AFMC RESPONSE TO OPIOID CRISIS

RÉPONSE de l'AFMC À LA CRISE DES OPIOÏDES

SIMULATION PLAYBOOK

With financial support from Health Canada, AFMC has developed a national curriculum for residents and practicing physicians to respond to the opioid crisis. A Simulation Playbook has also been created in collaboration with the Royal College of Physicians and Surgeons of Canada. The simulated clinical interactions will help provide hands-on experience for residents and practicing physicians to supplement current educational offerings on pain management, opioid stewardship and opioid use disorder.

opioids.afmc.ca

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA

COLLÈGE ROYAL DES MÉDECINS ET CHIRURGIENS DU CANADA

Simulation Scenarios

When delivered through an AFMC sponsored session, this Simulation Playbook has been certified for up to 6 MAINPRO+ Group Learning credits for Family Medicine Specialists and accredited for up to 6 hours of Section 3 Simulation credits for Royal College Specialists.

Participants will also receive a recognition letter for their time and commitment.

Permission can be granted to integrate the Simulation Playbook for off-site sessions. However, additional accreditation by medical schools or physician organizations would be required. For more information, please contact cpd.che@queens.ca

Production of this document has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Health Canada Santé Canada

STANDARDIZED PATIENT SIMULATION SCENARIO TEMPLATE

Learner group:	AFMC Response to the Opioid Crisis
Curriculum Topic:	Acute-on-chronic pain
Developed by:	Drs. Michelle Chiu, Sarika Alisic, Glenn Posner, Lisa Graves
Creation/Modification Date:	Jan 30 2022/Feb 17 2023

Development comments

Patient or Scenario Name

General description of scenario.

Acute-on-chronic pain & opioid use disorder.

Scenario Summary

One to two sentences summarizing the content/goals of the scenario.

Maria Gonzales has presented to the Emergency Department complaining of abdominal pain. She has signs and symptoms of an acute abdomen. She uses opioids for her chronic pelvic pain. She is waiting for surgery and wondering if there is anything that could be done to treat her pain.

Learning Objectives

Referenced to AFMC Curriculum Mapping Document (v. Feb17, 2023)

Learner Group	Objectives
PGME	PGME 1c. Discuss pain (both acute and chronic), symptom management, and opioid use disorder with patients and families/support networks.
PGME	PGME 2d. Explain strategies to achieve mutual expectations for opioid management with the individuals.
PGME	PGME 4c. Assess, diagnose, and plan management of chronic pain disorders and individuals with concurrent substance use disorder (SUD).
PGME	PGME 6.2a Interpret recommendations on optimizing non-opioid and opioid therapy for chronic non-cancer pain.

Simulation participants

Describes who is present and their role in the scenario.

Actual identity	Role in scenario
Learner	As themselves
Standardized Patient (female, not menopausal)	Patient
Faculty observer	As themselves

Props required for scenario

All props (☒) should be in the simulation room, applied to the mannequin/standardized pt.
If props are intended to be available for the scenario – but outside the room or hidden - please indicate this by writing '(Available only)' after the specified prop.

☒	hospital stretcher	☒	patient gown & blanket
☒	Clipboard + blank paper	☒	bedside table & chair
☒	Folder containing supporting documents	☐	

Supporting files (Chart, labs, imaging, etc)

Notes/Paperwork	Learner info sheet
Labs	n/a
Radiology	n/a
Other	n/a

Time Required for Simulation:

Event	Duration
Set-up	5 min
Simulation	15 min
Debrief	20 min

Programming Notes

Comments for setup (props, drapes, pregnant abdomen etc.)

Control Room (if applicable)	Ensure cameras aimed correctly Ensure correct image being recorded	
Mannequin/ Standardized Patient	Position:	The standardized patient will be lying on a stretcher, wearing a hospital gown.
	IVs:	Fake IV lock
	Monitors:	None
	Additional equipment:	None
	Draping:	Patient is appropriately covered with sheet/blanket
	Other:	
Other equipment	Bedside table, chair	
Space required	1. Clinic room (with one-way mirror for faculty observer if possible) 2. Medium sized room for debriefing (if >1 learner, otherwise could be done in clinic room)	
Personnel positioning	Ensure standardized patient and learner are visible from control room (one-way mirror)	

Information for Instructor & Standardized Patient

For the information of instructors/confederates only. Information provided to learners by SP during history taking.

Need to send to participants prior to simulation: email containing directions to simulation location & pre-simulation homework

Opening statement	"Hello doctor, I really need help with my pain. They have not given me anything for hours and I can't handle it anymore. Please help me!"
SP General appearance & demeanor	SP's general appearance is clean and wearing a hospital gown. You are in pain - grimacing, not wanting to move much, curled up on the stretcher. You desperately need something to help take the pain away and are unsure why you feel this bad, as this pain feels different than usual. You are worried that this doctor won't give you enough pain medications, therefore, you're cooperative (to facilitate/improve your chances of receiving analgesics). Discussions about minimizing your need or waiting for the next dose of medication may cause you to become more negative (i.e. avoidant body language, decreased eye contact, and may state 'that's not going to work' and/or 'I don't like what I'm hearing right now'). If the learner is calm / reassuring / makes eye contact with the SP, you'll start to settle. However, if the learner does not show empathy or provide any explanations, then you will become more agitated / upset. If the learner tries to do a physical examination, protest that there have been enough people poking at you and you refuse to let anyone else touch you until you get some pain meds.
Pain History	*Acute* abdo pain history: ONSET: The new pain started yesterday. LOCATION: Started in the central abdomen, stayed there for the longest time, then moved down to the lower right side of your abdomen.

	DURATION: Pain is constant, even when trying to sleep. It's a sharp, crampy, colicky pain. Hurts to move. Hurts to straighten out on the stretcher (you are curled up). They gave you an injection of pain medicine hours ago and it helped a bit but it's now completely worn off. CHARACTERISTICS/INTENSITY: Constant sharp stabbing pain. Visual Analogue Score (VAS): best 8/10 with meds, worst 12/10 right now, average - there is no average (you're getting frustrated with all the questions). RADIATION: Like you already said, it was around the belly button and now it's in the lower right side. ALLEVIATING FACTORS: Nothing seems to make the pain better. The medications have all worn off. AGGRAVATING FACTORS: Everything makes the pain worse. Sitting up, moving or straightening in the bed, coughing, You cannot imagine standing or getting out of bed right now. The ultrasound you just had was really painful and you're pissed off that they didn't give you any pain medications before the test. FUNCTIONAL LIMITATIONS: You cannot do ANYTHING right now. OTHER ALLIED HEALTH SERVICES USED: n/a. ADVERSE EFFECTS RELATED TO OPIOIDS: None. WITHDRAWAL SYMPTOMS: (also see below) You've never had any bad side effects or withdrawal symptoms as you take your pain meds regularly. Today has been another story, you missed a few doses and the medical team hasn't given you anything to help and you don't understand why. OTHER: The surgeon told you they booked you to have your appendix out, but they're not sure they will be able to take it out with the camera because of all the other surgeries you had before. You have no idea how long you will have to wait (don't allow the conversation to deviate to the specific treatment aspects of appendicitis) and you can't stay like this, in such agony. If they ask when your last bowel movement was, say this morning, and if they ask if you are still passing gas, say yes. <u>*Chronic* pelvic pain history:</u> Diagnosed with severe endometriosis at age 25. Had years of going from doctor to doctor, trying to make the diagnosis and then trying to treat the condition. Medications failed to make it better (or you couldn't tolerate the side-effects of the strongest endometriosis shots) and you ended up having at least 3 or 4 laparoscopic surgeries to "zap the spots". If the learner persists in asking about details of your treatment – say "can you please look at my chart; I'm in so much pain right now I can't remember any specifics". Your specialist told you that you had "one of the worst cases they've ever seen" and they have told your family doctor that your pain is real and to treat it accordingly. Your pain is in the lower abdomen and is always there. Between your family doctor and all the specialists, you have a variety of medications and you are extremely careful to follow the directions for taking them. On this regimen, the pain is manageable. ONSET: You've had pain of some sort in the abdomen since you were 25 years old.

	LOCATION: In central / lower abdomen, no specific location. DURATION: Pain is constant, even when trying to sleep. Used to feel like the medications would help your pain intermittently. Pain has been getting worse throughout the years, and you are needing more medications to get through the day. CHARACTERISTICS/INTENSITY: Dull, throbbing. Sometimes sudden and sharp stabbing pain. Worse during the menstrual cycle. Visual Analogue Score (VAS): best 7/10, worst 12/10 during your cycle, average 7/10. RADIATION: Not sure what this means; it's just always there. ALLEVIATING FACTORS: Nothing much. The pain is "best" when it is not during your cycle. AGGRAVATING FACTORS: Everything makes the pain worse. Sitting, standing or walking for too long aggravates your pain. "I spend most of my day resting at home". FUNCTIONAL LIMITATIONS: I feel my pain completely interferes with all aspects of my life including general activity, mood, getting around, being with people, sleep, having fun. OTHER ALLIED HEALTH SERVICES USED: None. ADVERSE EFFECTS RELATED TO OPIOIDS: None - you have never had issues taking pain medications. WITHDRAWAL SYMPTOMS: Began taking controlled release hydromorphone 5 years ago to manage the pain. With all the different medical treatments and surgeries, it started not working so you had to take more and some other medications in between as well. Last year you got put on a fentanyl patch and it has helped a lot. It's manageable with these medications. You've never had any bad side effects or withdrawal symptoms as you take your meds regularly. Today has been another story, you missed a few doses and the medical team hasn't given you anything and you don't know why. (Note to SP: missing opioid doses may result in symptoms like agitation / irritability, sweating, anxiety, muscle aches, fevers, abdominal pain, diarrhea, enlarged pupils)
Mood/Affect	Initially open and cooperative (a little desperate) but will become more hostile if discussion about not getting more pain medication. Example comment if learner seems reluctant to give opioids may be similar to: "You're the doctor, why can't you just give me more medication for my pain? I've been waiting for hours and it is SO bad. I don't understand why you won't give me the one thing that's ever worked for my pain, especially since I'm here in the hospital." Again, your demeanor will change depending on the actions / attitude of the learner. If the learner attempts to engage you in the decision making and is calm / making eye contact / providing reassurance and explanations, then you will become less hostile (and more concerned / anxious regarding your health). If the learner is not doing the above and proceeds without giving explanations, you may continue to be hostile and become withdrawn.

	During discussion about treatment, as you become less hostile and more concerned, you can express your concern (if not addressed by the learner): "Isn't there anything else that can be done for my pain while I'm waiting for surgery?" "Will you make sure that after the surgery, they give me enough pain medication?" "Will you make sure they send me home with enough pain medication?" If the learner provides you with suggestions for the above, you are comforted, start to relax and become more satisfied. If the word 'addiction' is used, you become offended because you don't feel you have an addiction. You have always been compliant with your medication prescriptions, and you feel your pain is legitimate.	
PMHx	("all my medical problems started when I got diagnosed with my endometriosis") <u>Endometriosis:</u> diagnosed at age 25; see above for management details. <u>Depression:</u> Diagnosed at age 25, around same time as above diagnosis; stable on escitalopram. No thoughts of self-harm. Concentration / energy / appetite have not been great over the years, likely related to the pain. <u>Anxiety:</u> Diagnosed age 25; stable on escitalopram and lorazepam. Struggling with anxiety on and off throughout the years. Main concern has been pain and whether it will ever get better.	
System Review	<u>Family History:</u> - No relevant family medical history. - Parents & siblings alive and well. <u>Social History:</u> - Married, lives with husband, Jorge. - Occupation: works as clerk in grocery store. - No biological children secondary to infertility - one adopted child - Minimal social contact with friends. - Social supports: family <u>Substance History:</u> - EtOH: rare - Smoker: Lifetime non-smoker - Marijuana: 2-5g (joints + gummies) daily	
Meds	Controlled release hydromorphone24mg po q12h Fentanyl patch 100ug/hr, q72h (last applied 2 days ago) Hydromorphone IR 4mg po q2h as needed for breakthrough; you take it pretty regularly every 2h) Escitalopram 20mg po daily Lorazepam 1 mg po q6h as needed	
Allergies	NKDA	
P/E	**General**	Can be specific to SP
	Wt/Ht	Can be specific to SP
	Vitals	BP 120/70, HR 70
	LOC	normal
	CVS	normal
	Resp	normal
	Abdo	normal
Investigations	N/A	

Information for Learner

Describes the 'initial script' given to participants. Give below stem + completed BPI.

Mrs. Maria Gonzales has presented to the Emergency Department complaining of a 24-hour history of abdominal pain. She has signs and symptoms of an acute abdomen, and an ultrasound has confirmed acute appendicitis. Her lab results are normal. She is on the operating room list for an urgent appendectomy but the timing of the procedure is uncertain. She also takes opioids for her chronic pelvic pain from endometriosis.

She was diagnosed with endometriosis at age 25 and had years of medical and surgical management with little success and ongoing progression of disease. She began taking CR hydromorphone 5 years ago to manage pain. A fentanyl patch was added last year.

Her past medical history includes endometriosis, depression and anxiety (all diagnosed at age 25).

Medications:
Hydromorphone CR 24mg po every 12h
Fentanyl patch 100ug/hr, every 72h
Hydromorphone IR 4mg po every 2h as needed for breakthrough
Escitalopram 20mg po daily
Lorazepam 1 mg po q6h as needed

Conduct a focused history examining key issues surrounding opioid use and management. Devise a treatment plan based on the information you obtain to manage her pain while in hospital.

Scenario timeline & events

Time	SP Status	SP Actions	Learner Actions
Baseline	Lying on stretcher	"Hello doctor, I really need help with my pain. They have not given me anything for hours and I can't handle it anymore. Please help me!"	Start taking history
0-5 mins		Provides information as requested; see details above re: behaviour	Additional questions
5-10 mins		Provides information as requested; see details above re: behaviour	Additional questions
10-15 mins		Provides information as requested; see details above re: behaviour; learner to address concerns and explain a plan	Formulate a plan & wrap-up

Discussion and Teaching Points for Debriefing

Debriefing points	Debriefing Content

Discuss pain (acute and chronic), symptom management and opioid use disorder with patients and families/support networks.	Learners will need to distinguish between acute pain and chronic pain. If the learner has taken a good history, it will be evident that this patient has chronic pain and does not have an opioid use disorder (OUD). She will have withdrawal symptoms when she does not have her usual prescribed opioids, but she does not have an OUD. This is an opportunity to review criteria for OUD. (See the one pager on OUD from DSM-5.) Patient appears to have an ongoing relationship with her family physician. Discuss review of prescribing opioids through provincial databases. (Clinicians should know how to access information through the provincial databases if available). Consider discussing value of connecting with FP during admission as well as post-discharge.
Establish mutual expectations for opioid management with the individual.	Patients with OUD or chronic pain may require treatment for acute pain. Acute pain needs to be managed, and patients may be fearful that their pain will not be treated. Discuss options for managing acute on chronic pain such as anti-inflammatories, opioid rotation/switch, local/topical and non-pharmacological options.
Assess, diagnose, and plan management of chronic pain disorders and individuals with concurrent opioid use disorder.	This patient does not have OUD. This is an opportunity to compare and contrast management of chronic pain and OUD. DSM-5 definition of OUD can be reviewed.
Assess pain in individuals using best evidence.	Pain scales can be helpful. This is an opportunity to review the pain scales.

Pre-Scenario Resources to Send Participants

PGME 1.1 module on communication

Post-Scenario Resources to Send Participants

Review diagnosis of OUD PGME modules 2.1 and 2.2

STANDARDIZED PATIENT SIMULATION SCENARIO TEMPLATE

Learner group:	AFMC Response to the Opioid Crisis
Curriculum Topic:	Management of pediatric pain
Developed by:	Drs. Michelle Chiu, Glenn Posner, Lisa Graves
Creation/Modification Date:	Jan 18 2022/Feb 17 2023

Development comments

Patient or Scenario Name

General description of scenario.

Management of pediatric pain.

Scenario Summary

One to two sentences summarizing the content/goals of the scenario.

Meet with the parent of a 13-year-old boy with pain related to a recent diagnosis and treatment of an Ewing sarcoma. Discuss treatment options and techniques to minimize risk of opioid use disorder.

Learning Objectives

Referenced to AFMC Curriculum Mapping Document (v. Feb17, 2023)

Learner Group	Objectives
CPD	CPD 5b. Describe non-pharmacological and pharmacological treatments of pediatric pain including use of opioids and non-opioids
CPD	CPD 5c. Explain pediatric pain treatment options to children and their families.
CPD	CPD 5e. Assess and describe techniques to minimize risk of opioid use disorder when prescribing opioids in pediatric/adolescent patients.

Simulation participants

Describes who is present and their role in the scenario.

Actual identity	Role in scenario
Learner	As themselves
Standardized Patient	“Alex”, parent of 13-year-old boy named Jack
Faculty observer	As themselves

Props required for scenario

All props (☒) should be in the simulation room, applied to the mannequin/standardized pt. If props are intended to be available for the scenario – but outside the room or hidden - please indicate this by writing '(Available only)' after the specified prop.

☒	2 chairs	☐	
☒	Clipboard + blank paper	☐	
☒	Folder containing supporting documents	☐	

Supporting files (Chart, labs, imaging, etc)

Notes/Paperwork	Brief Pain Inventory (completed)
Labs	
Radiology	
Other	Supporting documents not in room but can be requested by learner

Time Required for Simulation:

Event	**Duration**
Set-up	5 min
Simulation	15 min
Debrief	20 min

Programming Notes
Comments for setup (props, drapes, pregnant abdomen etc.)

Control Room (if applicable)	Ensure cameras aimed correctly Ensure correct image being recorded	
Mannequin/ Standardized Patient	Position:	The standardized patient will be seated, facing the door.
	IVs:	None
	Monitors:	None
	Additional equipment:	None
	Draping:	n/a
	Other:	
Other equipment	Bedside table, 2 chairs facing each other	

Space required	1. Clinic room (with one-way mirror for faculty observer if possible) 2. Medium sized room for debriefing (if >1 learner, otherwise could be done in clinic room)
Personnel positioning	Ensure standardized patient and learner are visible from control room (one-way mirror)

Information for Instructor & Standardized Patient

For the information of instructors/confederates only. Information provided to learners by SP during history-taking.

Need to send to participants prior to simulation: email containing directions to simulation location & pre-simulation homework

Opening statement	"Hello doctor, I'm coming to see you because I'm really worried about Jack's pain and him having pain during his cancer treatment. I'm wondering how best to manage it."
SP General appearance & demeanor	SP's general appearance is clean and wearing comfortable clothes. Pleasant and cooperative, anxious but not emotional. You are anxious about your son Jack's recent diagnosis of Ewing's sarcoma of the right leg (thigh bone) a few months ago. You are worried about pain and suffering during cancer treatment. Try to focus on this concern and redirect the learner if they try to reassure you about the diagnosis. Initially, you should be hesitant regarding the use of any opioid medication, even after surgery. You are also concerned about addiction.
Pain History	Jack is 13 years old and an active teen who is doing well in school. He is a competitive hockey player and the cancer was diagnosed after he had leg pain that wouldn't go away after playing. You took him to physiotherapy. There was not much improvement, which led to additional tests and the diagnosis of Ewing's sarcoma (a rare bone and soft tissue cancer that affects children and teenagers). <u>Pain History</u> ONSET: He's had this pain for weeks, maybe a few months, and it's getting worse. LOCATION: In the right thigh bone. DURATION: Pain is constant, even when trying to sleep. CHARACTERISTICS/INTENSITY: Constant, throbbing, and persistent. Jack says it is pretty bad, about an 8/10 all the time. RADIATION: Not sure what this means; it's just always there. ALLEVIATING FACTORS: Nothing seems to make the pain better. It doesn't respond to ice, warm compresses, ibuprofen or acetaminophen. AGGRAVATING FACTORS: Everything makes the pain worse. Sitting, standing, or walking for too long aggravates his pain.

	FUNCTIONAL LIMITATIONS: He's not able to play hockey, which he loves. He can now only walk on crutches because it hurts so much, and isn't sleeping well. He finds it hard to concentrate in the classroom because of the pain. OTHER ALLIED HEALTH SERVICES USED: Physiotherapy at the beginning, which didn't help. ADVERSE EFFECTS RELATED TO OPIOIDS: not applicable. WITHDRAWAL SYMPTOMS: not applicable.
Mood/Affect	You are anxious. Stressed. Not emotional but as discussion continues, you start to wring your hands. You feel helpless and desperate to help your son. You are worried about your son's potential for addiction and recreational drug use. Your demeanor will change depending on the actions / attitude of the learner. If the learner attempts to engage you in the decision-making and is calm / making eye contact / providing reassurance and explanations, then you will become less anxious. If the learner is not doing the above and proceeds without giving explanations or reassurance, you may continue to be very stressed and fearful.
PMHx	Jack has been healthy until now. It was a normal pregnancy and childbirth. Normal development socially and physically. Doing well at school. As you said before, Jack is a competitive hockey player and the cancer was diagnosed after he had leg pain that wouldn't go away after playing. That was a few months ago. You took him to physiotherapy but there was not much improvement, which led to additional tests, doctors' visits and the diagnosis of Ewing's sarcoma. The tumour is in the right thigh bone, and you've seen a pediatric orthopedic surgeon and oncologist so far. They've done scans and a bone marrow biopsy. Jack was in a lot of pain after the bone marrow biopsy (done under local anesthesia with sedation); he said he felt so great with the IV drugs and you are worried that he likes them too much. The specialists said he will need to have chemotherapy first to shrink the tumour and then surgery to remove the cancer. You've heard that some chemotherapy drugs can leave patients with nerve pain as a side effect. The surgeon said she didn't know if they would use a graft or implant to replace the bone and that there was a very small chance they might need to amputate the leg. Jack is not aware of this. This outcome is obviously very frightening for you and your spouse. This is a selection of questions you can ask: ● I'm coming to see you because I'm really worried about Jack having pain during his chemotherapy and wondering how best to manage it. ● I'm also worried about pain management after he has his surgery - does he have to take painkillers for a long time? I don't want him to get addicted to drugs! ● What are the treatment options for treating my son's pain? ● What are the possible short- and long-term side effects of the treatment? What can be done to prevent or manage these side effects? ● What about cannabis - would that help? Is it risky for a teenager? ● How will treatment affect my child's daily life? Will he be able to go to school and perform his usual activities? ● What treatment plan do you recommend? Why?

System Review	<u>Family History:</u> - none <u>Social History:</u> - only child; lives at home with parents. - Father works for the federal government; good health insurance plan. - Mother is a software engineer. - Played competitive hockey since he was 7 years old; plays 3 times / week. - Good social contact with friends. - Social supports: grandparents live in same city. <u>Substance History:</u> - none that you know of <u>Mood/Affect:</u> - Jack's mood varies depending on the day. Initially, he felt really sad about the whole diagnosis and treatment plan. Now, his mood is better. Some days he is pretty down. Other days, he's better and it doesn't seem to be on his mind at all. He has lots of good friends and they have been an excellent support to him. The hospital has provided good social work / psychological support to him and us, as parents.	
Meds	none	
Allergies	NKDA	
P/E	**General**	Can be specific to SP
	Wt/Ht	Can be specific to SP
	Vitals	not applicable
	LOC	normal
	CVS	normal
	Resp	normal
	Abdo	normal
Investigations	N/A	

Information for Learner

Describes the 'initial script' given to participants. Give below stem + completed BPI.

You will be seeing Alex, who is the parent of 13-year-old Jack, a boy who has just been diagnosed with Ewing's sarcoma of the right femur. Alex is anxious about Jack's recent diagnosis of Ewing's sarcoma and is especially worried about pain that he might experience during the proposed cancer treatment (chemotherapy and surgery), in addition to his current leg pain that brought him to see doctors which led to his diagnosis. Alex would like to discuss pain management options for Jack.

Scenario timeline & events

Time	SP Status	SP Actions	Learner Actions
Baseline	Sitting in exam room	"Hello doctor, I'm coming to see you because I'm really worried about Jack's pain and him having pain during his cancer treatment. I'm wondering how best to manage it."	Start taking history
0-5 mins		Provides information as requested; see details above re: behaviour	Additional questions

5-10 mins		Provides information as requested; see details above re: behaviour	Additional questions
10-15 mins		Provides information as requested; see details above re: behaviour; learner to address concerns and explain a plan	Formulate a plan & wrap-up

Discussion and Teaching Points for Debriefing

Debriefing points	Debriefing Content
Describe non-pharmacological and pharmacological treatments of pediatric pain including use of opioids and non-opioids	Options for pain management include nonpharmacologic and pharmacologic options. Reassure about use of opioids as needed and only for needed length of time. Discuss options within nonpharmacologic options that may include integrative medicine options
Explain pediatric pain treatment options to children and their families.	Parent in the discussion appears to have concerns about dependence. Discussing risks of early opioid use for future opioid use. Review family history for concerns.
Assess and describe techniques to minimize risk of opioid use disorder when prescribing opioids in pediatric/adolescent patients.	Reassure about use of opioids as needed and only for needed length of time. Discuss importance of treating pain to allow for recovery. Discuss that there is poor evidence at this time for cannabis use for pain. Discuss mental health risks associated with cannabis use in adolescence and early adulthood.

Pre-Scenario Resources to Send Participants

Module 1 on conversations PGME 1

Post-Scenario Resources to Send Participants

Pediatric pain module CPD 5

STANDARDIZED PATIENT SIMULATION SCENARIO TEMPLATE

Learner group:	AFMC Response to the Opioid Crisis
Curriculum Topic:	Opioid tapering/deprescribing
Developed by:	Drs. Michelle Chiu, Sarika Alisic, Glenn Posner, Lisa Graves
Creation/Modification Date:	Jan 6 2022/ Feb 17 2023

Development comments

Patient or Scenario Name

General description of scenario.

Manage opioid tapering and deprescribe opioids.

Scenario Summary

One to two sentences summarizing the content/goals of the scenario.

Toby Hoffman is a 47-year-old who wants to discuss their pain management after complications from a bowel resection for Crohn's disease last year left them with significant ongoing pain. Discussions should include optimization of pain management and exploration of an opioid taper. * Gender identity is left undetermined to allow the sim centers flexibility in female or male standardized patients. Please prepare your SPs to answer this question if the learner were to ask about gender identity.*

Learning Objectives

Referenced to AFMC Curriculum Mapping Document (v. Feb17, 2023)

Learner Group	Objectives
PGME	PGME 2.2a. Plan opioid tapering discussions that are evidence-based and responsive to the individual's readiness for change
PGME	PGME 2.2b. Explain how to deprescribe opioids where appropriate as safely as possible
PGME	PGME 2.1d. Explain strategies to achieve mutual expectations for opioid management with the individual

Simulation participants

Describes who is present and their role in the scenario.

Actual identity	Role in scenario
Learner	As themselves
Standardized Patient	Patient
Faculty observer	As themselves

Props required for scenario

All props (☒) should be in the simulation room, applied to the mannequin/standardized pt.
If props are intended to be available for the scenario – but outside the room or hidden - please indicate this by writing '(Available only)' after the specified prop.

☒	2 chairs	☐	
☒	Clipboard + blank paper	☐	
☒	Folder containing supporting documents	☐	

Supporting files (Chart, labs, imaging, etc)

Notes/Paperwork	ER triage note
Labs	
Radiology	
Other	

Time Required for Simulation:

Event	Duration
Set-up	5 min
Simulation	15 min
Debrief	20 min

Programming Notes

Comments for setup (props, drapes, pregnant abdomen etc.)

Control Room (if applicable)	Ensure cameras aimed correctly Ensure correct image being recorded	
Mannequin/Standardized Patient	Position:	The standardized patient will be seated, facing the door.
	IVs:	None
	Monitors:	None
	Additional equipment:	None
	Draping:	n/a
	Other:	
Other equipment	Bedside table, 2 chairs facing each other	

Space required	1. Clinic room (with one-way mirror for faculty observer if possible) 2. Medium sized room for debriefing (if >1 learner, otherwise could be done in clinic room)
Personnel positioning	Ensure standardized patient and learner are visible from control room (one-way mirror)

Information for Instructor & Standardized Patient

For the information of instructors/confederates only. Information provided to learners by SP during history taking.

Need to send to participants prior to simulation: email containing directions to simulation location & pre-simulation homework

Opening Statement	"Hello doctor, I really need help with my pain. It's become uncontrollable again and I can't do anything in my life. I think maybe my medications need to be increased again."
SP General appearance & demeanor	SP's general appearance is clean and wearing comfortable clothes. Pleasant and cooperative, not emotional. You are worried that this doctor won't give you the medications, and you are worried about increasing pain, therefore, you're cooperative (to facilitate/improve your chances of receiving the prescriptions). Initially, you should be hesitant regarding a potential opioid taper and subsequently alter your response, based on the communication skills of the learner. Discussions about opioid taper or going back to work, may become more negative (i.e. arms crossed in front of body, decreased eye contact, and may state 'no, I don't think that's going to work' and/or 'I don't like what you're saying right now'). If the learner is calm / reassuring / makes eye contact with the SP, you'll start to settle and will agree to a slow opioid taper. However, if the learner does not show empathy or provide any explanation, then you will become more agitated / hesitant and unwilling to attempt the opioid taper.
Pain History	Diagnosed with Crohn's disease at age 15. Had years of medical management with prednisone, azathioprine and infliximab with little success and ongoing progression of disease. Began taking hydromorphone CR 5 years ago to manage pain. Had your entire large bowel taken out and the insides re-connected^ last year, but this was complicated by having to go back to the operating room several times for them to open you up and fix a bowel leak and infection*. You had a prolonged and difficult hospital stay. Pain was difficult to manage while in hospital; eventually discharged home on multiple medications (see below). You started smoking pot last year (2g/day) to help with the pain and have a prescription for this. You have been adherent with medications. (There has been no history of early refill requests and you've never purchased your pain medications off the street or got them from anyone other than the pharmacist.) Investigations show no surgical cause of your ongoing pain. You have had multiple discussions with the surgeon. ^ *colectomy with ileorectal anastomosis* = removal of entire large intestine and joining the ileum (the last part of the small intestines) directly to the rectum **bowel leak* = surgical anastomosis fails and contents of a reconnected body channel leak from the surgical connection

	Currently your pain is precipitated by most activities and there are no fully alleviating factors for the pain. You have become very debilitated secondary to your pain. You have been off work since starting opioids. You rate your sleep, mood, energy, and appetite as poor. You have little contact with friends and don't participate in leisure activities. You are married and have an 8 year-old son who has been impacted by your limitations (see below). Your spouse is supportive and takes responsibility for most of the household and childcare. <u>Pain History</u> ONSET: You've been in pain for as long as you can remember. LOCATION: In central abdomen, no specific location. DURATION: Pain is constant, even when trying to sleep. The medications used to help your pain intermittently but now they give little relief. Pain has been getting worse through the years. CHARACTERISTICS/INTENSITY: Dull, throbbing. Sometimes sudden and sharp stabbing pain. Visual Analogue Score (VAS): best 10/10, worst 12/10, average 10/10. RADIATION: Not sure what this means; it's just always there. ALLEVIATING FACTORS: Nothing seems to make the pain better, it's just constant. The medications don't work anymore. "I feel like I'm in pain all the time". Medical marijuana helps; you don't get high, it just helps you relax and helps with the pain. (You smoke 2g/day.) AGGRAVATING FACTORS: Everything makes the pain worse. Sitting, standing or walking for too long aggravates your pain. "I spend most of my days resting at home". FUNCTIONAL LIMITATIONS: I feel my pain completely interferes with all aspects of my life including general activity, mood, getting around, being with people, sleep, having fun. OTHER ALLIED HEALTH SERVICES USED: None. ADVERSE EFFECTS RELATED TO OPIOIDS: You find you can be pretty drowsy and feel out of it (can't think straight), especially after taking hydromorphone, but you are still in pain so you continue to take more. You've gotten used to these feelings, but you don't feel like yourself. Sometimes you feel nauseated, but you figure this is because of all the surgeries you've had. <u>Note to SP:</u> Other adverse effects the learner may ask about include problems with constipation (none), dizziness / vertigo (sometimes), dry skin / pruritis (not really), weight gain (yes but you figured this is because of your inactivity), low libido (yes). <u>Note to SP:</u> you are unaware that the above effects could be related to the opioids that you are on. WITHDRAWAL SYMPTOMS: You use the medications as they've been prescribed. However, there was one time when you were returning from a vacation at a friend's cottage one day late and you ran out of pain medications. The pharmacy was closed when we got home so you didn't take any medications for 2 days. You remember feeling very hot, sweaty, your stomach hurt and you felt like you were getting sick. It all got better after you got your pain medications back. You still remember that feeling and don't want to go through that again.

	Note to SP: this may include agitation/irritability, sweating, anxiety, muscle aches, fevers, abdominal pain, diarrhea, enlarged pupils.
Mood/Affect	Initially open but will become more hostile if discussion regarding opioid taper or returning to work. Initial comment following introduction of opioid taper may be similar to: "You're the doctor, why can't you just take away my pain? I don't understand why you're trying to take away the one thing that's ever worked for my pain." Again, your demeanor will change depending on the actions / attitude of the learner. If the learner attempts to engage you in the decision-making and is calm / making eye contact / providing reassurance and explanations, then you will become less hostile (and more concerned or anxious regarding how the actual tapering protocol will occur) and eventually agree to an opioid taper. If the learner is not doing the above and proceeds without giving explanations, you may continue to be hostile but may not agree to the opioid taper (Can state 'I'll think about it but I can't promise anything'.) During discussion about taper, as you become less hostile and more concerned, you can express your concern (if not addressed by the learner): "Isn't there anything else that can be done?" "What if things go wrong? Who do I call?" "I'm scared. Who's going to help me with this?" If the learner provides you with suggestions for the above, you are comforted and agree to the opioid taper, because "nothing else has worked." If the word 'addictions' is used, you become offended because you don't feel you have an addiction. You have always complied with your prescriptions, and you feel your pain is legitimate. If the learner brings up your son and asks about your relationship with him, you are somewhat embarrassed / feel guilty. You can say that you think your relationship with him has suffered because of your pain and you wish you could do more with him. You used to be able to go out and play ball or hockey but you are in too much pain and the side effects of the meds prevent you from doing that now. If the learner suggests making goals surrounding improving your relationship with him, you are somewhat 'sheepish' and may state: "Yes, of all things, sometimes I feel guilty about my son and how I'm not really there for him like I used to be. I guess I can try making a goal towards reaching out to him." (The goal can be anything; taking him to the park once a month to watch him play, or playing a boardgame with him once a month etc.)
PMHx	Crohn's disease: diagnosed at age 15; see above for management details. Depression: Diagnosed at age 18; stable on escitalopram. Antidepressants increased a couple years ago but has been stable ever since. No thoughts of self-harm. Concentration/energy/appetite have not been great over the years, likely related to the pain. Anxiety: Diagnosed age 22; stable on escitalopram and lorazepam for several years. Struggling with anxiety on and off throughout the years. Main concern has been pain and whether it will ever get better.

System Review	Family History: - Father: HTN. - Mother: Presumed suicide (age 44). History of bipolar disease. - Brother: Healthy. No known psychiatric disease. - Father, brother live in another city/town several hundred kilometers away - Social History: - Married, lives with partner, in bungalow - Occupation: works for the federal government; off-work, has been on disability for 5 years. - Spouse's occupation: works for the federal government. - Private insurance via spouse. - 8-year-old son, Billy - Minimal social contact with friends. - Social supports: spouse, in-laws (who live in same city) Substance History: - EtOH: rare - Smoker: Lifetime non-smoker - Marijuana: 2 grams daily - Illicit drug use mostly as teenager (cocaine, ecstasy, heroin, mushrooms), some as an adult but none since having your son	
Meds	Note to SP: you can refer learner to the chart for dosing details. If asked about how the you take your meds, you can say a pre-prepared blister pack Hydromorphone CR 30mg po q8h Nortripyline 10mg po at night Pregabalin 50mg po q8h Venlafaxine 75mg po twice daily Escitalopram 20mg po daily Hydromorphone IR 4mg po, uses every 2 hours for breakthrough as needed Lorazepam 1 mg po q12h as needed Acetaminpphen 325mg po q4h Smokes cannabis for medical reasons (2 g/day)	
Allergies	NKDA	
P/E	**General**	Can be specific to SP
	Wt/Ht	Can be specific to SP
	Vitals	BP 120/70, HR 70
	LOC	normal
	CVS	normal
	Resp	normal
	Abdo	normal
Investigations	N/A	

Information for Learner

Describes the 'initial script' given to participants. Give below stem + completed BPI.

Toby Hoffman is a 47-year-old who wants to discuss his pain management after complications from a bowel resection for Crohn's disease last year left them with significant ongoing pain.

They were diagnosed with Crohn's disease at age 15. Had years of medical management with prednisone, azathioprine and infliximab with little success and ongoing progression of disease. Began taking hydromorphone CR 5 years ago to manage pain. Had a total colectomy with ileorectal anastomosis last year, complicated by postoperative bowel leak, repeat laparotomies and prolonged hospital stay. Pain was difficult to manage while in hospital. They were eventually discharged home on multiple medications. The completed BPI is attached.

Past medical history includes Crohn's disease (diagnosed at age 15), depression (diagnosed at age 18 and anxiety (diagnosed at age 22).

Medications:
Hydromorphone CR 30mg po q8h
Nortripyline 10mg po QHS
Pregabalin 50mg po q8h
Venlafaxine 75mg po BID
Escitalopram 20mg po OD
Hydromorphone IR 4mg po q2h PRN for breakthrough
Lorazepam 1 mg po q12h PRN
Acetaminophen 325mg po q4h

Conduct a focused history examining key issues surrounding opioid management, including discussion with patient the option of an opioid taper. Devise a treatment plan based on the information you obtain to manage opioid tapering / deprescribing opioids.

Scenario timeline & events

Time	SP Status	SP Actions	Learner Actions
Baseline	Sitting in exam room	"Hello doctor, I really need help with my pain. It's become uncontrollable again and I can't do anything in my life. I think maybe my medications need to be increased again."	Start taking history
0-5 mins		Provides information as requested; see details above re: behaviour	Additional questions
5-10 mins		Provides information as requested; see details above re: behaviour	Additional questions
10-15 mins		Provides information as requested; see details above re: behaviour; lead hotseat to address concerns and explain a plan	Formulate a plan & wrap-up

Discussion and Teaching Points for Debriefing

Debriefing points	Debriefing Content
Plan opioid tapering discussions that are evidence-based and responsive to the individual's readiness for change	If patient's pain is increasing with good reason, tapering is not reasonable. Discuss opioid rotation and deprescribing (this content is in the module that the instructor should preview). Discuss ongoing pain management with increasing current opioids as well as possibility of opioid medication. rotation/switching. Discuss other pharmacologic and non-pharmacologic options (this content is in the module that the instructor should preview). Discuss referral to chronic pain team.
Deprescribe opioids as safely as possible	Would not be appropriate to deprescribe at this time the way that this scenario is written. The patient request for taper should involve a discussion of them not having to taper, but choosing to do so at patient request. This is a good teaching point for this scenario. If tapering opioids, consider patient led taper. Slower tapers with close follow-up (e.g. 10% taper).
Establish mutual expectations for opioid management with the individual	Discuss plans with patient and engage in shared decision-making Discuss availability of the team during taper. Discuss team members with patient. (Learners should be asked to describe who they would see as members of the patient's pain management team.) Recognize potential to increase other medications during taper. Discuss that taper may fail and what is the plan if this happens. (This content is in the module that the instructor should preview.)

Pre-Scenario Resources to Send Participants

PGME 1

Post-Scenario Resources to Send Participants

PGME 2.2

STANDARDIZED PATIENT SIMULATION SCENARIO TEMPLATE

Learner group:	AFMC Response to the Opioid Crisis
Curriculum Topic:	Diagnosing Opioid Use Disorder
Developed by:	Drs. Glenn Posner, Michelle Chiu, Lisa Graves
Creation/Modification Date:	Jan 7 2022/Feb 17 2023

Development comments

Patient or Scenario Name

General description of scenario.

Manage chronic back pain and opioid use disorder of a patient who has been buying painkillers illegally to manage his pain.

Scenario Summary

One to two sentences summarizing the content/goals of the scenario.

Charlie is a 30-year-old man experiencing homelessness. He is coming to see you for chronic back pain, and who has been using street drugs. Take a history and discuss an initial plan for managing his concerns.

Learning Objectives

Referenced to AFMC Curriculum Mapping Document (v. Feb17, 2023)

Learner Group	Objectives
PGME	PGME 1e. Describe the impact of social determinants of health on a patient's care for pain and opioid use/ opioid use disorder.
PGME	PGME 1f. Demonstrate patient-centred, trauma-informed, and culturally safe approaches in conversations with patients about opioid use.
PGME	PGME 3a. Use a patient-centred approach to identify and assess patients with OUD.
PGME	PGME 3b. Explain the relationship between OUD, mental health, and physical health problems.

PGME	PGME 3d. Counsel patients with OUD regarding the continuum of treatment options.
PGME	PGME 3h. Develop approaches to support engagement and continuity of care, including navigating transitions between hospital and community.

Learners

Describes role in the scenario.

Actual identity	Role in scenario
Resident	Resident in the Emergency Department or ambulatory clinic

Props required for scenario

All props (☒) should be in the simulation room, applied to the mannequin/standardized pt.

☒	SP to be wearing a coat and a hoodie	☐	
☒	SP to be over 35 yo	☐	
☒	2 chairs	☐	
☐	SP should be male	☐	

Supporting files (Chart, labs, imaging, etc)

Notes/Paperwork	ER triage note
Labs	N/A
Radiology	N/A
Other	N/A

Time Required for Simulation:

Event	Duration
Set-up	5 minutes
Simulation	15 minutes

Debrief	20 minutes

Programming Notes
Comments for setup (props, drapes, pregnant abdomen etc.)

Control Room	Ensure cameras aimed correctly Ensure correct image being recorded	
Standardized Patient	Position:	Standing in the room, pacing
	IVs:	N/A
	Monitors:	N/A
	Additional equipment:	N/A
	Draping:	N/A
	Other:	Exam table
Other equipment	Exam table, two chairs	
Space required	Exam room / office exam room (with one-way mirror for faculty observer if possible) Ample room to pace, if possible	
Personnel positioning at beginning of scenario	SP pacing Ensure standardized patient and learner is visible from control room (one-way mirror)	

Information for Instructor & Standardized Patient
For the information of instructors/confederates only. Information provided to learners by SP during history taking.

Need to send to participants prior to simulation: email containing directions to simulation location & pre-simulation homework

Opening Statement	"Doc, can you please help me? I'm really having trouble taking care of my pain"
SP General appearance & demeanor	SP's general appearance is unkempt, wearing layered clothes. Friendly and cooperative, but a bit desperate. You are slightly worried that this doctor won't give you the medication, therefore, you're cooperative (to facilitate/improve your chances or receiving the prescriptions). But you are also becoming nervous that you are becoming addicted and you want help. Initially, you should be hesitant regarding treatment for addiction but subsequently alter your response, based on the communication skills of the learner. If the learner treats you as drug-seeking rather than trying to address both your back pain and your concerns about addiction, you become more negative (i.e. arms crossed in front of body, decreased eye contact, and may state 'you just think I'm a druggie/junkie' and/or 'I don't like what you're saying right now'). If the learner is calm / reassuring / makes eye contact with the SP, you'll start to settle and will agree to their suggestions.
Pain History	About 3 years ago, took a hard, awkward check during a pickup hockey game, was never the same after that. Medical management with anti-inflammatories (mostly ibuprofen and naproxen) caused terrible stomach pain, so you discontinued them. Tried taking "D's" (hydromorphone CR) from a buddy who had some leftovers and found that it helped. Currently your pain is precipitated by any activity and there are no alleviating factors for the pain. You have become very debilitated secondary to your pain. You are left with chronic back pain. You get some pain killers at the emergency room every few weeks but you've been flagged as drug-seeking. You obtain oxycodone, fentanyl or morphine on the street with money you make doing odd short-term jobs or panhandling. You started out just taking pills. In order to save money you have started to snort your opioids. You have not injected yet, but have heard that heroin may be less expensive for you. This has been going on for the last year. You have been living on the street and in homeless shelters for the last 2 years. You were a self-employed plumber until the acute back pain from the sports injury ended your career. You have no other education to fall back on, so after your savings were depleted, you were evicted and had nowhere to go. You have been able to pick up some seasonal work such as roofing, but invariably this stops when the pain or withdrawal gets too bad. You feel that you can't live without the drugs, you think about it all

	the time, and that is weighing on you. You do have access to a cell phone from time to time when you are able to charge it. You rate your sleep, mood, energy, and appetite as poor. You have little contact with friends and don't participate in leisure activities. You have no family in this city, never married, no children. You are estranged from your family of origin. You would describe growing up as abusive. Your mother always had a drink in hand. Your father left when you were young. He has another family in Florida, but you never fit in. Your mother died in a car accident and you know that alcohol was involved. Your stepfather was not a kind man, and you were out of the house as soon as possible. You do not have any contact with your half siblings. Your family physician retired and you do not have a new one. You have never overdosed, or been around anyone who overdosed. You do not have access to naloxone and don't know how to use it. You last consumed some Morphine yesterday evening, and your usual daily dose of oxycodone is approximately 200mg/day Your goal for this encounter is to get help for your chronic back pain and, more importantly, get some help for what you think is your addiction to opiates. <u>Pain History</u> ONSET: You've been in pain to some degree ever since the back injury 3 years ago. LOCATION: Low back, no specific location. DURATION: Pain is constant, even when trying to sleep, but waxes and wanes based on how active you are. CHARACTERISTICS/INTENSITY: Sharp, sudden spasms with movement. Sometimes sudden and sharp stabbing pain. Visual Analogue Score (VAS): best 6/10, worst 10/10, average 9/10. RADIATION: No. ALLEVIATING FACTORS: Opioids. AGGRAVATING FACTORS: Movement makes the pain worse. Sitting, standing or walking for too long aggravate your pain. FUNCTIONAL LIMITATIONS: You feel your pain completely interferes with all aspects of your life including general activity, mood, getting around, being with people, and sleep.

	OTHER ALLIED HEALTH SERVICES USED: None. ADVERSE EFFECTS RELATED TO OPIOIDS: If you are asked about side effects from the pills you take, say that you get a bit drowsy after taking more pain meds, but then you get accustomed, and it is not a problem. If you are asked about the following symptoms, you will agree that you sometimes get them but didn't think they were from the pills: nausea/vomiting, problems with constipation, dizziness, dry skin / itchiness, weight gain, low libido. WITHDRAWAL SYMPTOMS: If a day or two goes by and you can't get your hands on any drugs, you start to feel sick, in addition to the horrible back pain. You get hot and sweaty, and your stomach hurts. (Note to SP: this may include agitation/irritability, sweating, anxiety, muscle aches, fevers, abdominal pain, diarrhea, enlarged pupils)
Mood/Affect	Initially a bit hesitant, will become hostile if discussion is about drug-seeking rather than helping. Again, your demeanor will change depending on the actions / attitude of the learner. If the learner attempts to engage you in the decision-making and is calm / making eye contact / providing reassurance and explanations, then you will become less hostile. **This is a sample of statements or questions you can ask**: - Doc, can you please help me? - Do you believe I'm in pain? - Am I addicted to oxy? (Act genuinely remorseful that you ever started buying illegal drugs, but you were desperate.) - I've hit rock-bottom, doc, what can you do for me? - How am I going to go for treatment if I don't know where I'm sleeping every night?
PMHx	nil, other than the back pain
System Review	<u>Family History:</u> - Father: Type II DM - Mother: Deceased, MVA at age 45 - No siblings - Father lives in Florida. <u>Social History:</u> - Unmarried - Occupation: trained as plumber, not currently employed - Minimal social contact with friends.

	- Social supports: none <u>Substance History:</u> - EtOH: weekly, when available - Smoker: Lifetime non-smoker - Marijuana: 1-2 joints weekly, when available - Illicit drug use as teenager: marijuana	
Meds	None	
Allergies	NKDA	
P/E	**General**	Appears older than stated age, walks with difficulty due to low back pain
	Weight/ Height	Can be specific to SP
	Vitals	BP 140/85, P90, T 37.5
	CNS/LOC	normal, pupils constricted
	A/W	normal
	CVS	normal
	Resp	normal
Investigations	N/A	

<u>Information for Learner</u>
Describes the 'initial script' given to participants

Charlie is a 30-year-old man experiencing homelessness, who is coming to see you for chronic back pain, and who has been using street drugs. Take a history and discuss an initial plan for managing his concerns.

Notes from clinic/ER triage nurse:
"BP 140/85, P90, T 37.5
30 yo male, % back pain, frequent flyer (drug seeking)"

<u>Scenario timeline & events</u>

Time	SP Status	SP Actions	Learner Actions

Baseline	Pacing in room, holding his back	"Doc, can you please help me?"	Start taking history
0-3 mins	Gives history	Answer questions	
3-6 mins		Provides information as requested; see details above re: behaviour	Address concerns
6-10 mins		Provides information as requested; see details above re: behaviour	Formulate a plan
10-15 mins		learner to address concerns and explain a plan	Wrap-Up

Discussion and Teaching Points for Debriefing

Debriefing points:	**Debriefing Content**
Describe the impact of social determinants of health on a patient's care for pain and substance use/ substance use disorder and demonstrate patient-centered, trauma-informed, culturally safe, and equity-based approaches in conversations with patients about opioid use and misuse.	Discuss Social Determinants of Health that can be identified with this patient. Discuss Adverse Childhood Experiences (ACEs). Discuss need for trauma-informed care
Assess patients to identify opioid misuse, opioid dependence, and opioid use disorder.	Review DSM V criteria for Opioid Use Disorder (OUD) (Cs-cravings, compulsion, consequences) 1. Taking the substance in larger amounts or for longer than you're meant to 2. Wanting to cut down or stop using the substance but not managing to 3. Spending a lot of time getting, using, or recovering from use of the substance 4. Cravings and urges to use the substance

	5. Not managing to do what you should at work, home, or school because of substance use 6. Continuing to use, even when it causes problems in relationships 7. Giving up important social, occupational, or recreational activities because of substance use 8. Using substances again and again, even when it puts you in danger 9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance 10. Needing more of the substance to get the effect you want (tolerance) 11. Development of withdrawal symptoms, which can be relieved by taking more of the substance
Counsel patients regarding the diagnosis of opioid use disorder and treatment options.	Discuss use of buprenorphine/naloxone and methadone as treatment of choice Patient is not a candidate for Slow-release oral morphine (SROM) or injectable opioid agonist therapy (iOAT) at present.
Recognize the relationships between opioid use disorder, mental health, and physical health problems.	Discuss role of trauma and ACEs in persons with OUD
Identify regional resources and assist with referrals to community agencies, supports, and treatment facilities, as appropriate.	Discuss local resources for treatment. Have participants identify local resources.

Pre-Scenario Resources to Send Participants
PGME module 1

Post-Scenario Resources to Send Participants
PGME module 3

STANDARDIZED PATIENT SIMULATION SCENARIO TEMPLATE

Learner Group	AFMC Response to the Opioid Crisis
Curriculum Topic:	Peripartum Management of Opioid Agonist Treatment (Methadone)
Developed by:	Drs. Glenn Posner, Michelle Chiu, Lisa Graves
Creation/Modification Date:	Jan 26, 2022/Feb 17 2023

Development comments

Patient or Scenario Name

General description of scenario.

Antenatal care for a patient currently on methadone

Scenario Summary

This is Thi's first antenatal visit with her family physician or obstetrician. Take a focused history and discuss the ramifications of methadone on her pregnancy and on her newborn.

Learning Objectives

Referenced to AFMC Curriculum Mapping Document (v. Feb17, 2023)

Learner Group	Objectives
CPD	CPD 4a. Describe the approach to the diagnosis and assessment of women with substance use disorders and concurrent physical and mental health conditions.
CPD	CPD 4b. Establish pain management plans for women with substance use disorders and concurrent physical and mental health conditions.
CPD	CPD 4c. Explain how to manage pain safely in women during the prenatal, perinatal, and postpartum life stages
CPD	CPD 4d: Discuss the implications of treating women with opioid use disorder and concurrent pain-related disorders.
CPD	CPD 5f. Evaluate and treat neonatal abstinence syndrome/neonatal withdrawal.

Simulation Participants

Describes role in the scenario.

Actual identity	Role in scenario
Physician	Physician in the ambulatory clinic
Simulated Patient	Pregnant patient
Faculty Observer	As themselves

Props required for scenario

All props (☒) should be in the simulation room, applied to the mannequin/standardized pt.

☒	SP clothes not specific	☐	
☒	SP to be young, in 20s	☐	
☒	2 chairs	☐	
☒	Folder containing supporting documents	☐	

Supporting files (Chart, labs, imaging, etc)

Notes/Paperwork	Referral note from family physician to FM-OB, OB or Midwife
Labs	N/A
Radiology	Dating ultrasound indicating an 8-week intrauterine pregnancy
Other	N/A

Time Required for Simulation:

Event	Duration
Set-up	5 minutes
Simulation	15 minutes
Debrief	20 minutes

Programming Notes
Comments for setup (props, drapes, pregnant abdomen etc.)

Control Room	Ensure cameras aimed correctly Ensure correct image being recorded	
Standardized Patient	Position:	Relaxed, sitting in chair
	IVs:	N/A
	Monitors:	N/A
	Additional equipment:	N/A
	Draping:	N/A
	Other:	Exam table
Other equipment	Exam table, two chairs	
Space required	Exam room / office exam room (with one-way mirror for faculty observer if possible)	
Personnel positioning at beginning of scenario	Ensure standardized patient and learner is visible from control room (one-way mirror)	

Information for Instructor & Standardized Patient
For the information of instructors/confederates only. Information provided to learners by SP during history taking.

Need to send to participants prior to simulation: email containing directions to simulation location & pre-simulation homework

Opening Statement	"Hello, I've been very anxious to meet with you and talk about methadone in pregnancy"
SP General appearance & demeanor	SP's general appearance is dressed casually and comfortably. Friendly and cooperative, but a bit anxious about her pregnancy. You are slightly worried that this doctor will suggest that you stop the methadone, but you are also worried about the potential effects of methadone on the pregnancy. If the physician tries to dissuade you from taking the methadone, you will become sad. Ask about the risks and why they are

	suggesting you stop, then focus on how your pain will be controlled during and after the delivery and how you will be treated by the hospital staff. Express concern about having a relapse of your substance use disorder. If the physician suggests that you stay on the methadone, then try to get as much information as possible about the effects of methadone on pregnancy. Generally, you are also concerned about being judged by your Ob provider.
History	About 5 years ago, a girlfriend introduced you to heroin and you became dependent. You were roommates and she often had wild parties and you became wrapped up in her lifestyle. You hit rock-bottom 2 years ago and dropped out of nursing school. Your family intervened and after a period of rehabilitation you are now back in school and in a methadone program. This is an unplanned pregnancy after you might have missed a birth control pill (or two) but you are in a monogamous relationship with your boyfriend (Jin) and you're both now excited about the pregnancy. SP needs to think of a realistic last menstrual period based on the date that the encounter is planned – approximately 8 weeks earlier (subtract 2 months from date of encounter). You rate your sleep, mood, energy, and appetite as good. You have a few close friends, and family in another province. This is your first pregnancy. WITHDRAWAL SYMPTOMS: If you ever forget to take your methadone or try to quit, you start to feel sick, you get hot and sweaty, and your stomach hurts. (Note to SP: this may include agitation/irritability, sweating, anxiety, muscle aches, fevers, abdominal pain, diarrhea, enlarged pupils)
Mood/Affect	Calm, good eye contact, appropriate concern. This is an unplanned but desired pregnancy, and you have not had any pre-pregnancy counseling. You are very anxious about the possible effects of methadone on your pregnancy. (This is a lot of questions to get through in addition to the history, so SP should interrupt with questions after about 5 minutes) 1. Hello, I've been very anxious to meet with you and talk about methadone in pregnancy 2. Can I stay on methadone during my pregnancy? I think I still really need it. 3. Can methadone cause miscarriage? 4. What about the risk of birth defects?

	5. Are there any risks to my pregnancy? Preterm labour? 6. Will I be able to get an epidural? 7. What about pain control after the baby is born? 8. What about the baby when it's born? Will my baby go into withdrawal? What will be done for my baby? 9. Will Children's Aid need to be involved? Could I have the baby taken away? 10. Can I breastfeed? 11. I'm worried the nurses and doctors at the hospital will be all judgey and treat me like an addict.	
PMHx	appendectomy	
System Review	<u>Family History:</u> - Father: HTN - Mother: healthy - No siblings <u>Social History:</u> - Unmarried, living with boyfriend, Jin - Occupation: nursing student (RPN) <u>Substance History:</u> - EtOH: weekly, when available, not since pregnancy diagnosed - Smoker: Lifetime non-smoker - Marijuana: 1-2 joints weekly, when available - Illicit drug use as late teenager: as above, heroin - HBV immunized and HCV negative	
Meds	Methadone 70 mg PO qd - She is level 6 (monitored weekly dose and 5 carry doses); prenatal vitamin	
Allergies	NKDA	
P/E	**General**	normal
	Weight/ Height	Can be specific to SP
	Vitals	BP 120/70, P95, T 36.8
	CNS/LOC	normal
	A/W	normal
	CVS	normal
	Resp	normal
Investigations	N/A	

Information for Learner
Describes the 'initial script' given to participants.

This is Thi's first antenatal visit with her family physician or obstetrician. Take a focused history and discuss the implications of methadone on her pregnancy and on her newborn.

Notes from clinic nurse:
"New Ob appointment, 25 yo G1P0 at 9 weeks GA
Currently in a methadone program
BP 120/70, P95, T 36.8"

Scenario timeline & events

Time	SP Status	SP Actions	Learner Actions
Baseline	Sitting patiently in room	"Hello, I've been very anxious to meet with you and talk about methadone in pregnancy"	Start taking history
0-3 mins	Gives history	Provides information as requested; see details above re: behaviour	
3-6 mins		Provides information as requested; see details above re: behaviour	Address concerns
6-10 mins		Provides information as requested; see details above re: behaviour	Formulate a plan
10-15 mins		Provides information as requested; see details above re: behaviour; learner to address concerns and explain a plan	Wrap-Up

Discussion and Teaching Points for Debriefing

Debriefing points:	Debriefing Content
Assess females with substance use disorder and concurrent physical and mental health conditions	(Please include specifics on questions to be asked, evaluating ongoing need for methadone.) Work on meeting patient's immediate needs first. If there are significant issues related to Social Determinants of Health (e.g. food, housing, security). These should be addressed.

	Medical issues to be addressed at first prenatal visit if not already done outside of usual prenatal care: HBV HCV Connecting with methadone prescribing physician Concurrent mental health Trauma-informed care as many women with Opioid Use Disorder have experienced trauma Methadone needs may increase during pregnancy, this can be challenge for women on very low doses of methadone. Useful to discuss importance of baby not going in withdrawal in utero Additional ultrasounds for growth Urine toxicology screen for social work/CAS
Establish pain management plans for females with substance use disorder and concurrent physical and mental health conditions	Specifics about the safety of methadone in pregnancy Studies have shown that methadone does not increase the chance of birth defects or complications during pregnancy. Exception: possible risk of preterm delivery. The exposure of infants to methadone through their mothers' breast milk is minimal. Women using methadone for treatment of opioid dependence **should not be discouraged from breastfeeding**. The benefits of breastfeeding largely outweigh any theoretical minimal risks. Breastfeeding may reduce the need for infant to receive medication to treat withdrawal.
Manage pain safely in females during the prenatal, perinatal, and postpartum life stages	Discuss epidural and post-partum pain control No contraindications Reassure patient that their pain needs will be met and that she may need more pain medication than women who are not taking opioids

Evaluate and treat neonatal abstinence syndrome.	Discuss neonatal abstinence/withdrawal and how it is managed: Opioid-dependent women should be informed that neonates exposed to heroin, prescription opioids, methadone, or buprenorphine during pregnancy are monitored closely for symptoms and signs of neonatal withdrawal (neonatal abstinence syndrome). A small percentage of newborns will require medication to treat withdrawal. Most infants experiencing withdrawal can be managed without medication. Rooming-in and breastfeeding appear to reduce the need for medical treatment of withdrawal
Discuss the health, social and psychological implications of opioid use disorder experienced by females	Address her concerns about stigma Address guilt. Validate choice for treatment, concerns regarding child welfare involvement & confidentiality Provide support Early and positive referral to social work may be useful Discuss how child protection services can work with her if needed Discuss importance of addressing any concerns about stability as soon as noted

Pre-Scenario Resources to Send Participants

Ordean A, Wong S, Graves L. No. 349-Substance Use in Pregnancy. J Obstet Gynaecol Can. 2017 Oct;39(10):922-937.e2. doi: 10.1016/j.jogc.2017.04.028. PMID: 28935057.

2022 guidelines will be published by end of 2022
PGME module 1

Post-Scenario Resources to Send Participants
CPD module 4

Appendix A: Referral Note from Family Physician

Dear Colleague,

Would you kindly see Thi for antenatal care? She is a 25 year-old woman who just found out she is pregnant and is currently in a methadone program. Please see dating u/s attached"

Appendix B: Dating ultrasound

An early intra-uterine pregnancy is detected, with a fetal heart rate of 160bpm and a crown-rump length consistent with 8 weeks + 4 days gestational age. Routine anatomy scan is recommended at 19-20 weeks gestational age but has not been booked.

STANDARDIZED PATIENT SIMULATION SCENARIO TEMPLATE

Learner Group:	AFMC Response to the Opioid Crisis
Curriculum Topic:	Management of Opioid Side Effects
Developed by:	Drs. Michelle Chiu, Glenn Posner, Lisa Graves
Creation/Modification Date:	Jan 29 2022/ Feb 17 2023

Development comments

Patient or Scenario Name

General description of scenario.

Management of Opioid Side Effects

Scenario Summary

One to two sentences summarizing the content/goals of the scenario.

Robin is a 39-year-old individual (they/them), complaining of side effects related to their medication. Take a focused history and outline a management plan to manage their side effects.

Learning Objectives

Referenced to AFMC Curriculum Mapping Document (v. Feb17, 2023)

Learner Group	Objectives
PGME	PGME 6.1c. Assess patients suffering from pain, including the identification of factors contributing to pain and how pain affects their life.
PGME	PGME 6.1d. Discuss approaches to comprehensive pain management assessment.
PGME	PGME 6.2c. Determine the most appropriate treatment plan for a patient in pain using pharmacological non-opioid and procedural approaches, including preventive interventions

Simulation participants

Describes who is present and their role in the scenario.

Actual identity	Role in scenario
Learner	As themselves
Standardized Patient	"Robin"
Faculty observer	As themselves

Props required for scenario

All props (☒) should be in the simulation room, applied to the mannequin/standardized pt.
If props are intended to be available for the scenario – but outside the room or hidden - please indicate this by writing '(Available only)' after the specified prop.

☒	2 chairs	☐	
☒	Clipboard + blank paper	☐	
☒	Folder containing supporting documents	☐	

Supporting files (Chart, labs, imaging, etc)

Notes/Paperwork	Note from clinic nurse
Labs	NONE
Radiology	N/A
Other	Supporting documents not in room but can be requested by learner

Time Required for Simulation:

Event	**Duration**
Set-up	5 min
Simulation	15 min
Debrief	20 min

Programming Notes

Comments for setup (props, drapes, pregnant abdomen etc.)

Control Room (if applicable)	Ensure cameras aimed correctly Ensure correct image being recorded	
Mannequin/Standardized Patient	Position:	The standardized patient will be seated, facing the door.
	IVs:	None
	Monitors:	None
	Additional equipment:	None
	Draping:	n/a
	Other:	Any gender SP can play this role
Other equipment	Bedside table, 2 chairs facing each other	
Space required	1. Clinic room (with one-way mirror for faculty observer if possible)	

	2. Medium sized room for debriefing (if >1 learner, otherwise could be done in clinic room)
Personnel positioning	Ensure standardized patient and learner are visible from control room (one-way mirror)

Information for Instructor & Standardized Patient

For the information of instructors/confederates only. Information provided to learners by SP during history taking.

Need to send to participants prior to simulation: email containing directions to simulation location & pre-simulation homework

Opening statement	"I think I may be having side effects from my pain pills, and I'm not sure how to fix it."
SP General appearance & demeanor	SP's general appearance is clean and wearing comfortable clothes. Pleasant and cooperative, anxious but not emotional.
Pain History	You have chronic neck pain and paresthesias (tingling or numbness) after a car accident 2 years ago, for which you take oxycodone and gabapentin. You were the passenger in a Honda Civic that was rear-ended by another similar sized car. Despite physiotherapy and neurosurgical consultation, you have lingering neck pain but full range of motion if you take you oxycodone regularly. You also have paresthesias and a burning sensation in the right arm down to the hand. The parasthesias have not responded completely to any chiropractic maneuvers or physiotherapy; the burning sensation is well-treated with gabapentin. Pain History ONSET: You've had this pain for 2 years, and it's fairly stable. LOCATION: In the neck, mostly with turning the head to the right, and down the right arm. DURATION: Some amount of pain is constant, even when trying to sleep. CHARACTERISTICS/INTENSITY: Constant, exacerbated by movement of the neck. Ranges from 3/10 to 7/10. RADIATION: The pain doesn't radiate, but the paresthesias and burning sensation radiate down the right arm. ALLEVIATING FACTORS: Pain responds well to oxycodone, paresthesias respond partially to gabapentin. Gabapentin seems to treat the burning sensation. Sometimes you add cyclobenzaprine if you get muscle spasms in your neck.

	AGGRAVATING FACTORS: Movement of the head and neck, especially to the right. FUNCTIONAL LIMITATIONS: You are not able to play tennis anymore, which you used to enjoy. OTHER ALLIED HEALTH SERVICES USED: Physiotherapy and chiropractor visits at the beginning, which didn't help. WITHDRAWAL SYMPTOMS: Has never stopped taking medications long enough to find out.
Mood/Affect	You have asked for this appointment to discuss possible side effects from your pain medications. You are annoyed that you didn't know about these side effects in advance and you are anxious because you can't stop taking the medications due to your ongoing pain. You will be very receptive to strategies to rotate medications or manage side effects but less receptive to suggestions regarding limiting your opioid use. You will become very offended if there is any implication that you are addicted and should wean from your medications.
PMHx	You are otherwise healthy, with no history of surgeries or medical problems. You have been noticing significant constipation in the last 6 months, as well as nausea - these are your two biggest concerns. The nausea is starting to make it hard to work, and the constipation is causing abdominal pain. You are a bit distended and gassy. You've tried dimenhydrinate over the counter for the nausea, but it doesn't work that well and it makes you groggy. You've tried a psyllium fibre supplement for constipation, but it seems like it's making the problem worse. You have not noticed any difference with different foods. There has not been any recent change to your medications. You manage to have a bowel movement every 2-3 days. There is no blood in your stool. You consume 3-4 cups of water per day. You deny any lack of concentration or lethargy, except when you also take cyclobenzaprine. This is a selection of questions you can ask: ● I think I may be having side effects from my pain pills, and I'm not sure how to fix it. ● I can't stop taking my pills, is there anything you can suggest? ● Do you think the gabapentin is making it worse? ● What about the cyclobenzaprine? Engage in problem-solving with the physician, as needed, asking appropriate questions based on the suggestions made.

System Review	Family History: - none Social History: - Works as a real-estate lawyer - Played competitive tennis from age 9-19 and was playing casually until the accident. - Good social contact with friends. - Social supports: parents and sibling live in the same city. Substance History: - none	
Meds	Oxycodone 40 mg bid, gabapentin 300 mg tid, cyclobenzaprine 10 mg tid prn	
Allergies	NKDA	
P/E	**General**	Can be specific to SP
	Wt/Ht	Can be specific to SP
	Vitals	not applicable
	LOC	normal
	CVS	normal
	Resp	normal
	Abdo	normal
Investigations	N/A	

Information for Learner

Describes the 'initial script' given to participants. Give below stem and note from nurse.

Robin is 39-years-old and is complaining of possible side effects related to their medications. They have chronic neck pain and paresthesias after a car accident 2 years ago, for which they take oxycodone and gabapentin. They have been struggling with side effects lately and want to meet with you to discuss strategies to alleviate these problems.

Note from nurse:
"Robin prefers they/them, wants to talk about side effects of their medications
Oxycodone dose 40 mg bid
Gabapentin dose 300 mg tid"

Scenario timeline & events

Time	SP Status	SP Actions	Participant Actions
Baseline	Sitting in exam room	"Hi, I think I may be having side effects from my pain pills, and I'm not sure how to fix it."	Start taking history
0-5 mins		Provides information as requested from past medical history; see details above re: affect	Additional questions

5-10 mins		Provides information as requested; see details above re: affect	Additional questions
10-15 mins		Provides information as requested; see details above re: affect; learner to address concerns and explain a plan	Formulate a plan & wrap-up

Discussion and Teaching Points for Debriefing

Debriefing points	Debriefing Content
Identify barriers to adequate pain management in practice	Discuss opioid rotation and switching discuss maximal dose of gabapentin discuss pharmacologic and non-pharmacological treatments
Address barriers to adequate pain management in practice	Discuss stigma, demonstrate lists of non-stigmatizing language
Diagnose side effects and interactions of pain medications	Constipation secondary to opioids and treatment
Manage side effects and interactions of pain medications	Treatment of constipation

Pre-Scenario Resources to Send Participants

Swegle JM, Logemann C. Management of common opioid-induced adverse effects. Am Fam Physician. 2006 Oct 15;74(8):1347-54. PMID: 17087429.

PGME module 1

Post-Scenario Resources to Send Participants

PGME module 6.1 and 6.2