Opioid Safe-prescribing Training Initiative (OSTI)
Faculty Development

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The faculty have no actual or potential conflicts of interest in relation to this program/presentation.
Agenda

• Welcome + Background — 10 min
• OSTI overview — 10 min (with video)
• Effective Facilitation and Feedback — 10 min (with video)
• Sessions (cases, panel) — 50 min (with video)
• Conclusion and Q&A — 10 min
• Optional tour
WELCOME & INTRODUCTIONS
The problem: a high prevalence of pain coexists with a public health crisis of opioid abuse

• MA medical schools developed 10 competencies re: prevention & management of prescription drug misuse

• Our goals are to:
  – train clinicians in safe and effective opioid prescribing;
  – prevent and minimize risks of opioid misuse (diversion, addiction, overdose)
  – identify and treat patients with opioid use disorders (OUD’s) with compassion and attention to bias
Competencies for the prevention and management of prescription drug misuse

- Developed originally for medical student education
- Embraced by UMMS for interprofessional learning
  - Provide experiential learning in all 10 competencies using simulation (OSTI)
  - Engage learners and faculty across disciplines
  - Expanded to Continuing Medical Education and Graduate Medical Education
OSTI 1 and 2 overview

• OSTI 1: rising 3rd yr medical students
• OSTI 2: graduating medical and nursing students
• Formative

• 4 1/2-hour sessions scheduled this spring:
  – 2 hours: team of 1 faculty + 4 students participate in 4 ½ hour scenarios with standardized patients (round-robin)
  – 2 hours: students attend patient panel discussion (1 hr, facilitated by faculty) and naloxone training (1 hr)
  – Pre and post testing, Panel Reflection
OSTI overview

• Process:
  – Faculty work with same students for 4 cases
  – Standardized patients rotate from one room to another
  – Each student conducts one interview and observes and provides feedback for the others
  – 15-20 min for each interview, 10-15 min for debriefing
  – *If a student is missing, the group can share the interview
Timing for cases 101, 102, 104, 108

- 0 min: staff announce start prep in the room
- 5 min: SP knocks and enters
- 17 min: staff announce 2 min warning
- 19 min: staff announce end of encounter, SP leaves room, faculty begins debrief
- 27 min: staff announce 2 min warning – read key points together
- 29 min: staff announce end of feedback, transition to next case; direct learners to prepare for next case
OSTI overview

• Materials:
  – Walk through the faculty folder
    – case summaries with additional information, supporting materials, lessons learned
    – Students do NOT have Additional history, Pain and Functional Assessment or Recommendations for Prescribing/Counseling case information

• Students pre-assigned to cases and viewed prep materials in advance
Role of faculty facilitator

• Preparation: self-study in www.scopeofpain.com
  – You are not expected to be a content expert; it is OK to say “I don’t know” and follow up on students’ questions.

• Key points:
  – Be supportive and allow “mistakes” and experimentation to encourage growth;
  – Observe and name students’ behaviors and language as concrete feedback, tied to learning objectives for each case;
  – Engage other students in the room as active observers and peer mentors – they should be giving constructive feedback.
‘SMART’ Feedback

• Ask for self-assessment first; offer specific feedback
  – Present non-judgmentally, focus on behaviors:
    (I saw, I observed...)

• **M**easurable: based on learner tasks
• **A**chievable: limited in amount, constructive
• **R**elevant (to training level) and **r**espectful
• **T**imely
Key points for Observation

- Watch your learner
- Know what you are looking for (learner tasks)
- Record positives (+) and opportunities (Δ)
- What did you see? What did you not see?
- Be non-judgmental and aware of your biases
- Record specific language & behaviors when possible
### Observation: the plus/delta sheet

<table>
<thead>
<tr>
<th><strong>plus +</strong></th>
<th><strong>delta Δ</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Established rapport with greeting, body language, willingness to listen</td>
<td>Missed opportunity to show empathy when she said she was worried about missing work due to illness</td>
</tr>
<tr>
<td>Appeared calm and able to sit with strong emotion when patient got upset</td>
<td>Did not offer non-pharm options for pain</td>
</tr>
<tr>
<td>Used PMP query effectively to frame risk-benefit discussion</td>
<td>Did not articulate a follow-up plan (including non-abandonment)</td>
</tr>
</tbody>
</table>
What does this look like?
A word about safety...

- Highly emotional topic
- Personal and professional experiences
- Create safe spaces for all
- Student counseling services, employee assistance program (details on “Lessons Learned” doc)
Case 101

Acute traumatic pain in a patient of color who is appropriate for treatment with opioids (setting: orthopedic clinic)
Key Points


- Comprehensive pain assessment includes cardinal 7 features, past and current treatments, and impact on functioning and quality of life.

- Patients of color, particularly men may not be comfortable expressing frustration or anger with the medical system given historic maltreatment of men of color (dating back to the Tuskegee experiments) and ongoing societal bias in the US. An opioid epidemic has ravaged minority communities for years, and is receiving more attention now that impact has increased in majority communities, which highlights disparities in healthcare.

- Systems-based practice for prescribing opiates includes informed consent, patient-provider agreements, counseling regarding risks/benefits/side effects, and safe storage and disposal of unused medications.

- SAFE prescribing does not mean NO prescribing. (Pain Medicine 2016; 17:2153-2154)
Case 102

Chronic low back pain in a patient at high risk for opioid misuse - opioids should be discontinued (setting: family medicine clinic)
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)
Case 104

Pelvic pain in a patient with red flags who should be referred for OUD treatment (setting: OB Gyn office)
Key Points

• A thorough substance use history must start with assessing use as a youth include family history, stressors, how patients obtain drugs (borrowing from friends or stealing), route and pattern of use and impact on their function (home, work and relationships) (McCabe S, et al., Trends in Medical and Nonmedical Use of Prescription Opioids Among US Adolescents: 1976-2015, Pediatrics March 2017).

• The Screening, Brief Intervention & Referral to Treatment (SBIRT) model can help guide care and to use it effectively providers should be familiar with local substance use treatment options to facilitate referral as these differ by location. SBiRT can be used across all settings. http://www.masbirt.org/

• Medication assisted treatment with agents such as methadone, buprenorphine and naltrexone can act as a bridge or long-term therapy to assist patients in overcoming opioid misuse disorders (https://www.samhsa.gov/medication-assisted-treatment).

• Prescription monitoring program data can help prescribers identify misuse or confirm appropriate use by patients and should be integrated into patient-care discussions and decision-making. These vary by state, a link to the Massachusetts site: https://www.mass.gov/prescription-monitoring-program-pmp
Case 108

Patient with acute on chronic pain from pancreatitis, admitted to the hospital for management, requiring reinforcement of appropriate use of medications

(setting: inpatient)
Key Points

• Monitoring for opioid misuse 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.

• For a patient that has had stable opioid use and appropriate monitoring, a “yellow flag” may not mean discontinuing opioids but offers an opportunity to reassess benefits vs. risks and review the pain management agreement. It is essential to coordinate this plan directly with the primary prescriber.

• Patient-centered approach to outpatient prescribing of chronic opioids must include periodic review of patient-provider agreement, safe storage (including discussion of co-habitants/children), counseling regarding risks, benefits and side effects of treatment, and consequences of misuse including discontinuation of opioids. Also review of potential interactions with other and new medications.

• Co-prescribing of nasal naloxone should be considered for all patients receiving chronic opioid prescriptions.
Case 105 – OSTI 2 only

Patient with relapse from recovery who overdoses and requires naloxone rescue; then needs counseling on substance abuse treatment and nasal naloxone use.

(setting: ED)
Case 105: Schedule

• 10” didactic session
  – Signs and symptoms of overdose
  – Narcan training and assembly
  – Video available at: https://www.youtube.com/watch?v=Jis6NlZMV2c

• Assignment of student roles before leaving session
  – Interviewer
  – Presentation of patient to provider
  – Presentation of plan to patient and partner
  – Narcan co-prescribing and patient education
Key Points

• Naloxone can fail for multiple reasons including: fentanyl co-ingestion or not using the medication due to concern about being ‘caught’ (this is also a reason some people do not call 911);
• Classic triad of opiate overdose: pinpoint pupils, unconsciousness, respiratory depression.
• Effective treatments for opioid dependence exist. MAT may help approximately 60% of patients in recovery abstain from opiate misuse, but only 25% of publicly funded treatment programs offer FDA approved MAT, and as few as 10% of patients receive it (WHO information sheet 2014: http://www.who.int/substance_abuse/information-sheet/en/).
• Opiate misuse disorder is a chronic disease. Patients should be counseled to seek support to maintain behavioral change, identify triggers that may promote relapse and set proactive plans should these arise.
• Patients in recovery can be prescribed opiates when benefit outweighs risk (such as major surgery, trauma), but there must be careful planning, open discussion, safe dispensing and close monitoring.
Patient Discussion Panel

- Patients in recovery and family members
- Safe environment to share stories
- Learning goals:
  - Humanize the disease
  - Consider our own biases
  - Understand their experience in healthcare system
- Reflection exercise for students, faculty and others
Key Concepts

• OUD is a chronic illness and should be treated as such.
• The opiate epidemic has impacted communities of color for years. The current national focus suggests bias not only in prescribing, but in the response of the healthcare system, policy-makers and media.
• Safe prescribing does **NOT** mean NO prescribing -- even for patients in recovery.
• The prescription monitoring program (PMP or MassPAT) provides accurate, up to date prescribing information.
• Co-prescribing naloxone should be considered for any patients on chronic opiates.
• Best practices include risk assessment (including diversion), informed consent, monitoring, safe storage and disposal counseling.
Questions?

Thank you for participating in this important curriculum for our learners.