

LEARNER TASKS: You are a provider seeing a patient who was admitted overnight on the inpatient unit. This is your first meeting.

Gather Data:

- Assess the patient's pain and treat so that you can continue the interview.
- Develop a treatment plan for patient's acute pain episode using opioids and non-pharmacologic treatment in a way that adjusts for baseline level of opioid tolerance. Use inpatient order sets and opioid conversion table. Consider how to involve available inpatient team members.

Build Relationship:

- Discuss the risks of taking opioids in amounts greater than instructed and in combination with other sedating pharmaceuticals (benzodiazepines).

Engage Patient in Care Plan:

- Build a partnership with the patient and PCP to set the stage for an enhanced monitoring plan after discharge as part of the current controlled-substances agreement with the PCP, engaging the spouse and support system as possible.
- Counsel the patient on the signs and symptoms of withdrawal and overdose and co-prescribe a nasal naloxone overdose reversal kit for family members.

CASE DETAIL

Patient Profile:

Name: Jean Clark, age per SP (30-60), gender per SP, married with children.

Occupation: Home Health Aid

Pain Complaint: Acute on chronic pancreatitis.

Setting:

You are the student caring for a patient admitted last night with 4 days of acute on chronic pain from idiopathic pancreatitis, which has been managed with long- and short-acting opioids by the PCP with input from the outpatient GI clinic for 4 years. The patient had a celiac plexus block last year, which was ineffective and caused hypotension and diarrhea. For this episode, the patient took extra short-acting opioids due to increasing pain and presented to the ED with epigastric pain and saying, "I ran out of my pain meds and have no appetite." Abdominal CT showed pancreatic calcifications consistent with chronic pancreatitis but no ductal dilatation, mass, fluid collection or stone; no ascites. KUB and upright films without air-fluid levels. Comprehensive metabolic panel was within normal limits, lipase elevated at 480 (nl 160) and stool guaiac was negative. Urine and serum toxicology in the ED were positive for opioids and benzodiazepines, negative for other substances. Serum ethanol 0. Based on the patient's severe pain, mildly elevated lipase, nausea and dehydration the patient was admitted to the hospital medicine team for bowel rest, IV fluids and pain control. Patient is NPO and receiving morphine 1 mg IV q 4 hrs PRN with minimal effect. Patient has a controlled substances agreement with the PCP and there have been no red flags.

Prescription drug monitoring program (MASSPAT) review shows oxycodone prescriptions only from the PCP's office, a monthly prescription for clonazepam from the same mental health provider (consistent medications, dosing, refills).

Current medications:

- Oxycodone LA/ER 40mg twice a day, Oxycodone 10mg max 4/day (ran out yesterday)
- Amitriptyline 50 mg daily, Duloxetine 60mg/day (these 2 are good non-opioid adjuvants), Clonazepam 1 mg q day prn anxiety

SMALL GROUP FACILITATION

<i>iCELS staff will announce timing to assure the day flows correctly. Please make every effort to stay on time.</i>	Encounter Timing:	
	0 min	• Staff announce time to prep for the case: direct learners to review materials and tasks.
	5 min	• The SP knocks and enters the exam room.
	17 min	• Staff give the 2 minute warning.
	19 min	• Staff announce the end of the encounter. • The SP will not participate in feedback but exit the exam room to complete a checklist. • You will begin debriefing.
	27 min	• Staff give the 2 minute warning to finish up debriefing.
	29 min	• Staff announce the end: stop debriefing and direct learners to prepare for the next case.

<p><i>Use this space to record feedback notes, or any points to support ongoing learning.</i></p>	<p style="text-align: center;">+</p> <p style="text-align: right;">Δ</p>
<p><i>Include these questions in your discussion.</i></p>	<p>Debriefing:</p> <ul style="list-style-type: none"> • How did that feel for you? What went well? Where did you feel stuck? • How can we frame these system-based practices (hospital order sets, medication agreements, naloxone prescribing, etc.) to enhance relationships with patients and improve transitions in care? • How might we work with patients to identify goals and empower them in their care (beyond prescribing medications)? <p><u>You may not make it through all elements of the case – this is ok: use this experience to emphasize that the case is difficult and may require more time or multiple visits. You may also finish early. If so, please use that time to share your personal experiences or discuss the key points in more detail.</u></p>
<p><i>Ask each learner to read a key point aloud.</i></p>	<p>Key Points:</p> <ul style="list-style-type: none"> • Opioid misuse monitoring includes a history of behaviors (such as taking other patients' meds, self-escalating doses), functional assessment and objective sources (PMP, urine toxicology screen, pill counts) over time. Prescribers must know the characteristics of their lab's urine toxicology screen. Note: Urine toxicology screens do not reliably detect synthetic and semisynthetic opioids (e.g., oxycodone, hydrocodone, methadone, buprenorphine, fentanyl.) • For patients with stable opioid use and appropriate monitoring, a 'yellow flag' may not indicate discontinuing opioids but offers an opportunity to reassess benefits and risks and review the pain management agreement. Plans must be coordinated directly with the primary prescriber. • Patient-centered 'informed consent' approach to outpatient prescribing of chronic opioids must include periodic review of patient-provider agreement, safe storage (including discussion of co-habitants/), counseling regarding risks, benefits and side effects, and consequences of misuse including discontinuation of opioids. Also potential medication interaction review. • Co-prescribing nasal naloxone should be considered for all patients receiving chronic opioid prescriptions, for instance as part of a chronic pain management plan (pain lasting greater than 3 months): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4450869/. • Inpatient teams should utilize existing order sets, conversion tables and resources such as clinical pharmacologists to help guide treatment plans.