other relevant factors, comparisons with accepted methods of marketing for legitimate nonprescription drugs for medicinal purposes rather than for drug abuse or any similar nonmedicinal use, including consideration of the packaging of the drug and its appearance in overall finished dosage form, promotional materials or representations, oral or written, concerning the drug, and the methods of distribution of the drug and where and how it is sold to the public.

§18.2-248. Manufacturing, selling, giving, dispensing, distributing or possessing with intent to manufacture, sell, give or distribute a controlled substance or an imitation controlled substance prohibited; penalties.

A. Except as authorized in the Drug Control Act (§54.1-3400 et seq.), it shall be unlawful for any person to manufacture, sell, give, *dispense*, distribute, or possess with intent to manufacture, sell, give, *dispense* or distribute a controlled substance or an imitation controlled substance.

B. In determining whether any person intends to manufacture, sell, give, *dispense* or distribute an imitation controlled substance, the court may consider, in addition to all other relevant evidence, whether any distribution or attempted distribution of such pill, capsule or tablet included an exchange of or a demand for money or other property as consideration, and, if so, whether the amount of such consideration was substantially greater than the reasonable value of such pill, capsule or tablet, considering the actual chemical composition of such pill, capsule or tablet and, where applicable, the

price at which over-the-counter substances of like chemical composition sell.

C. Any person who violates this section with respect to a controlled substance classified in Schedule I or II shall upon conviction be imprisoned for not less than five nor more than forty years and fined not more than \$500,000. Upon a second or subsequent conviction of such a violation, any such person may, in the discretion of the court or jury imposing the sentence, be sentenced to imprisonment for life or for any period not less than five years and be fined not more than \$500,000.

D. If such person proves that he gave, *dispensed*, distributed or possessed with intent to give, *dispense* or distribute a controlled substance classified in Schedule I or II only as an accommodation to another individual who is not an inmate in a community correctional facility, local correctional facility or state correctional facility as defined in § 53.1-1 or in the custody of an employee thereof, and not with intent to profit thereby from any consideration received or expected nor to induce the recipient or intended recipient of the controlled substance to use or become addicted to or dependent upon such controlled substance, he shall be guilty of a Class 5 felony.

E. If the violation of the provisions of this article consists of the filling by a pharmacist of the prescription of a person authorized under this article to issue the same, which prescription has not been received in writing by the pharmacist prior to the filling thereof, and such written prescription is in fact received by the pharmacist within one week of the time of filling the same, or if such violation consists of a request by such authorized person for the filling by a pharmacist of a prescription which has not been received in writing by the pharmacist and such prescription is, in fact, written at the time of such request and delivered to the pharmacist within one week thereof, either such offense shall constitute a Class 4 misdemeanor.

F. Any person who violates this section with respect to a controlled substance classified in Schedule III, IV or V or an imitation controlled substance which imitates a controlled substance classified in Schedule III, IV, or V, except for an anabolic steroid classified in Schedule III constituting a violation of §18.2-248.5, shall be guilty of a Class 1 misdemeanor.

G. Any person who violates this section with respect to an imitation controlled substance which imitates a controlled substance classified in Schedule I or II shall be guilty of a Class 6 felony. In any prosecution brought under this subsection, it is not a defense to a violation of this subsection that the defendant believed the imitation controlled substance to actually be a controlled substance.

H. "Drug kingpin" means a person who was the principal or one of several principal administrators, organizers or leaders of a continuing criminal enterprise if (i) the enterprise received at least \$500,000 in gross receipts during any twelve-month period of its existence from the manufacture, importation, or distribution of heroin or cocaine or ecgonine or the derivatives, salts, isomers, or salts of isomers thereof or (ii) the person engaged in the enterprise to manufacture, sell, give, distribute or possess with the intent to manufacture, sell, give or distribute the following:

1. 100 kilograms or more of a mixture or substance containing a detectable amount of heroin;
2. 500 kilograms or more of a mixture or substance containing a detectable amount of:
 - a. Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed;
 - b. Cocaine, its salts, optical and geometric isomers, and salts of isomers;
 - c. Ecgonine, its derivatives, their salts, isomers, and salts of isomers; or
 - d. Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in subdivisions a through c; or
3. 1.5 kilograms or more of a mixture or substance described in subdivision 2 which contains cocaine

base.

Any person who is found to be a drug kingpin shall upon conviction be guilty of a felony punishable by a fine of not more than one million dollars and imprisonment for twenty years to life, twenty years of which shall be a mandatory, minimum sentence which shall be served with no suspension in whole or in part, nor shall anyone convicted hereunder be placed on probation or parole.

I. For purposes of subsection H of this section, a person is engaged in a continuing criminal enterprise if (i) he violates any provision of this section, the punishment for which is a felony and (ii) such violation is a part of a continuing series of violations of this section which are undertaken by such person in concert with five or more other persons with respect to whom such person occupies a position of organizer, a supervisory position, or any other position of management, and from which such person obtains substantial income or resources.

2. That the provisions of this act may result in a net increase in periods of imprisonment in state correctional facilities. Pursuant to §30-19.1:4, the estimated amount of the necessary appropriation is \$0.

 [Go to \(General Assembly Home\)](#)

1998 Legislation

APPROVED

SJR 102

SJR 165

HJR 172

HJR 318

Chapter 496: SB 549

SENATE JOINT RESOLUTION NO. 102

Requesting the Medical College at Hampton Roads, the Medical College of Virginia of Virginia Commonwealth University and the University of Virginia Medical Center to maintain their cooperative approach to curricula content and the inclusion of pain management instruction.

Agreed to by the Senate, February 13, 1998

Agreed to by the House of Delegates, March 12, 1998

WHEREAS, most laymen would probably find it hard to understand that physicians seldom receive formal, integrated, and comprehensive instruction on the management of pain; and

WHEREAS, in reality, the management of pain is frequently relegated to a lower priority, while medical students cram to retain the information presented in various science courses; and

WHEREAS, Senate Joint Resolution No. 366 of 1997 requested the three medical schools to study the inclusion of pain management in their curricula; and

WHEREAS, the report of this study provides an inventory of the pain management curricula offered in the three medical schools; and

WHEREAS, there is little research on the depth and components of instruction in pain management among medical schools; and

WHEREAS, therefore, the report of the three medical schools may be a groundbreaking effort-one of the first in the country to examine instruction of pain management in medical schools; and

WHEREAS, the three schools have worked together over the past year to produce this report on pain management in medical school curricula; and

WHEREAS, as a result of the joint effort in conducting the study, the three medical schools have developed a unique working relationship on their curricula content and education in pain management; and

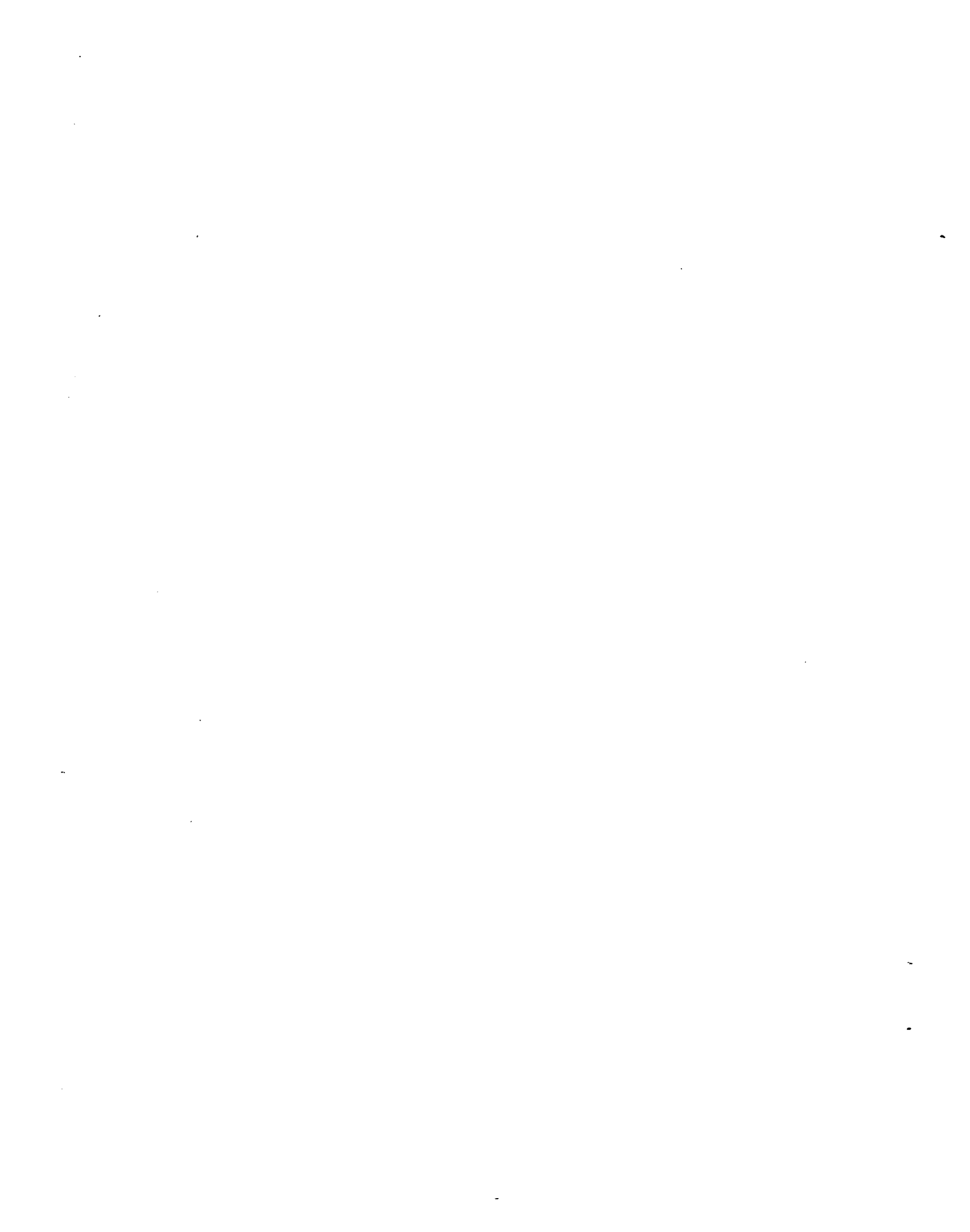
WHEREAS, the study demonstrated that the three medical education programs are distinct, yet the schools have demonstrated commitment to community education; and

WHEREAS, all three medical schools offer continuing medical education in pain and pain management; and

WHEREAS, the future focus of the medical schools should be to emphasize studying clinical outcomes associated with pain management and to initiate the inclusion of pain management instruction in the formal curricula; and

WHEREAS, the study and its report have stimulated an effort to increase pain management education and a cooperative atmosphere has emerged; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Medical College at Hampton Roads, the Medical College of Virginia of Virginia Commonwealth University and the University of Virginia Medical Center be requested to maintain their cooperative approach to curricula content and the inclusion of pain management instruction. The three medical schools are encouraged to lead the country in an innovative approach to integrating instruction in pain management.



SENATE JOINT RESOLUTION NO. 165

Conveying the Medical Society of Virginia's guidelines for the use of Opioids in the Management of Chronic, Non-Cancer Pain.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute and Cancer Pain Management was established in 1994 and has been continued in the years since to conduct such activities as a symposium in 1995;

WHEREAS, the joint subcommittee found that, although there are national guidelines for acute and cancer pain management, no national guidelines have been developed for the management of chronic pain; and

WHEREAS, the joint subcommittee also found that physicians treating chronic pain patients frequently do not prescribe adequate dosages of drugs because of a lack of understanding of the proper treatment for chronic pain and because they fear regulatory or law-enforcement actions; and

WHEREAS, the proper treatment for chronic pain may include the use of alternative or complementary therapies as well as the prescribing of anti-inflammatories and opioids; and

WHEREAS, in 1997, the joint subcommittee arranged to cooperate with the Medical Society of Virginia in the development of chronic pain guidelines; and

WHEREAS, this effort has also been supported by the Board of Medicine, with the publishing of the guidelines as a stand alone Board newsletter; and

WHEREAS, these guidelines are Virginia's guidelines and are unique in the nation as a bell weather development accomplished through cooperation between a legislative group, the regulatory agency, and the professional association; and

WHEREAS, these guidelines, it is hoped, will improve treatment practices and increase the awareness of proper chronic pain management; and

WHEREAS, it is the joint subcommittee's wish that these guidelines will be officially recognized and transmitted to the citizens and physicians of the Commonwealth; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute and Cancer Pain Management does hereby place into the public record and convey to the General Assembly of Virginia and the people and physicians of this Commonwealth, the following document:

REPORT TO MEDICAL SOCIETY OF VIRGINIA AD HOC PAIN MANAGEMENT COMMITTEE

Preface

Recently, there has been increasing interest on the part of physicians, regulatory agencies, legislators, the public, and patients for the proper diagnosis, timely workup, and state of the art treatment for acute, cancer, and non-cancer, chronic pain conditions. While there is widespread agreement among health care providers concerning the treatment of acute and cancer pain with opioids (also known as narcotics)-as exemplified by Federal Clinical Practice Guidelines published by the Agency for Health Care Policy and Research, U.S. Department of Health and Human Services-there has been a lack of consensus, misunderstanding and hesitation among health care providers (physicians, nurses, pharmacists), regulatory agencies, patients, and third party providers concerning the use of these same agents in the management of chronic, non-cancer pain.

Inadequate understanding about issues such as addiction, tolerance, physical dependence, and abuse has lead to unfounded stigma against proper opioid prescription. Fears of legal and regulatory sanctions or discipline from local, state, and federal authorities often result in inappropriate and inadequate treatment of chronic pain patients. Undertreatment or avoidance of appropriate opioid therapy increasingly has been reported by physicians, patients, and other health care team members.

The discipline of pain medicine has produced a new awareness about the necessity of proper diagnosis, history and physical examination, and treatment planning for the patient with chronic pain. Unfortunately, the paucity of specially trained physicians in the field of pain management often precludes patient access to specialized pain treatment facilities. The treatment for these patients will appropriately fall within the realm of the primary care or specialty physician. Until adequate

guidelines are made for prescribers of opioids for patients with chronic non-cancer pain, episodes of undertreatment of this deserving population will continue.

As a result of the efforts and recommendations of the Governor's joint subcommittee studying pain, the House of Delegates of the Medical Society of Virginia, at the 1996 annual meeting of its legislative body, recognized the lack of national consensus as well as the need for parameters concerning the proper use of opioids for patients with intractable pain of non-cancer origin within the Commonwealth of Virginia. The following guidelines are presented with the hope that they will attenuate fears about professional discipline, encourage adequate and proper treatment of chronic pain with all appropriate therapies, and educate about and protect patients as well as the general public from unsafe or inappropriate prescribing patterns or abuses.

The Society believes that physicians have an obligation to treat patients with intractable pain and to lessen suffering and that opioids may be appropriately and safely prescribed for many acute, cancer, and chronic pain conditions as long as acceptable protocols and standards are closely followed. The Society feels that physicians should be encouraged to prescribe, dispense, and administer opioids when there is demonstrated medical necessity and proper indication for these agents without fear of discipline, excessive scrutiny, or remunerative or restrictive legal penalties. These guidelines should not be interpreted as absolute standards of care in the treatment of chronic pain patients, nor are they absolute directives for clinical practice. Rather, they are guidelines by which, all physicians may more safely and comfortably evaluate and treat this very problematic and needy group of patients.

**MEDICAL SOCIETY OF VIRGINIA'S
GUIDELINES FOR THE USE OF OPIOIDS
IN THE MANAGEMENT OF CHRONIC, NON-CANCER PAIN**

For the purposes of this document, the following terms shall mean:

"Acute pain" is the normal, predicted physiological response to an adverse (noxious) chemical, thermal, or mechanical stimulus. Acute pain is generally time limited and is historically responsive to opioid therapy, among other therapies.

"Addiction" is a disease process involving use of opioids wherein there is a loss of control, compulsive use, and continued use despite adverse social, physical, psychological, occupational or economic consequences.

"Chronic pain" is persistent or episodic pain of a duration or intensity that adversely affects the function or well-being of the patient, attributable to any nonmalignant etiology.

"Opioid withdrawal" is characterized by three or more of the following symptoms that develop within hours to several days after abrupt cessation of the substance; (a) dysphoric mood, (b) nausea and vomiting, (c) muscle aches and abdominal cramps, (d) lacrimation or rhinorrhea, (e) pupillar dilation, piloerection, or sweating, (f) diarrhea, (g) yawning, (h) fever, (i) insomnia.

"Physical dependence" is a physiologic state of adaptation to specific opioids characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. Physical dependence is a predictable sequelae of regular, legitimate opioid or benzodiazepine use, and does not equate with addiction.

"Substance abuse" is the use of any substances for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

"Tolerance" is a state resulting from regular use of opioids in which an increased dose of the substance is needed to produce the desired effect. Tolerance may be a predictable sequelae of opiate use and does not imply addiction.

"Withdrawal syndrome" is a specific constellation of signs and symptoms due to the abrupt cessation of, or reduction in, a regularly administered dose of opioids.

Assessment, Documentation, and Treatment

A. History and Physical Examination. The physician must conduct a complete history and physical exam of the patient prior to the initiation of opioids. At a minimum, the medical record must contain documentation of the following history from the chronic pain patient:

1. Current and past medical, surgical, and pain history including any past interventions and treatments for the particular pain condition being treated.
2. Psychiatric history and current treatment.

3. History of substance abuse and treatment.
4. Pertinent physical examination and appropriate diagnostic testing.
5. Documentation of current and prior medication management for the pain condition, including types of pain medications, frequency with which medications are/were taken, history of prescribers (if possible), reactions to medications, and reasons for failure of medications.

6. Social/work history.

B. Assessment. A justification for initiation and maintenance of opioid therapy must include at a minimum the following initial workup of the patient:

The working diagnosis (or diagnoses) and diagnostic techniques. The original differential diagnosis may be modified to one or more diagnoses.

Medical indications for the treatment of the patient with opioid therapy. These should include, for example, previously tried (but unsuccessful) modalities/medication regimens, diverse reactions to prior treatments, and other rationale for the approach to be utilized.

Updates on the patient's status including physical examination data must be periodically reviewed, revised, and entered in the patient's record.

C. Treatment plan and objectives. The physician must keep detailed records on all patients which at a minimum include:

1. A documented treatment plan.
2. Types of medication(s) prescribed, reason(s) for selection, dose, schedule administered, and quantity.
3. Measurable objectives such as:
 - a. social functioning and changes therein due to opioid therapy.
 - b. activities of daily living and changes therein due to opioid therapy.
 - c. adequacy of pain control using standard pain rating scale(s) or at least statements of the patient's satisfaction with the degree of pain control.

D. Informed consent and written agreement for opioid treatment. Written documentation of both physician and patient responsibilities must include:

1. Risks and complications associated with treatment using opioids.
2. Use of a single prescriber for all pain related medications.
3. Use of a single pharmacy, if possible.
4. Monitoring compliance of treatment:
 - a. urine/serum medication levels screening (including checks for non-prescribed medications/substances) when requested.
 - b. number and frequency of all prescription refills.
 - c. reason(s) for which opioid therapy may be discontinued (e.g., violation of written agreement item(s)).

E. Periodic review. Intermittent review and comparison of previous documentation with the current medical records are necessary to determine if continued opioid treatment is the best option for a patient. Each of the following must be documented at every office visit:

1. Efficacy of treatment.
 - a. subjective pain rating (e.g., 0-10 verbal assessment of pain).
 - b. functional changes.
 - i. improvement in ability to perform activities of daily living (ADL's).
 - ii. improvement in home, work, community, or social life.
2. Medication side effects.
3. Review of the diagnosis and treatment plan.
4. Assessment of compliance (e.g., counting pills, keeping record of number of medication refills, frequency of refills, and disposal of unused medications/prescriptions).

5. Unannounced urine/serum drug screens and indicated laboratory testing, when appropriate.

F. Consultation. Most chronic non-cancer patients, like their cancer pain counterparts can be adequately and safely managed by most physicians without regard for specialty. However, the treating physician must be cognizant of the availability of pain management specialists to whom the complex patient may be referred. The physician must be willing to refer the patient to a physician or a center with more expertise when indicated or when difficult issues arise. Consultations must be documented.

The purpose of this referral should not necessarily be to prescribe the patient opioids.

G. Medical records. Accurate medical records must be kept, including, but not limited to documentation of:

- a. all patient office visits and other consultations obtained.
- b. all prescriptions written including date, type(s) of medication, and number (quantity) prescribed.
- c. all therapeutic and diagnostic procedures performed.
- d. all laboratory results.
- e. all written patient instructions and written agreements.

Summary and concluding remarks

The treatment of patients with chronic, non-cancer pain should not be limited to pain specialists only. Because of complex social, regulatory, ethical, and legal issues surrounding the use of opioids in these patients, the physician who elects to help treat these patients may find it useful to utilize the guidelines and examples outlined in this document. While these guidelines do not define standard of care, it is the hope of the Medical Society of Virginia, working in close conjunction with the Virginia Board of Medicine, and the Commonwealth of Virginia's Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management, that physicians who do treat this very difficult and deserving patient population will find significant clinical benefits from this document and will be enlightened by the suggestions offered herein.

This document is the product of the Medical Society of Virginia's Ad Hoc Subcommittee on the Treatment of Chronic Non-Cancer Pain and is the result of many months of deliberation and study.

GENERAL ASSEMBLY OF VIRGINIA -- 1998 SESSION

HOUSE JOINT RESOLUTION NO. 172

Continuing the Joint Subcommittee Studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management as the Joint Subcommittee Monitoring the Implementation of Certain Guidelines for Use of Opioids in Chronic Pain.

Agreed to by the House of Delegates, March 12, 1998

Agreed to by the Senate, March 10, 1998

WHEREAS, the Joint Subcommittee Studying the Commonwealth's Current Laws and Policies Relating to Acute and Cancer Pain Management was established pursuant to Senate Joint Resolution No. 72 (1994), continued by House Joint Resolution No. 583 (1995), and revised by House Joint Resolutions No. 256 (1996) and No. 565 (1997); and

WHEREAS, the joint subcommittee has been very active, conducting an intensive study of pain management in 1994, conducting a symposium on pain management in 1995 without the use of state funds, bringing together law-enforcement and medical experts to discuss pain management issues in 1996, and supporting, in 1997, in cooperation with the Medical Society of Virginia, the development of chronic pain guidelines; and

WHEREAS, in 1996 the joint subcommittee sought data from various entities on the economic implications of chronic pain management; and

WHEREAS, because of the scarcity of any data, the joint subcommittee initiated a Medicaid study of the effects of chronic pain management in certain conditions, e.g., lower back pain; and

WHEREAS, the Medicaid study provided some interesting, but inconclusive, results; and

WHEREAS, the joint subcommittee also requested a study of medical school curricula in 1997 that has resulted in a new attitude of cooperation; and

WHEREAS, the publication in October 1997 of the Report of the Medical Society of Virginia Pain Management Subcommittee conveyed the chronic pain guidelines to physicians across Virginia; and

WHEREAS, the joint subcommittee has granted the excess funds from the 1995 symposium to the Medical Society of Virginia to conduct educational programs or otherwise promote awareness of the need for pain management instruction; and

WHEREAS, the Board of Medicine has been an active participant in these educational activities and will publish the chronic pain guidelines in its newsletter; and

WHEREAS, although the joint subcommittee has accomplished much, the attitudes of fear and avoidance which so often result in undertreatment of chronic, acute, and cancer pain still abound; and

WHEREAS, in the coming year, the effects of the newly developed chronic pain guidelines will be important to monitor; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Studying the Commonwealth's Current Laws and Policies Related to Chronic, Acute, and Cancer Pain Management be continued for another year as the Joint Subcommittee Monitoring the Implementation of Certain Guidelines for Use of Opioids in Chronic Pain. The total membership of the joint subcommittee shall be 15 members and shall include 4 new members as provided for in this resolution. The members duly appointed pursuant to SJR No. 72 (1994) shall continue to serve. Any vacancies shall be filled as provided in the enabling resolution, except that appointments of the members of the House of Delegates to fill vacancies shall also be in accordance with the principles of Rule 16 of the House Rules. The four additional members of the joint subcommittee shall be appointed as follows: two members of the House of Delegates to be appointed by the Speaker of the House in accordance with the principles of Rule 16 of the House Rules; and two members of the Senate to be appointed by the Senate Committee on Privileges and Elections. The additional pain management expert, chosen from among the members of the steering group which served for the symposium, will also continue to serve as provided in HJR No. 256 (1996).

In its deliberations the joint subcommittee shall monitor the implementation of the chronic pain guidelines and shall continue to examine third party reimbursement for pain treatment, as well as the issues set forth in SJR No. 72 (1994). The joint subcommittee shall limit its meetings to one in the

coming year.

The direct costs of this study shall not exceed \$1,950.

All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall submit its findings and recommendations on all aspects of pain management to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

GENERAL ASSEMBLY OF VIRGINIA -- 1998 SESSION

HOUSE JOINT RESOLUTION NO. 318

Commending the Medical Society of Virginia for developing Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain.

Agreed to by the House of Delegates, January 30, 1998

Agreed to by the Senate, February 5, 1998

WHEREAS, the legislative study of pain management has demonstrated dramatically that physicians frequently avoid treating chronic pain patients with adequate medications, fearing regulatory or law-enforcement scrutiny; and

WHEREAS, in 1996 Virginia was in the news throughout the nation because of a Board of Medicine disciplinary action relating to a physician who had treated chronic pain patients with large doses of opioids; and

WHEREAS, such cases frequently have a chilling effect on medical decisions; and

WHEREAS, in 1997 the joint subcommittee on pain management cooperated with the Medical Society of Virginia (MSV) to support the MSV's development of Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain; and

WHEREAS, the guidelines have been adopted by the MSV House of Delegates in November 1997, endorsed by the Board of Medicine, and presented to the joint subcommittee; and

WHEREAS, the guidelines emphasize patient evaluations and documentation; and

WHEREAS, the guidelines are a first in the nation, assisting Virginia physicians in making tough decisions in palliative care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Medical Society of Virginia be commended for the development of Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit copies of this resolution to the Medical Society of Virginia and the members of the Medical Society of Virginia's Ad Hoc Pain Management Committee in order that they may be apprised of the sense of the General Assembly in this matter.

VIRGINIA ACTS OF ASSEMBLY -- 1998 SESSION

CHAPTER 496

An Act to amend the Code of Virginia by adding a section numbered 54.1-2912.2, relating to the Board of Medicine.

[S 549]

Approved April 15, 1998

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2912.2 as follows:

§ 54.1-2912.2. Board may endorse certain document.

In the furtherance of its responsibility to ensure continued practitioner competency, the Board of Medicine may endorse the Medical Society of Virginia's Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain, developed and adopted in 1997.

For the purpose of this section, "endorse" means to publicize and distribute such guidelines as providing an appropriate standard of care; however, the Board's endorsement shall not be construed to mean that the guidelines must be followed or are regulations or are in any way intended to be enforceable law.

1998 Legislation
CONTINUED
SB 127



SB 127 Drug Control Act; penalty for violations.

Patron-Jane H. Woods

Summary:

Violations of the Drug Control Act; penalties. Increases the penalty for second and subsequent controlled substance violations involving Schedule III drugs from a Class 1 misdemeanor to a Class 6 felony. First offenses involving Schedule III drugs and any violation involving Schedules IV and V drugs and imitation controlled substances which mimic Schedules III, IV or V drugs remain Class 1 misdemeanors as established in the current law. This bill is a recommendation of the Joint Subcommittee to Study the Commonwealth's Current Laws and Policies Related to Chronic, Acute & Cancer Pain Management.

Full text:

01/14/98 Senate: Presented & ordered printed 986789760

Amendments:

Senate Amendments

Status:

01/14/98 Senate: Referred to Committee for Courts of Justice

01/20/98 Senate: Assigned to C. J. sub-committee: Criminal Law/Procedure

02/04/98 Senate: Reported from Courts of Justice w/amd. (13-Y 0-N)

02/04/98 Senate: Rereferred to Finance

02/12/98 Senate: Continued to 1999 in Finance



Go to (General Assembly Home) or (Bills and Resolutions)

summary

986789760

SENATE BILL NO. 127

Offered January 14, 1998

A BILL to amend and reenact § 18.2-248 of the Code of Virginia, relating to violations of the Drug Control Act; penalties.

Patrons-- Woods, Bolling, Lambert, Newman and Saslaw; Delegates: Behm, Jones, J.C. and Keating

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §18.2-248 of the Code of Virginia is amended and reenacted as follows:§18.2-248. Manufacturing, selling, giving, distributing or possessing with intent to manufacture, sell, give or distribute a controlled substance or an imitation controlled substance prohibited; penalties.

A. Except as authorized in the Drug Control Act (§54.1-3400 et seq.), it shall be unlawful for any person to manufacture, sell, give, distribute, or possess with intent to manufacture, sell, give or distribute a controlled substance or an imitation controlled substance.

B. In determining whether any person intends to manufacture, sell, give or distribute an imitation controlled substance, the court may consider, in addition to all other relevant evidence, whether any distribution or attempted distribution of such pill, capsule or tablet included an exchange of or a demand for money or other property as consideration, and, if so, whether the amount of such consideration was substantially greater than the reasonable value of such pill, capsule or tablet, considering the actual chemical composition of such pill, capsule or tablet and, where applicable, the price at which over-the-counter substances of like chemical composition sell.

C. Any person who violates this section with respect to a controlled substance classified in Schedule I or II shall upon conviction be imprisoned for not less than five nor more than forty years and fined not more than \$500,000. Upon a second or subsequent conviction of such a violation, any such person may, in the discretion of the court or jury imposing the sentence, be sentenced to imprisonment for life or for any period not less than five years and be fined not more than \$500,000.

D. If such person proves that he gave, distributed or possessed with intent to give or distribute a controlled substance classified in Schedule I or II only as an accommodation to another individual who is not an inmate in a community correctional facility, local correctional facility or state correctional facility as defined in §53.1-1 or in the custody of an employee thereof, and not with intent to profit thereby from any consideration received or expected nor to induce the recipient or intended recipient of the controlled substance to use or become addicted to or dependent upon such controlled substance, he shall be guilty of a Class 5 felony.

E. If the violation of the provisions of this article consists of the filling by a pharmacist of the prescription of a person authorized under this article to issue the same, which prescription has not been received in writing by the pharmacist prior to the filling thereof, and such written prescription is in fact received by the pharmacist within one week of the time of filling the same, or if such violation consists of a request by such authorized person for the filling by a pharmacist of a prescription which has not been received in writing by the pharmacist and such prescription is, in fact, written at the time of such request and delivered to the pharmacist within one week thereof, either such offense shall constitute a Class 4 misdemeanor.

F. Any person who violates this section with respect to a controlled substance *shall, upon conviction, be guilty of a Class 1 misdemeanor for (i) any first violation involving a drug classified in Schedule III, or*

(ii) any violation involving a drug classified in Schedule IV or V or an imitation controlled substance which imitates mimics a controlled substance classified in Schedule III, IV, or V, except for an anabolic steroid classified in Schedule III constituting a violation of § 18.2-248.5, shall be guilty of a Class 1 misdemeanor. If the violation of this section is a second or subsequent offense involving a drug classified in Schedule III, such offense shall constitute a Class 6 felony.

G. Any person who violates this section with respect to an imitation controlled substance which imitates a controlled substance classified in Schedule I or II shall be guilty of a Class 6 felony. In any prosecution brought under this subsection, it is not a defense to a violation of this subsection that the defendant believed the imitation controlled substance to actually be a controlled substance.

H. "Drug kingpin" means a person who was the principal or one of several principal administrators, organizers or leaders of a continuing criminal enterprise if (i) the enterprise received at least \$500,000 in gross receipts during any twelve-month period of its existence from the manufacture, importation, or distribution of heroin or cocaine or ecgonine or the derivatives, salts, isomers, or salts of isomers thereof or (ii) the person engaged in the enterprise to manufacture, sell, give, distribute or possess with the intent to manufacture, sell, give or distribute the following:

1. 100 kilograms or more of a mixture or substance containing a detectable amount of heroin;
2. 500 kilograms or more of a mixture or substance containing a detectable amount of:
 - a. Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed;
 - b. Cocaine, its salts, optical and geometric isomers, and salts of isomers;
 - c. Ecgonine, its derivatives, their salts, isomers, and salts of isomers; or
 - d. Any compound, mixture, or preparation which contains any quantity of any of the substances referred to in subdivisions a through c; or
3. 1.5 kilograms or more of a mixture or substance described in subdivision 2 which contains cocaine base.

Any person who is found to be a drug kingpin shall upon conviction be guilty of a felony punishable by a fine of not more than one million dollars and imprisonment for twenty years to life, twenty years of which shall be a mandatory, minimum sentence which shall be served with no suspension in whole or in part, nor shall anyone convicted hereunder be placed on probation or parole.

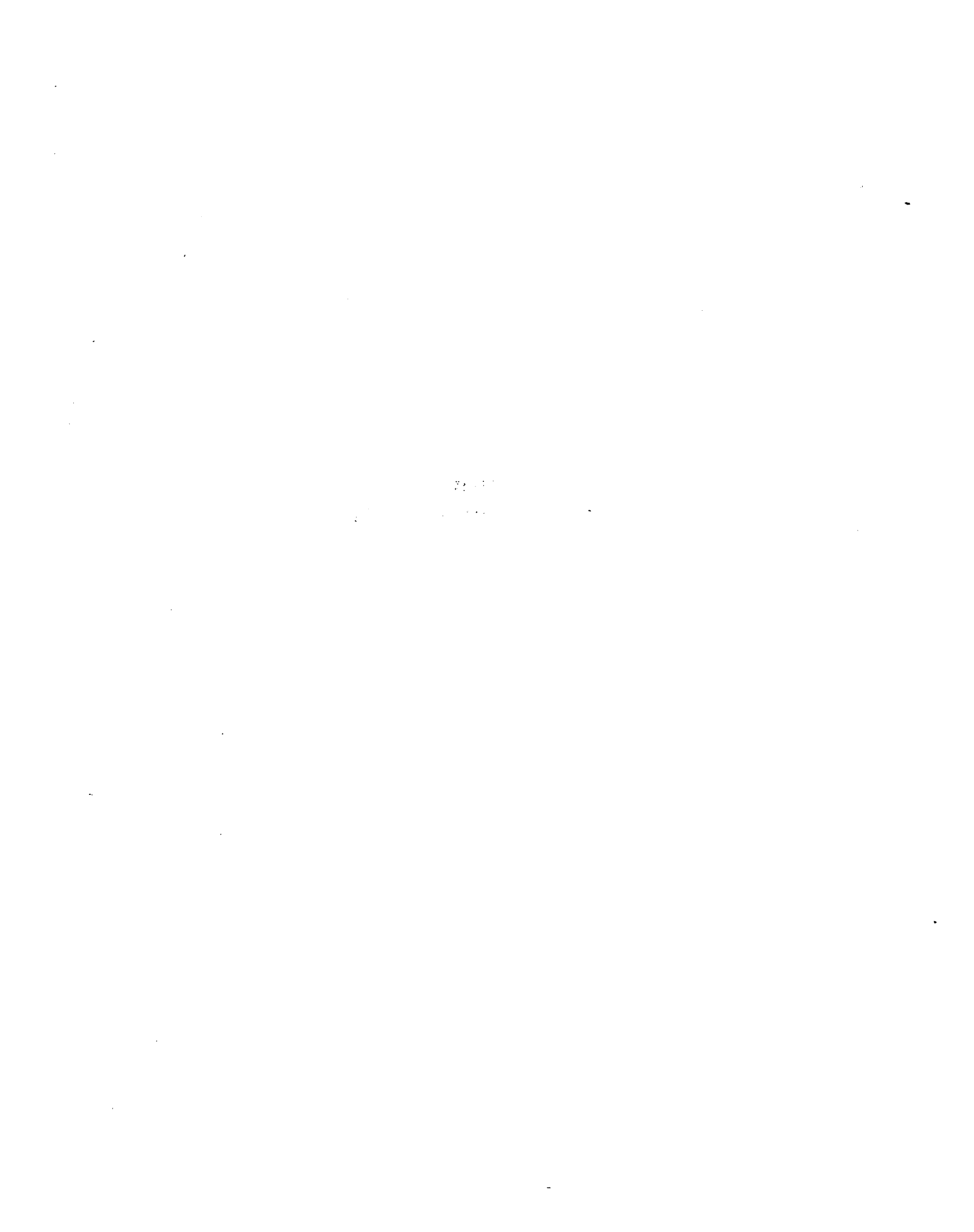
I. For purposes of subsection H of this section, a person is engaged in a continuing criminal enterprise if (i) he violates any provision of this section, the punishment for which is a felony and (ii) such violation is a part of a continuing series of violations of this section which are undertaken by such person in concert with five or more other persons with respect to whom such person occupies a position of organizer, a supervisory position, or any other position of management, and from which such person obtains substantial income or resources.

2. That the provisions of this act may result in a net increase in periods of imprisonment in state correctional facilities. Pursuant to §30-19.1-4, the estimated amount of the necessary appropriation is \$62,500.

**Appendix C:
Symposium Materials**

PRESS RELEASE: November 17, 1995

SYMPOSIUM PROGRAM



COMMONWEALTH OF VIRGINIA



SENATE

SUSAN CLARKE SCHAAR
CLERK OF THE SENATE
PO BOX 396
RICHMOND, VIRGINIA 23203

P R E S S R E L E A S E

JOINT LEGISLATIVE SUBCOMMITTEE STUDYING THE COMMONWEALTH'S CURRENT LAWS AND POLICIES RELATED TO ACUTE AND CANCER PAIN

November 17, 1995

Administrative Contact

Brian Taylor
(804) 786-5742

For Immediate Release

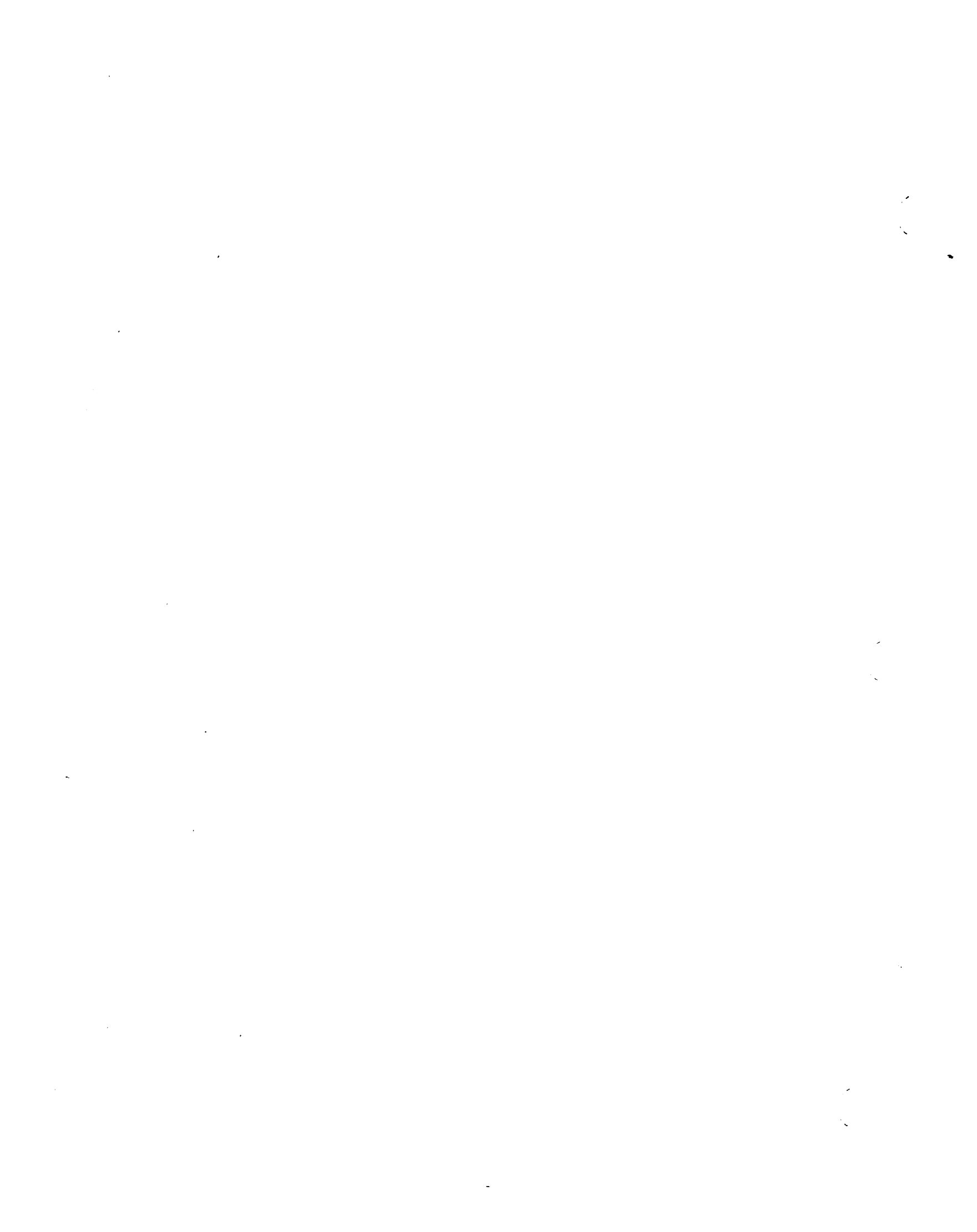
Legislative Contact

Norma E. Szakal
(804) 786-3591

The Joint Subcommittee Studying the Commonwealth's Current Laws and Policies Related to Acute and Cancer Pain, chaired by Senator Jane H. Woods, is presenting a symposium on acute and cancer pain management on Wednesday, December 6, 1995, from 8:00 a.m. to 5:30 p.m. at the Richmond Marriott. During its 1994 study, the Joint Subcommittee learned that pain is not effectively managed in many postoperative and cancer patients, particularly young children and older adults. The reasons for ineffective management of pain include physicians' fear of regulatory agencies, reimbursement patterns, and lack of understanding of current pain management methodologies, including the Agency for Health Care Policy and Research's (AHCPR) pain management guidelines. Therefore, the Joint Subcommittee's continued study has focused on increasing professional discussion and knowledge of pain management.

The Symposium, *Pain Management: Attitudes, Obstacles and Issues*, is being supported through various unrestricted educational grants, presented in cooperation with the Medical Society of Virginia, and designed to promote dialogue between the faculty and the participants. Featuring nationally known physicians, nurses and other experts, the symposium will cover implementation of AHCPR pain management guidelines; ethical, legal and regulatory issues; cost and reimbursement issues; and pain management in young children and older adults. Continuing medical education credits may be obtained from the American Society of Regional Anesthesia (8 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association) and the American Academy of Family Physicians (7 prescribed hours); this continuing education activity also meets the criteria of Virginia Commonwealth University and the Southern Association of Colleges and Schools (8 contact hours). The registration fee of \$65 includes lunch with the faculty and a reception.

The symposium press conference will be held at 8:15 a.m. on December 6 in the Capital Salon in the Richmond Marriott by Senator Jane H. Woods, Chairman of the Joint Subcommittee; Delegate I. Vincent Behm, Jr., Vice Chairman of the Joint Subcommittee; Dr. Stephen P. Long, member of the Joint Subcommittee; and Dr. John C. Rowlingson, member of the symposium steering group. Other members of the Joint Subcommittee are Delegate David G. Brickley; Delegate Arthur R. Giesen, Jr.; Delegate Jerrauld C. Jones; Senator Benjamin J. Lambert III; Senator Elliot S. Schewel; Ms. Betsy H. Schofield; Dr. Vincent Speckhart; and Ms. Mildred M. Torian.



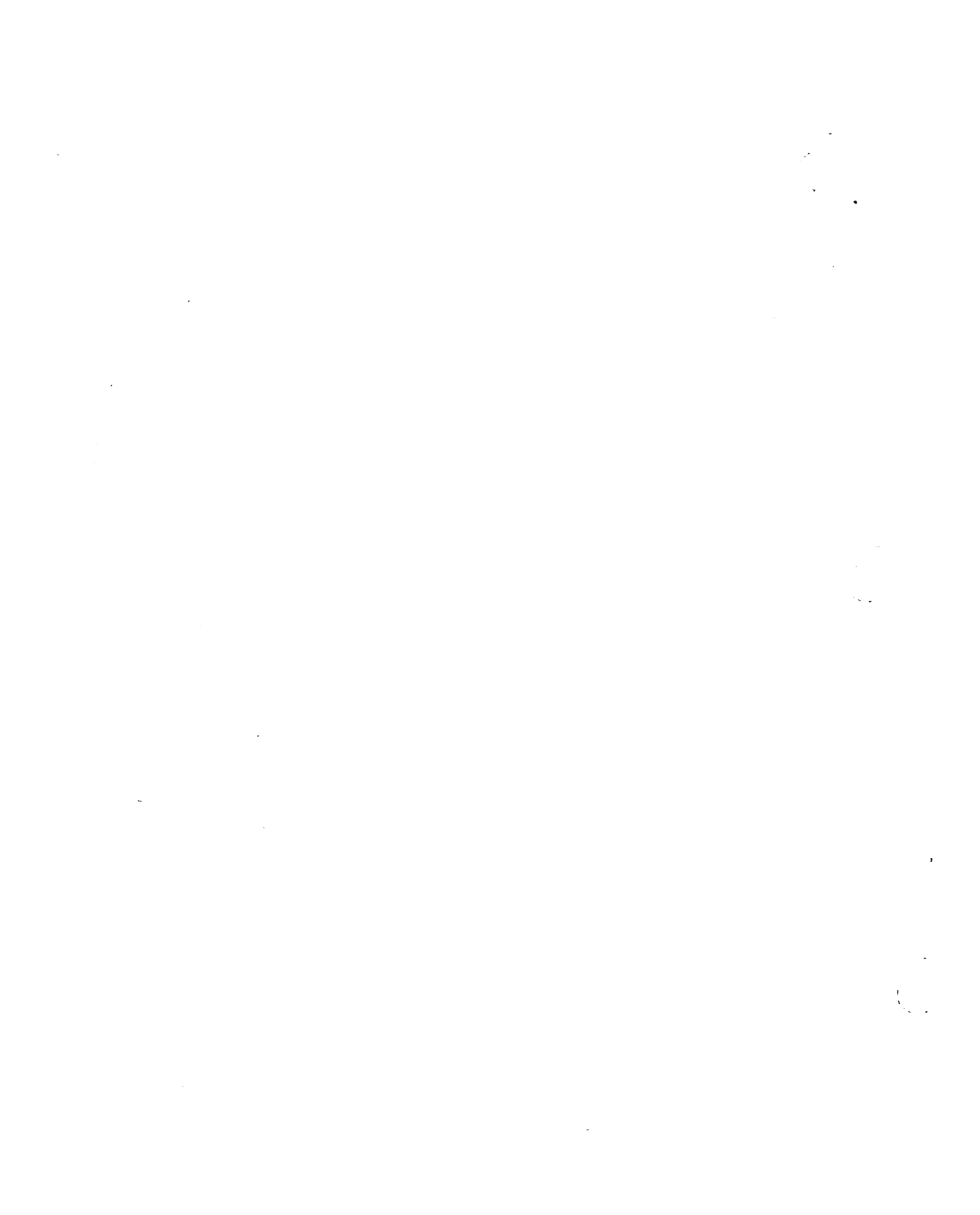
A SYMPOSIUM

Pain Management: Attitudes, Obstacles and Issues

December 6, 1995 ■ Richmond Marriott



*Presented by the Joint Subcommittee Studying the Commonwealth's
Current Laws and Policies Related to Acute and Cancer Pain Management,
General Assembly of Virginia,
in cooperation with the Medical Society of Virginia
and supported with unrestricted educational grants from various sponsors.*



Symposium Objective: To increase knowledge, understanding and implementation of effective, up-to-date acute and cancer pain management techniques, both pharmacological and nonpharmacological.

8:00 a.m. - 8:30 a.m.

Registration

8:30 a.m. - 8:40 a.m.

Opening Remarks and Introductions

Senator Jane H. Woods, *Chairman*

Delegate I. Vincent Behm, Jr., *Vice Chairman*

Joint Subcommittee on Acute and Cancer Pain Management, Virginia General Assembly

8:40 a.m. - 9:40 a.m.

Keynote Address

AHCPR Clinical Practice Guidelines:

Management of Cancer Pain

Michael H. Levy, M.D., Ph.D., *Director, Supportive Oncology Program, Fox Chase Cancer Center*

Objectives. Following completion of this program, participants will:

- Utilize a pain rating scale in the assessment of cancer pain.
- Select an appropriate analgesic, based upon a patient's level of pain and response to prior therapy.
- Delineate alternative routes of opioid administration and indications for their usage.
- Describe the role for nonpharmacologic interventions in the management of cancer pain.
- List three ways in which clinicians and institutions can implement the AHCPR guidelines.

9:40 a.m. - 10:00 a.m.

Welcome and Presentation of Freedom From Cancer Pain Week Proclamation

Lieutenant Governor Donald S. Beyer, Jr.

10:00 a.m. - 10:15 a.m.

Break

10:15 a.m. - 11:15 a.m.

Keynote Address

Issues in Acute and Cancer Pain Management

Ada Jacox, R.N., Ph.D., *Professor and Independence Foundation Chair in Health Policy, Johns Hopkins University*

Objectives. Following completion of this program, participants will:

- Identify the scope of acute and cancer pain undermanagement.
- Identify the barriers to effective pain management.

■ Describe the process used and issues addressed in the development of the AHCPR guidelines for the management of acute and cancer pain.

■ Describe the evidence underlying acute and cancer pain management.

11:15 a.m. - 12:30 p.m.

Panel

Implementing the Guidelines in Your Practice

Moderator: Stephen P. Long, M.D., *Medical College of Virginia*

Patrick J. Coyne, R.N., M.S.N., C.S., C.R.N.H., *Medical College of Virginia*

Ada Jacox, R.N., Ph.D., *Johns Hopkins University*

Michael H. Levy, M.D., Ph.D., *Fox Chase Cancer Center*

Michelle Whitehurst-Cook, M.D., *Medical College of Virginia*

Renée A. Woodford, M.D., *Virginia Beach General Hospital*

Objectives. Following completion of this program, participants will:

■ Understand the basic principles, pathophysiology, pharmacology, and modern treatment options for the effective treatment of acute postoperative and cancer pain.

■ Understand and discuss the benefits of proper and aggressive management of acute postoperative, procedure-related, and cancer pain vis-a-vis local, regional and national influences, legislative efforts and barriers to such treatment.

■ Gain a perspective on initiating, developing, and implementing a comprehensive, multidisciplinary pain service.

Upon completion of this panel discussion, Dr. Long will briefly introduce the faculty who will lead lunch-time group discussions of pain management issues.

12:30 p.m. - 1:30 p.m.

Lunch with the Faculty

Objectives. During this session, participants will:

■ Engage in an interactive dialogue on the principles set forth in the acute and cancer pain treatment guidelines.

■ Address technical, medical and administrative questions about acute and cancer pain management in the everyday practice environment.

1:30 p.m. - 2:45 p.m.

Panel

Ethical, Legal and Regulatory Issues

Moderator: Warren W. Koontz, Jr., M.D., *Virginia Board of Medicine*

John C. Fletcher, Ph.D., *University of Virginia*

James L. Levenson, M.D., *Medical College of Virginia*

Joseph P. McMenam, M.D., J.D., *McGuire, Woods, Battle and Boothe*

Thomas R. Pellegrino, M.D., *Eastern Virginia Medical School*

Objectives. During this session, participants will:

- Examine the ethical considerations of pain management, specifically as related to parameters of pain endurance, narcotic treatment of pain, and differences between treatment of cancer pain versus acute pain of short duration.
- Identify and understand the legal considerations of pain treatment in Virginia, including the requirements in Virginia law and regulations for prescribing excess dosages.
- Identify regulatory agencies and clarify the regulatory environment in Virginia, including the government entities involved.

2:45 p.m. - 3:00 p.m.

Break

3:00 p.m. - 4:00 p.m.

Panel

Cost and Reimbursement Issues

Moderator: Jim G. Weeks, *Provider Business Services, Inc.*

Francis J. Balestrieri, D.D.S., M.D., *Woodburn Surgery Center*

J. Lawrence Colley, M.D., *Trigon Blue Cross Blue Shield*

Carolyn H. Ray, *Virginia Department of Personnel and Training*

Joseph M. Teefey, *Virginia Department of Medical Assistance Services*

Objectives. During this session, participants will:

- Examine various third-party reimbursement patterns for pain management and the effects of these patterns on patient care and medical practice.

- Examine the issues related to the increasing reliance on managed care and its potential effects on effective pain management, particularly in relation to referrals for specialty care, the discharge of cancer and acute pain patients back to the communities, and the role of primary care practitioners in handling acute and cancer pain.

- Understand and discuss the effects on health care costs of aggressive pain management, including side effects, morbidity and length of hospital stays.

4:00 p.m. - 5:00 p.m.

Panel

Extremes in Age, Young Children and Older Adults

Moderator: Thomas J. Smith, M.D., F.A.C.P., *Medical College of Virginia*

Richard W. Lindsay, M.D., *University of Virginia*

Edward Clifton Russell, M.D., *Medical College of Virginia*

Navil F. Sethna, M.B., Ch.B., *Harvard Medical School*

Holly Lyn Stanley, M.D., *St. Mary's Hospital*

Objectives. Following completion of this program, participants will:

- Understand differences in palliative care in children and the elderly.
- Know standard approaches to pain management in children and the elderly.
- Identify resources for help in treating pain in children and the elderly.

5:00 p.m. - 5:30 p.m.

Summation

John C. Rowlingson, M.D., *University of Virginia*

Objective:

- Participants will be provided with a concise summary of the proceedings of the symposium, thereby concluding the meeting and reinforcing the increased awareness and knowledge of pain management modalities and related issues.

5:30 p.m. - 7:00 p.m.

Reception

Accreditations

- The American Society of Regional Anesthesia designates this continuing medical education activity for 8 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association. The American Society of Regional Anesthesia is accredited by the Accreditation Council for Continuing Medical Education to sponsor medical education for physicians. Certificates of attendance will be awarded following the meeting, based upon the accumulation of individual evaluation forms. ■ This continuing education activity

meets the criteria of Virginia Commonwealth University and the Southern Association of Colleges and Schools. A total of 0.8 continuing education units (8 contact hours) will be awarded and recorded with the University Enrollment Services, Virginia Commonwealth University.

- This program has been reviewed and is acceptable for 7 prescribed hours by the American Academy of Family Physicians. ■ This program has been approved by the Virginia Board of Pharmacy for 7 hours of continuing education for pharmacists licensed in Virginia. This program may not meet continuing education requirements in other states.

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