Challenges and Opportunities During Transitions in Care: A New Provider's Experience of Chronic Pain Management

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Disclosures

- Drs. Gordon & Sowicz have nothing to disclose

Educational Objectives

- Discuss the *transitions middle-range theory* as a framework for considering transitions
- State challenges and opportunities associated with transitions in care for both patients and health care providers generally and those specifically related to the use of opioids chronically
- Discuss non-pharmacologic and pharmacologic treatments for chronic, non-malignant pain
- Discuss diagnostic criteria for opioid use disorder

"Transition" Defined

- "The broad concept of transition, a period of change between two relatively stable states that comes to be associated with some degree of self-redefinition" (Chick & Meleis, 1986, p. 253)
- "A passage or movement from one state, condition, or place to another" (Shumacher & Meleis, 1994, p. 119)

TRANSITIONS (SHUMACHER & MELEIS, 1994)

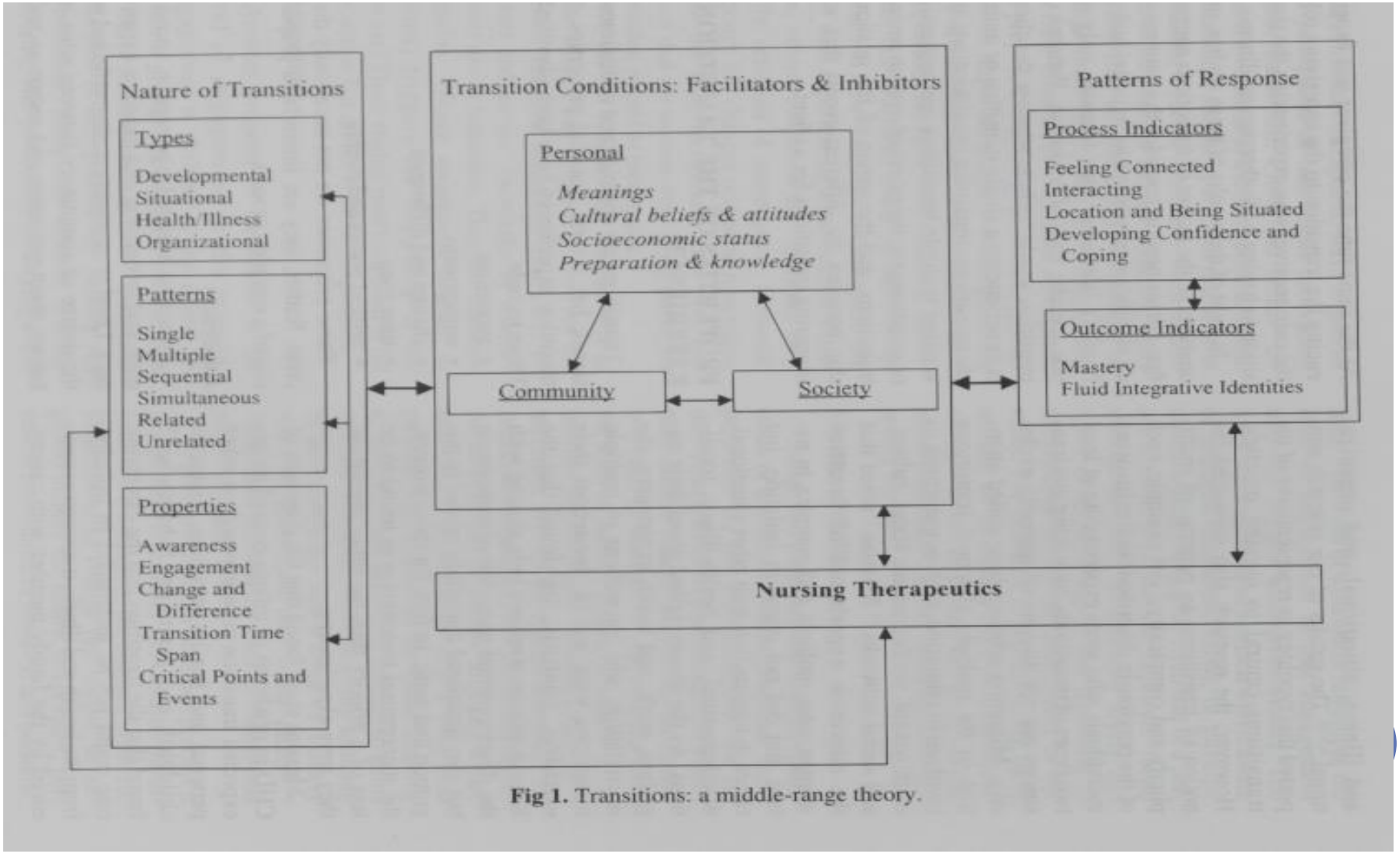

Fig 1. Transitions: a middle-range theory.

Questions

- Generally, what are some challenges and opportunities during transitions in health care (e.g., patient begins seeing a new primary care provider)?
- Are these different for patients with chronic, non-malignant pain who use prescription opioids?

Ms. S.

- Age 53 years
- Chronic pain (> 25 years) which she attributes to hidradenitis suppurativa
- Current analgesics: Ibuprofen 800 mg Q8 PRN; oxycodone 10 mg Q6 PRN

Question

- Based just on this information, what are your initial impressions/thoughts/questions as Ms. S.’s new primary care provider?

Ms. S.

- PMH
  - Type II DM
  - Major depression w/ suicide attempts
  - Obstructive sleep apnea
  - Generalized anxiety disorder
  - CAD
  - HTN
  - Obesity
  - Cocaine use disorder
  - Alcohol use disorder
- PSH
  - CABG (7 months ago)

Other Medications

- Atenolol
- Lisinopril
- Aspirin
- Atorvastatin
- Citalopram
- Clonazepam (recently d/c)
- Insulin glargine

Personal & Social History

- Lives w/ male partner in a house; has two adult children
- Christian faith
- Unemployed; previous laborer
- No regular exercise
- Diet – No restrictions
- Sexually active with single female partner; no condoms
- Tobacco – 1 PPD x 34 years; 4/day x 2 months
- Alcohol – None
- Illicit drugs – Last used cocaine 8 months ago

Primary Care Encounters – Since 2014

- Previous PCPs
  - PCP #1: 3 in 6 months
  - PCP #2: 9 in 18 months
- Current PCP
  - PCP #3: 3 in 4 months (w/ multiple phone calls)

Specialty Care Encounters

- Cardiology: Last visit 6 months ago
- Dermatology: 2008, 2010 seen once each; no show x 3 appointments
- Endocrinology: > 2 years ago
- ID: 3 visits in 2015; 1 visit in 2017
- Pain: > 2 years ago
- Psychiatry: 11 months ago (6 encounters in > 2 years)

Other Referrals

- OT – 2012; back scratcher for pruritus
- Pain clinic – 2006, 2015*
- PT – 2010 x 2; 2011; cane due to obesity and chronic back pain, knee and back braces
- Weight management - 2010

Diagnoses – Per ID

- Recurrent folliculitis, soft tissue nodules, hidradenitis

Question

- Given this additional information, what are your thoughts about Ms. S. and her care and interactions with the health care system?

Pain Clinic Notes - 2015

- Severe pain in back, buttocks, and groin
- Past medications
  - Cyclobenzaprine, naproxen, indomethacin, salsalate, ibuprofen, gabapentin
  - Acetaminophen-codeine, oxycodone-acetaminophen, oxycodone, hydrocodone-acetaminophen
- UDS
  - Cocaine in 2006, 2010, 2013, 2015
- Tender, draining ulcerations in suprapubic area

Pain Clinic Notes - 2015

- Neuropathic pain
- Recommendations
  - Stop NSAID and gabapentin
  - Start duloxetine; if not effective after titrating up, try pregabalin
  - No opioids (high risk for abuse, misuse)
  - Several random UDS; restart opioids in 3-6 months if appropriate

PCP Transition – Former PCP

- Note #1
  - Continue gabapentin and titrate up; NSAID and acetaminophen PRN
  - Continue oxycodone (#240), 1-3 tabs Q4 PRN
  - Discussed OUD/OEND
  - No skin PE documented
- Note #2 (< month later)
  - PDMP showed meds prescribed by other providers, including bup/nal
  - Stop opioids
  - Advised her to seek addictions services
- Note #3 (~ 1.5 months later)
  - Same recs from Note #1 above contained in this note
  - No PE documented
- Note #4 (1 month later)
  - PCP refills meds, including oxycodone

QUESTIONS

- How does reviewing other providers' notes shape our view of patients and facilitate or hinder transitions in care?
- Should be "bracket" these initial impressions and feelings?
- How can we "bracket" these initial impressions and feelings?

PCP Transition – Current PCP

- Seen for first time 4 months after last visit with former PCP
  - Seen for H.S. She reports this has been a concern since 1970s
  - Upset that oxycodone refilled for 28 days, not 30 prior to this visit
  - Reports taking 4 tabs oxycodone Q 4-5 hours
  - PE without skin lesions
  - Referred to ID (last seen 2015)
  - Stop gabapentin as taking it only PRN
  - Alternate oxycodone and ibuprofen
  - Check UDS – last was almost 1 year prior
  - Naloxone education and Rx provided
  - F/U 1 month

PCP Transition – Current PCP

- Saw ID in less than 1 month
- That provider expressed that depression is most important concern at this time
- ID provider expressed that pain level not proportional to diagnosis

PCP Transition – Current PCP

- Second encounter about 1 month after first
  - Not taking opioids x 2 weeks; ran out because taking more than Rx
  - Frustrated having to see multiple providers
  - Became agitated when we discussed ID referral
  - Walked out of encounter
  - Saw patient advocate
  - Agreeable to pain clinic and opioid review clinic
  - Concern for OUD

PCP Transition – Current PCP

- Third encounter one month after 2nd encounter
  - Seen in opioid review clinic 2 weeks prior
    - Pharmacist's review noted past topical lidocaine and tramadol use in addition to other meds
    - Continue opioid; stop BZD
    - Agreeable to F/U with current PCP
  - Seen for hip pain
    - X-ray normal
    - Labs for other conditions ordered; UDS ordered

Questions

- What concerns, feelings, or thoughts do you have about Ms. S. and her care to date?
- How do you feel about the recommendations made by the providers in the opioid review clinic?
- If they conflict with what your recommendations, how would you reconcile these?

PCP Transition – Current PCP

- Recent phone encounters
  - X-ray and labs done 1 month after ordered
    - UDS + for cocaine and oxycodone
  - Denied cocaine use; explained need for weekly UDSs
  - Last UDS negative for oxycodone
  - Agitated, yelling on phone; called to speak with opioid review clinic provider
  - This provider explained that the health center would no longer prescribe opioids

Next Steps & Learning Points

- What are suggestions for her plan of care?
- How could her “transitions” be improved?
- Does she meet criteria for OUD or some other SUD?
- Does just stopping the opioid really help Ms. S.?

References

- Chick, N., & Meleis, A.I. Transitions: A nursing concern. In P.L. Chinn (Ed.).(1986). Nursing research methodology, (pp. 237-257). Boulder, CO: Aspen Publication
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