LEARNER TASKS

Gather Data:
- Perform a risk assessment for the misuse of prescription opioids using the Opioid Risk Tool (ORT) and assessing personal and family mental health and substance use histories.
- Review the completed pain scale, discuss how the patient has been treating the pain and the impact on life.

Build Relationship:
- Discuss the MRI results.
- Discuss the findings from the prescription monitoring program and the risks of taking medications from other people.
- In a non-judgmental conversation, communicate to the patient your assessment that the risks outweigh the benefits associated with ongoing use of opioid pain medication.

Engage Patient in Care Plan:
- Create and prescribe a non-opioid treatment plan for his pain, including NSAIDS and other non-opioid analgesics, stretching, physical therapy and core strength training, activity and rest cycles.
- Discuss strategies for patient to self-manage his condition in safer ways and set short-term goals to help monitor his progress in follow up visits.

CASE DETAIL

Patient Profile:
Name: Dana Johnson, age per SP (30-50), gender per SP, married with children.
Occupation: Construction (Carpentry, roofing, plowing snow).
Pain Complaint: Low back pain unresolved from work injury 6 months ago.

Setting: The patient is a construction worker seeing you in Family Medicine clinic. You evaluated the patient initially 3 months ago. You treated them with hydrocodone-acetaminophen 5/325 mg 1-2 q 4 hrs. as needed for pain #80. The patient continued to complain of pain and 1 mos. later you increased this to 10/325 mg 1-2 hrs. as needed for pain #80 and ordered an MRI (report in folder) which was unremarkable. You referred to Physical Therapy. Pt. returns with ongoing symptoms after 2 mos of PT. You have the MRI results to review at this visit (see report). Physical exam findings have been normal throughout. PMH includes mildly elevated blood pressure (no medications). No known allergies.

Learners do not have this case detail. You may wish to share this information during debriefing.

Additional History:
- Frustrated, worried about work, concerned about serious illness as it has not healed.
- Ibuprofen, Tylenol did not work and PT 3x/week is impossible with work.
- A check of the prescription drug monitoring program (see copy) shows 6 prescriptions for opioids in the last 6 months (2 from you and 4 from other providers using multiple pharmacies) and 1 prior to the injury. Pt. admits to taking opioids from friends at work and a cousin due to poor pain control.
- Friend and cousins get “strong meds” every month for their back pain.
- In 20's went through a period of heavier alcohol and cocaine use, but cut back due to problems with the law, currently drinks alcohol 2-3x/month and 4-6 beers at once during football season.
- Smokes 1 pack cigarettes/day. Family history: father with HTN, high cholesterol, alcohol use disorder. Mother w/adult onset diabetes.
- MRI shows only mild degeneration (no spinal stenosis, compression fracture, nerve root impingement).

Pain and Functional Assessment:
- Pain 8/10, lumbar area, no radiation to legs, bowel or bladder changes, numbness, tingling or weakness in arms or legs; worse w/standing, lifting, bending, better w/rest & sitting.
- Impairing ability to work.

Recommended Prescription and Counseling:
It is appropriate to wean the patient, who has been taking daily opioids for 3 months. For example, you could write a script for hydrocodone/acetaminophen 5/325 mg (#40) and counsel the patient to taper the dose over a 2-week period: 1 tab PO tid x 5 days, then 1 tab PO bid x 5 days, then 1 tab PO qd x 5 days then stop. In general, you want to taper by 20-50% per week (but more slowly if high doses).
**SMALL GROUP FACILITATION**

**iCELS staff will announce timing to assure the day flows correctly.**

*Please make every effort to stay on time.*

**Encounter Timing:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 min</td>
<td>Staff announce time to prep for the case: direct learners to review materials and tasks.</td>
</tr>
<tr>
<td>5 min</td>
<td>The SP knocks and enters the exam room.</td>
</tr>
<tr>
<td>17 min</td>
<td>Staff give the 2-minute warning.</td>
</tr>
<tr>
<td>19 min</td>
<td>Staff announce the end of the encounter.</td>
</tr>
<tr>
<td>27 min</td>
<td>Staff give the 2-minute warning to finish up debriefing.</td>
</tr>
<tr>
<td>29 min</td>
<td>Staff announce the end: stop debriefing and direct learners to prepare for the next case.</td>
</tr>
</tbody>
</table>

**Use this space to record feedback notes, or any points to support ongoing learning.**

**Include these questions in your discussion.**

- How did that feel for you? What went well? Where did you feel stuck?
- How might we work with this patient to identify his goals and empower him in his own care (beyond prescribing medications)?
- How do we manage our own discomfort when setting limits on prescribing while remaining empathetic and patient-centered?

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.

**Ask each learner to read a key point aloud.**

**Key Points:**

- Simple, evidence-based tools are efficient to help assess patient risk for substance use disorder and develop a treatment plan (ex. Opioid risk tool, PMP).
- All pain treatment plans should consider non-pharmacologic and pharmacologic (both opioid and non-opioid) treatments-stretching, PT, ice/heat, core strengthening and impact on function/work.
- Providers should take a compassionate, non-judgmental stance in sharing their decisions not to prescribe opioids due to excessive risks to their patients.
- Prescription of opioids for low back pain has limited efficacy and substantial risk and is more common in the US than Europe. (BMJ 2015; 350: g6380.)
  http://www.bmj.com/content/350/bmj.g6380
- In October 2017 Governor Baker reported that 97% of health care providers who prescribe narcotics in MA had registered for the Massachusetts Prescription Monitoring Program (MassPAT), which has helped reduce opiate prescriptions in the state by approximately 28%