Lessons learned from prior OSTI 2 sessions

1. This is a sensitive topic and some of our students will have personal and professional experiences with it prior to the OSTI day. Please start your session noting that our goal is for this to be a supportive learning environment, but students can excuse themselves if necessary and take advantage of support resources.
2. Students are assigned and should prepare a case in advance, please review the case order and details when you get to your room to ensure they are aware of the order and their specific case.
3. Walk through case materials with students in the room before each one starts, Read the learner tasks together (which will guide both the interview and the feedback), and ensure that they are aware they can use some of the resources/print outs in the SP interaction.
4. If someone is missing, or you have a group of 3, students can interview the unassigned SP as a group.
5. If a student gets "stuck" let them think for a moment (silence is ok), if necessary they can ask the group to assist.
6. If a student ends the interview prematurely, ask the SP to stay in the room so you can redirect the student to continue the interview.
7. Engage the students in feedback, one goal of these sessions is to help them get more comfortable with that skill.
8. End each session by going around the group and asking students to read the key points out loud. This will ensure that regardless of the focus of your debrief, they have all heard these key points (note: some of them are on the pre-post knowledge test)

OSTI Case timing -- note that case 105 timing is different

Staying on time is important to the flow of the day. iCELS staff will make announcements through the speakers to facilitate this but the basic timing is below. We recognize that you may not make it through all elements of each case – this is ok, and you can use this experience to emphasize that these cases are complex and often require more time or multiple visits – you should still read all the ‘key points’ in your debriefing. You may also finish some components or cases early. In those circumstances please take time to share your personal experiences or discuss the key points on your faculty guide in more detail:

Case 105
- 0 min: begin naloxone didactic
- 10 min: assign student roles and move to appropriate SP room (students bring case folders with them).
  Roles are interviewer, presenter, counselor, naloxone trainer
  - Interviewer – interviews the SP team
  - Presenter – presents the patient history to the attending as collected by the interviewer, asks attending for any additional information desired but not obtained by the first student (you have extra information in your case 105 packet and so can provide that – if you feel there is important information that was NOT obtained and the students don’t ask for it you can prompt them with “is there any other information you would like to know” similar to precepting in clinic)
  - Patient counselor – discusses the plan with patient
  - Naloxone demonstrator – teaches patient and partner how to use naloxone, including when to use it and how to obtain from the pharmacy (note: if there are only 3 students then 1 of the students should take on this role as well)
- 15 min: team enters the room, interviewer begins SP interaction
- 25 min: staff gives signal to begin faculty-student group discussion, beginning with presentation. This can happen in the room with the SPs, but they will not participate.
- 35 min: team returns to SP interaction, counselor discusses plan with the patient
- 40 min: final student provides naloxone training
- 45 min: SPs leave room to complete checklist, faculty and students stay in room to debrief
- 55 min: students move to next session
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Key points for framing cases and discussion:

Case 101 is a person of color whose pain is being undertreated. This case is written to compel reflection on racism and the impact of historic and ongoing mistreatment of patients of color by both our medical system and society. It is important to note that patients of color, particularly black men may be uncomfortable opening up about this and other health issues given these circumstances. Multiple ED studies show Black and Latino patients are less likely to receive prescriptions for opiate medications for certain conditions. www.ncbi.nlm.nih.gov/pubmed/27501459. For Black patients in particular this includes treatment of back and abdominal pain, but not kidney stone, toothache or long bone fracture.

Research that shows racial and ethnic minorities receive less adequate pain treatment for acute and chronic pain than non-hispanic whites (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3111792/) The results section of the abstract for one of these papers reads:

“Racial/ethnic minorities consistently receive less adequate treatment for acute and chronic pain than non-Hispanic whites, even after controlling for age, gender, and pain intensity. Pain intensity underreporting appears to be a major contribution of minority individuals to pain management disparities. The major contribution by physicians to such disparities appears to reflect limited awareness of their own cultural beliefs and stereotypes regarding pain, minority individuals, and use of narcotic analgesics.”

Case 102 is a person in whom there is no indication for continuing opioids—however based on the patient’s daily use of opiates, a taper has been provided as an option. Spend some time reviewing the handout that discusses ‘communicating with patients regarding planned discontinuation of opioids.’ This provides recommendations regarding language for this conversation and describes circumstances that can arise related to a decision to not prescribe opioids. This is an opportunity to discuss our healthcare system—what are some structural issues that might encourage providers to prescribe opioids even if not indicated (time to counsel vs prescribe; patient satisfaction measures; lack of knowledge of how to discuss discontinuation...). This is a good time to reemphasize that any comprehensive pain management treatment plan includes non-pharmacologic therapy such as physical therapy, acupuncture, ice/heat, regular exercise, mindfulness practice; and that pharmacologic therapies include over-the-counter and prescription medications including NSAIDS, Acetaminophen, classes of drugs originally used for depression or seizures, opiates and muscle relaxants.

Case 104 is a woman with substance use disorder who needs referral for treatment. If you have additional time you can review the guide to assessing treatment needs of patients who misuse opioids (Dr. Mullin’s OUD Referral Decision Tree), discuss the variability of access based on location and insurance (you can refer to the sample OUD treatment programs), and the fact that this is a chronic illness and needs to be treated as such by patients and providers. This may help both to understand the potential waxing and waning nature of the acuity of the illness, reinforce the need for regular appointments and an ongoing treatment and assessment plan without making patients feel as though they are being stigmatized. You can also emphasize the data that supports the effectiveness of MAT in decreasing craving and improving abstinence from opiate misuse.
Lessons learned from prior OSTI 2 sessions

**Case 105** is a patient in recovery who has relapsed and required naloxone to reverse heroin usage. Though it is not addressed specifically in this case, patients with substance misuse disorder may suffer from co-existing psychiatric illness and be prescribed or purchase medications to treat those symptoms as well. Gaining this history, discussing the risk and referral for psychiatric assessment is important. Opiate misuse disorder is a chronic disease and it is likely that these patients, as all others, may face changes in stress, security and emotional stability which could impact their underlying OUD. This is important to consider before prescribing other classes of medications that can promote dependence or be misused such as benzodiazepines. Patients should be counseled to seek support to maintain behavioral change, identify triggers that may promote relapse and set proactive plans should these arise.

**Case 108:** This hospitalized patient is suffering from acute on chronic pain, a common event for this population. This case addresses the importance of engaging a team to help calculate and manage appropriate pain dosing and partnering the PCP and patient for an appropriate plan moving forward. Please point out the inpatient order sets, opioid conversion table and walk the students through the dose conversion (which is in the faculty only case materials) as well as reminding them they can and should call the pharmacist to verify dosing/conversion. If you have time, you can grow the discussion of this case to consider how to manage a patient who is in recovery and needs pain medication, for instance for a required surgical procedure, following a severe injury, etc. In those cases, pain medication can be safely prescribed by partnering with the patient, family/support systems and PCP as well as community resources. Successful partnership might include meetings with the patient, family/support and surgeon in advance to plan treatment, identifying who will fill and manage the prescription and the specific goals for care, tapering and discontinuation of opiates.

**Local updates:** Related research, legislation and data are continually evolving. Here are a few items of Note:

As of March 2016, Massachusetts state law limits first prescriptions of opiates to 7 days. The MA Medical Society fact sheet can help prescribers understand this comprehensive opiate legislation.

[http://www.massmed.org/opioidbill2016/#.WKycHRsrLIU](http://www.massmed.org/opioidbill2016/#.WKycHRsrLIU)