

# SIMULATION-BASED TRAINING TO AUGMENT A DEPARTMENTAL OPIOID STEWARDSHIP PROGRAM

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## COURSE OVERVIEW

### FORMAT

- 2-hours, 3-4 participants per session, 3 facilitators and 3 simulated patient actors.
- Opening session group discussion and questionnaire (15 minutes)
- Rotation of participants between 3 simulated patient encounters (90 minutes, 20 minutes/case and time to turnover rooms)
- Closing group reflection and feedback (15 minutes)

### CASES BY OUD TAXONOMY

- Case 1 Acute pain management in the ED / prevention of OUD
- Case 2 Revealed as having OUD and willing to engage in treatment
- Case 3 Revealed as having OUD but unwilling to engage in treatment

### LEARNING OBJECTIVES FOR CASES:

1. For patients with severe acute pain, prevention of OUD involves judicious prescribing of opioids based on an explicit calculation of benefit and harm, counseling on side effects, analgesic goals, risk of overdosing, risk of dependence, and safe storage and disposal of unused medications. (Case1)
2. For patients who are willing, emergency physicians can evaluate and initiate buprenorphine and/or refer to comprehensive medication-based outpatient addiction treatment. (Case 2)
3. For patients with OUD who are not willing to be treated with buprenorphine, OUD harm reductions strategies should be provided. (Case 3)
4. Components of motivational interviewing may help distinguish those who are willing or unwilling to receive medication-based treatment for OUD and provide positive encouragement for those who remain unwilling, in hopes that they will become willing in the future. (Case 2, 3)
5. Opioid use disorder is a disease of disordered brain chemistry that may require prolonged treatment with medications and should be considered a chronic condition. (Case 1, 2, 3).

### OPENING SESSION PROMPTS:

- Discuss practice patterns, experiences with patients with OUD, and perceived responsibilities to patients with OUD who present to ER.
- Attitudes and knowledge to discuss
  - OUD is an organic brain disease, not a moral failing, poor choice, or failure of willpower
  - Many if not most patients with OUD were first exposed to opioids through a doctor's prescription; overprescribing of opioids is thought to be the primary driver of the current opioid addiction epidemic.
  - For patients not willing to seek recovery at the time of an ED visit, what other resources and strategies are available to improve their safety?

### CLOSING SESSION REFLECTION:

- Invite participants to reflect on any changes in practices after their interactions
- Discuss resources and possibilities to engage patients with OUD. Topics for advanced discussion: X Waiver, home initiation, low threshold buprenorphine
- Elicit any other feedback for department or institutional changes that may further support opioid stewardship program.

## CASE 1: PREVENTION OF OUD

### LEARNING OBJECTIVES

- Examine appropriate use of opioids for acute pain management
- Summarize alternatives to opioids for acute pain management
- Practice counseling patients who receive opioid prescriptions

### OVERALL CASE PROGRESSION (20 MIN):

Physician briefing (2 minute)

Case Progression (6 minutes)

Debrief (12 minutes)

- Facilitator will start with “How do you feel” to allow physician a moment to exhale. If there are any issues the physician brings up, address them.
- Frame the debriefing to cover each of the learning objectives
  - Review scripted discharge instructions and opioid alternatives as a guide
  - Can make the analogy of deciding to prescribe opioids for pain with the concept of choosing wisely in antibiotic stewardship – its ok to do, simply do so in an informed and regimented fashion
- Close by asking the physician with a lesson learned, or more aptly a skill they will integrate into their everyday practice to steward opioids in the treatment of pain.
  - Advocate for practice change and review current operational systems in place

### SUPPLIES / MOULAGE

- Empty stretcher or chair
- Blank prescription
- Handouts
  - <https://emupdates.com/wp-content/uploads/2016/09/Opioid-Alternatives.png>
  - <https://emupdates.com/helpcard-and-opioid-misuse> (opioid discharge instructions)

### CRITICAL ACTIONS

- Assess and treat acute pain with explicit consideration of opioid benefit and harm
- Provide adequate discharge instructions on appropriate pain management

### FACILITATOR NOTES:

- Instruct learner that they are at a simulated patient (SP) station. They will be presented a scenario and are expected to interact with the SP as they would a real person in real life. Acknowledge that we can't make the scenario completely authentic as it would happen in the actual ED, ask them to do the best to “suspend disbelief”
- Give the learner the briefing document and allow them to ask any questions as needed.

## SIMULATED PATIENT NOTES

### BACKGROUND

You are a 50-year-old man who presents to the emergency room for severe 10/10 left-sided flank (lower back) pain. You have a history of hypertension (you take amlodipine for this) and a remote history of kidney stones several years ago. It is unusual for you to seek treatment in an ED because you hate hospitals. Your significant other strongly encouraged you to come despite wanting to wait for the symptoms to pass at home.

When you first arrived to the ER, a “triage doctor” evaluated you and ordered you pain medications (acetaminophen and ketorolac, which is an intravenous version of ibuprofen). Unfortunately, your pain is still very severe, a 10/10.

### CASE PROGRESSION (6 MINUTES)

When the learner enters the room, you will be holding your left side or left lower back and rocking back and forth in pain. Your facial expressions will make it obvious that you are still in severe pain. You should answer questions regarding your symptoms but while in obvious distress.

- If asked, you have nausea, vomiting (once at home). You do NOT have burning with urination, change in frequency of urination, blood in the urine, fever, chills, change in bowel movements. You never had any surgeries. You cannot recall what your prior kidney stone felt like but you remember being in severe pain.

You should say:

- “The pain is really bad. What’s going on?”
- “I’ve never been in so much pain. I really can’t stand this anymore.”
- “Can you do something to help me? The pain is killing me.”

You should be offered pain-relieving medications, and your response should be as follows:

- If LIDOCAINE is given, you will have no improvement in pain.
- If KETAMINE is given, you will have adequate pain relief.
- If MORPHINE is given, you will have adequate pain relief.
- If PERCOCET (oxycodone) or VICODIN (hydrocodone) are ordered, you will have some pain relief. You will recall that you had a prescription for VICODIN during your last kidney stone.

Once your pain is adequately treated in the ER (with the above options), you will say that you are feeling better and are ready to go home. Your body language should reveal that you are more relaxed.

You should then pivot to ask questions regarding care at home in anticipation for discharge:

- “Thank you for making me feel better. I hope I don’t get another pain attack at home.”
- “Hey doc, are you going to give me any medicine for home in case my pain comes back?”

If the physician learner recommends IBUPROFEN (MOTRIN) and ACETAMINOPHEN (TYLENOL) then you should say:

- “I remember how much my stone hurt last time. I needed strong painkillers. I really don’t want to come back to the ER.”

If the physician does not give any other medications, you should be persistent for stronger medications and say:

- “Doc, I just want to feel better. I promise I’ll see my urologist next week. I just need some meds to hold me over since the holiday is coming up this weekend.”
- “You don’t want to treat my pain? Do you think I’m an addict? Clearly you have no compassion.” (You will act angry and stand up to leave)

If the physician agrees to give you another prescription (in addition to IBUPROFEN and ACETOMINOPHEN), the facilitator in the room will hand the physician a blank prescription and ask the physician to write down the prescription being signed.

As you take the prescriptions, you should ask:

- “Ok thanks. How do I use this? Should I take all 3 medications at the same time.”
- “What if my pain is not so bad? Do I still take it?”
- “Are there any side effects I should be worried about?”
- “What if my stone passes and I have extra pills left over?”

You can end the case by thanking the doctor and walking out the door.

## PHYSICIAN BRIEFING

You are working in ER and are about to evaluate a 50-year-old patient with a history of hypertension (on amlodipine) and renal stones (several years ago). The chief complaint is left-sided flank pain radiating to the groin x 1 day.

At triage, the patient was given ketorolac 15mg IV, acetaminophen 975mg PO, and 1 L IV fluids. A CT scan was already performed and revealed a 4mm left-sided mid-ureteral stone with mild-moderate hydronephrosis.

The nurse asks you to evaluate the patient because the patient still appears uncomfortable despite receiving the medications listed above 2 hours ago. Please enter the room and evaluate the patient.

## REFERENCE MATERIAL

### Opioid Discharge Script

You are being discharged with a prescription for an opioid pain medication. Opioids are powerful analgesics that can be very effective for pain but also have the potential to harm you. You should only take opioid pain medications if you are still suffering with pain after you've optimized non-medication strategies (rest, position of comfort, ice, heat, etc) and non-opioid medications such as acetaminophen (Tylenol) and ibuprofen (Motrin). Take opioid pain medications as prescribed; do not take more than prescribed or take the pills in a different way than prescribed.

Opioids often cause constipation, nausea, and itching. Opioids can also cause more dangerous problems such as feeling ill, excessive sleepiness, confusion, and falls. Older people and people with liver or kidney disease are more prone to these harms. You should not drive or perform dangerous work while using opioid pain medications.

If you take too much opioid pain medication, your breathing can slow or even stop, which can be fatal. This is how people die from an opioid overdose.

Opioids can cause acute physical dependence after only a few days, which means that if you take opioid pain medications for a few days and then stop, you might experience withdrawal symptoms such as muscle aches, pain, insomnia, feeling nauseated and ill, depressed, agitated, or anxious, and you might even crave more pills. If you take more opioid pills, these symptoms will be greatly relieved, however this is the beginning of a very dangerous cycle of dependence, which can lead to addiction. If it is possible that you are experiencing acute physical dependence, do not take more opioid pills and discuss the problem with your doctor.

Lastly, once this painful episode is over, dispose of any unused pills—you can take them back to the pharmacy or flush them down the toilet. Leftover opioid pills can be extremely dangerous to children, and are a major source of recreational use, especially among adolescents and young adults.

### Opioid Alternatives, Risk Stratification for Misuse, and Opioid Harms

- <https://emupdates.com/wp-content/uploads/2016/09/Opioid-Alternatives.png>
- <https://emupdates.com/wp-content/uploads/2015/06/opioid-misuse-flow.png>
- <https://emupdates.com/wp-content/uploads/2016/09/Opioid-Harms.png>

#### References:

- <https://emupdates.com/category/opioid-misuse/>

## Opioid Alternatives for Outpatient

### Management of Acute and Chronic Pain

**Ibuprofen** 400-800 mg, three times daily (or equivalent NSAID)

**Acetaminophen** 1000 mg, four times daily

**Methocarbamol** 1500 mg, four times daily (back pain, muscle spasm)

**Topical Diclofenac Gel** 3%, apply three times daily (musculoskeletal pain)

**Gabapentin** 100 mg three times daily increase by 100 mg every 3 days up to 900 mg/day (neuropathic pain)

**Lidocaine patch**, apply 12 of 24 hours every day (back pain, postherpetic neuralgia)

**Topical capsaicin cream** 0.025% or patch 8%, apply twice daily (back pain, neuropathic pain)

**Lidocaine cream or gel** 2-3%, apply three times per day (burns, painful rashes)

**Sumatriptan** 100 mg once at onset of headache (or equivalent triptan)

**Amitriptyline** 10 mg at bedtime (neuropathic pain) (or equivalent tricyclic)

**Medical cannabis** referral (all chronic pain)

## Parenteral Opioid Alternatives for

### Management of Acute and Chronic Pain

**Ketorolac** 15 mg IV or 30 mg IM

**Acetaminophen** 1000 mg IV over 15 minutes

**Cardiac Lidocaine** 2% 1.5 mg/kg IV over 15 minutes (renal colic, back pain, neuropathic pain)

**Bupivacaine** 0.25% 10-15 mL infiltrated at point of maximal pain (back pain, musculoskeletal pain)

**Metoclopramide** 10 mg (headache, abdominal pain) (may substitute prochlorperazine)

**Propofol** 10 mg IV every five minutes until relief (headache)

**Ketamine** .25 mg/kg IV over 10 minutes, then .25 mg/kg/hour, titrated (all acute and chronic pain)

**Droperidol** 2.5 mg IV or IM (chronic pain) (may substitute haloperidol 5 mg)

**Dexmedetomidine** IV 0.5 mcg/kg bolus then by 0.3 mcg/kg/h infusion (all acute and chronic pain)

**Nitrous Oxide** 50-70% inhaled (acute pain or end of life pain)

## CASE 2: OPIOID WITHDRAWAL

### LEARNING OBJECTIVES

- Practice counseling patients to promote treatment for OUD
- Employ buprenorphine for acute withdrawal, home induction, and maintenance therapy
- Develop a follow up plan for patients with OUD

### OVERALL CASE PROGRESSION (20 MIN):

Physician briefing (2 minute)

Opioid Withdrawal Case Progression (8 minutes)

Debrief (10 minutes)

- Facilitator will start with “How do you feel” to allow physician a moment to exhale. If there are any issues the physician brings up, address them.
- Frame the debriefing to cover 2 major points.
  - First, review misuse treatment map to guide ED and outpatient plan for treatment (buprenorphine administration, prescription, and referral) (5 minutes)
  - Second, bring attention to resources available for patients as part of counseling, and encouragement to further treatment with medication for OUD.
    - Integrated SP feedback (3 minutes)
- Close by asking the physician a lesson learned, or more aptly a skill they will integrate into their everyday practice to manage opioid withdrawal/opioid use disorder.
  - Obtaining X-waiver, or being proactive about providing prescription for colleagues
  - Strategies for engaging patients in treatment

### SUPPLIES / MOULAGE

- Empty stretcher or chair for simulated patient
- Handouts
  - [ED opioid misuse treatment map](https://emupdates.com/wp-content/uploads/2016/09/Opioid-Misuse-Treatment-Map-v4-NonLocalized.pdf)  
<https://emupdates.com/wp-content/uploads/2016/09/Opioid-Misuse-Treatment-Map-v4-NonLocalized.pdf>
  - [ED initiation of buprenorphine](https://emupdates.com/wp-content/uploads/2016/09/EDIB.png)  
<https://emupdates.com/wp-content/uploads/2016/09/EDIB.png>
  - COWS - <https://www.mdcalc.com/cows-score-opiate-withdrawal>

### CRITICAL ACTIONS

- Initiation of buprenorphine in accordance with misuse treatment map (emupdates.com or similar)
- Address outpatient treatment plan with buprenorphine
- Assessment of patient’s withdrawal symptoms using COWS

### FACILITATOR NOTES:

- Instruct learner that they are at a simulated patient (SP) station. They will be presented a scenario and are expected to interact with the SP as they would a real person in real life. Acknowledge that we can’t make the scenario completely authentic as it would happen in the actual ED, ask them to do the best to “suspend disbelief”
- Give the learner the briefing document and allow them to ask any questions as needed.
- State that they will be encounter in a patient that has a history of opioid use
- If they attempt to offer resources to patient you may supply them with a misuse treatment map
- May provide buprenorphine initiation algorithm and COWS scoring systems as needed
- You can quietly observe the case from a corner of the room. At the end of the SP encounter, please state “**The encounter is now complete.**”

## SIMULATED PATIENT NOTES

### BACKGROUND

The physician is working a busy afternoon shift when they arrive to evaluate a patient for a “medical clearance.” This is a 35-year-old female in police custody. She has been in holding for the past day. She is an active heroin abuser who hasn't taken in the last 24-48 hours. She presents with multiple episodes of vomiting, anxiety and abdominal cramping. She has chills, feels flushed, complains of being achy all over. On exam, she is unable to sit still, constantly moving around, yawns occasionally, and wipes nose a few times. She was given ibuprofen for headache and an anti-emetic (Ondansetron) medication on arrival, but still feels “dope sick.”

### CASE PROGRESSION (6 MINUTES)

A physician will introduce herself after you have been waiting handcuffed to a stretcher for 1-2 hours. The physician will come in and introduce herself in order to evaluate you. They may attempt to get your history.

Disposition: You are visibly uncomfortable and somewhat irritable, resigned to your circumstances and the idea that nobody really wants to help you. You are somewhat burdened with the idea that no one wants to help you because of the stigma of opioid use, and in the past people have only been disparaging in the ER. You can start off being resistant to answering questions stating “whatever you guys gave me isn't working so I just want to get out of here so that I can go through processing at the precinct.”

Your drug use history:

- You use heroin almost every day
- You typically inhale, but have injected in the past
- You DO NOT have a fever or any other skin irritation, swelling or redness
- Last time you used was the day prior to getting caught attempting to steal a purse from Century21 so that you could sell it for money.

If the physician asks how you feel after getting the medications for nausea, you can respond that you “still feel like crap.”

If the physician offers clonidine (or any other medication that isn't an opioid such as Reglan, Compazine or Haldol), you can say that “whatever you have gotten in the ER in the past never works”

If the physician shows some compassion or empathy to your situation. You can become silent and start to consider sharing stressors and become emotional

- *“I don't know if I can keep doing this...my life is in shambles; I lost my job, and now I got arrested. The police officers said I'm probably getting released this afternoon after meeting with the judge, but I don't know where to go from here”.*

If the physician offers suboxone/buprenorphine you can say that you have heard of it, but never tried it. And you are NOT sure if it would help at this point. At this point you might leave space for them to encourage you to engage in treatment further, if they reflect any portion of your turmoil and recommend treatment as a possible step in the right direction, then you can respond positively; ***“I guess I can give it a try, but I'm not sure what will happen after I leave.”***

The physician may evaluate you for acute withdrawal with an evaluation tool.

- You feel flushed, sweaty and you are having chills
- You are anxious and feeling restless

- You are achy all over in shoulders and hands
- Your nose is running and you are constantly sniffing
- Still nauseous and cramping
- Fine tremor
- Yawn a few times during interview
- Irritable

If the physician administers buprenorphine you can say that you do notice some improvement of your symptoms, but still a little resigned about what your options are.

If physician asks you if you would like to continue therapy with buprenorphine you can seem interested and say something like “I guess this is a good a time as ever.”

If they do not offer a treatment plan, then you can ask “what’s next?”

Physician should address

- Follow-up clinic or referral to a service for maintenance therapy
- Dosing of medication
- Prescription
- Information of what to do if you relapse

Once discharge instructions are given the case can close.

The goal of the case is to provide compassion to a patient who is otherwise feels hopeless in regards to treatment in the past, but who is contemplating treatment if the physician is able to point out the discrepancy between what they want in their life and how opioid use is interfering. Additionally, the provider should offer a treatment plan using buprenorphine.

## PHYSICIAN BRIEFING

You are working a busy afternoon shift when you pick up a patient for a “medical evaluation.” This is a 35 year old female in police custody. She has been in holding for the past day. She is an active heroin abuser, hasn't used in the last 24 hours. She presents with multiple episodes of vomiting, anxiety and abdominal cramping. She has the chills, feels flushed. Complaints of being achy all over. On exam, unable to sit still, constantly moving around, yawns occasionally, and wipes nose a few times. Vitals with HR 110, BP 125/90. Given ibuprofen and ondansetron from triage provider.

## REFERENCE MATERIAL

### References:

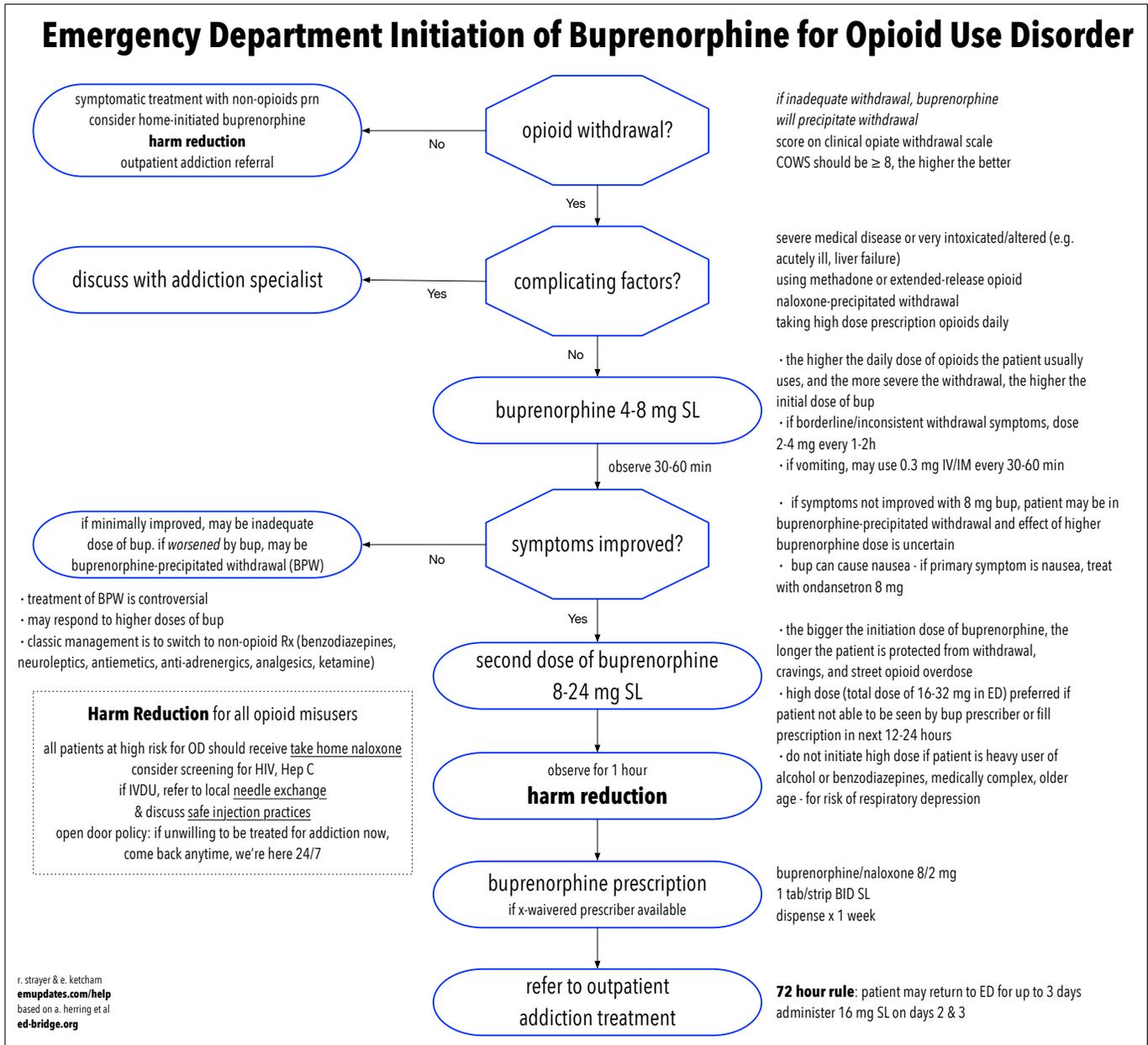
Strayer, R. ED Initiation of Buprenorphine Pathway: <https://emupdates.com/category/opioid-misuse/>

ED opioid misuse treatment map:

<https://emupdates.com/wp-content/uploads/2016/09/Opioid-Misuse-Treatment-Map-v4-NonLocalized.pdf>

ED initiation of buprenorphine: <https://emupdates.com/wp-content/uploads/2016/09/EDIB.png>

COWS: <https://www.mdcalc.com/cows-score-opiate-withdrawal>



<https://emupdates.com/wp-content/uploads/2016/09/EDIB.pdf>

## CASE 3: HARM REDUCTION IN OUD

### LEARNING OBJECTIVES

- Describe harm reduction strategies in OUD
- Apply motivational interviewing to promote behavior change

### OVERALL CASE PROGRESSION (20 MIN):

Physician briefing (2 minute)

Case Progression (6 minutes)

Debrief (12 minutes)

- Facilitator will start with “How do you feel” to allow physician a moment to exhale. If there are any issues the physician brings up, address them.
- Frame the debriefing to cover 2 major points.
  - Review strategies for motivational interviewing in the setting of addiction. Integrate SP feedback
  - Second, review harm reduction strategies
- Close by asking the physician with a lesson learned, or more aptly a skill they will integrate into their everyday practice to initiate harm reduction strategies for patients with OUD.
  - Advocate for practice change and review current operational systems in place

### SUPPLIES / MOULAGE

- Empty stretcher or chair for simulated patient

### CRITICAL ACTIONS

- Initiation of harm reduction strategies consistent (as presented by MMC opioid misuse treatment map or similar) (<https://emupdates.com/category/opioid-misuse/>)
- Use of motivational interviewing techniques

### FACILITATOR NOTES:

- Instruct learner that they are at a simulated patient (SP) station. They will be presented a scenario and are expected to interact with the SP as they would a real person in real life. Acknowledge that we can't make the scenario completely authentic as it would happen in the actual ED, ask them to do the best to “suspend disbelief”
- Give the learner the briefing document and allow them to ask any questions as needed.
- If during the case, the learner does not mention that family had previously called, please given them a prompt that the patient representative was just notified again that the family is on their way in the next hour, and to please “try to get him some help.”
- At the conclusion of the dialogue that covers discrepancy and self efficacy, if harm reduction strategies are not offered, please provide opioid misuse treatment map (e.g. clean needles, alcohol wipes, take home naloxone, peer recovery services, etc.)
- You can quietly observe the case from a corner of the room. At the end of the SP encounter, please state “**The encounter is now complete.**”

## SIMULATED PATIENT NOTES

### BACKGROUND

You have the medical disease of being addicted to heroin. You have been escalating your use recently. You do not know exactly how you arrived to the ED, but remember waking up with the paramedics from the ambulance. You were given Narcan (rescue drug for heroin overdose which reverses the effects of heroin) because you accidentally overdosed on heroin – you procured it from a different supplier and perhaps it was tainted. This was the second time this has happened this month. You mostly enjoy the way heroin makes you feel. In the past, your family has tried unsuccessfully to get you to quit. Your relationship with your family is important, and this addiction is causing strain with the family relationship.

Your experience the last time you were taken to the ED after accidental overdose was not positive. During the prior visit, you were not treated well, and essentially thrown out of the ED. Today, you were asked by an initial doctor in the triage area to stay to be observed for a bit longer to before that you are medically cleared as safe for discharge. You are skeptical, but agree to wait a little longer.

### CASE PROGRESSION (6 MINUTES)

Your assigned physician walks into the room, you will express a desire to leave, but would like some food first, e.g. “I haven't really eaten in past day and am starving”. You can be a little snarky and impatient – “and hurry it up, I don't have all day”.

You may be asked some other basic medical questions first:

- you have no other medical complaints
- you have no prior medical history
- you don't take any medications, though you use heroin regularly

The physician may ask some questions about your family, as they had called the hospital. That will be a prompt to share insight into your social history. Some points to cover include:

- Work history - have been doing odd jobs to make a little money, but haven't been able to hold down regular job. Previously worked at a restaurant, but you were laid off after you missed a few shifts related to heroin use.
- Living situation - You've been intermittently living with siblings as it's been difficult to keep a steady stream of income for your own place. Occasionally sleep in shelters when “I don't want to deal with the harassment about the drugs from my family”.

In order to progress the scenario once some of this information is elicited

- “I don't know why I'm telling you all this anyways, it's not like you care about me”, “once I get a tray of food, I'm out of here”.

If the physician doesn't mention anything about the family, the facilitator will provide a prompt that “the family called again and sounded really concerned, asking if we can do something to help.”

The goal is to have the physician engage in motivational interviewing to broach and initiate some form of addiction treatment. If not, the facilitator will prompt the doctor that the family has called again.

The physician is expected to be empathetic.

- If no empathy displayed (e.g. reflective listening, supportive dialogue, active listening), SP can state that “you really don’t care about me, do you”.
- If empathy is displayed, SP can state “This is the first time I’ve been in the ED and the doctor has actually listened to me”.

There are other strategies that are important to motivating you to change your behavior, including discrepancy and self-efficacy.

- If learner doesn’t make an attempt to develop discrepancy about family concern, SP can ask “what do you think will happen to the relationship with my family if I keep this up”
- If learner doesn’t make an attempt to support self-efficacy, SP can ask “Do you think I can quit, I tried once before and failed”

You will ultimately respond positively if above actions are taken, appreciate the feedback, and will “think about cutting back”. Maybe one day I’ll change my ways, in the meantime is there anything else I can do to not hurt myself?

The case should end once harm reduction strategies (e.g. safe injection practices, needle exchange) are offered. If no strategies are offered, the facilitator can provide OUD treatment map.

## PHYSICIAN BRIEFING

27-year old presents to ED after being found unresponsive and cyanotic with a heroin needle in his arm. He received 2 mg intravenous naloxone by EMS and is now agitated and requests to be discharged. Convinced by triage doc to be observed for a short while longer to ensure he doesn't become unconscious and stop breathing again. Prior to seeing patient, you get a message from patient rep that sibling called ED after being notified by police. They expressed significant concern as this is the second time in the past month patient overdosed and needed to be rescued by EMS with Narcan.

## REFERENCE MATERIAL

**Motivational interviewing** has been practical in focus. The strategies of motivational interviewing are more persuasive than coercive, more supportive than argumentative. The motivational interviewer must proceed with a strong sense of purpose, clear strategies and skills for pursuing that purpose, and a sense of timing to intervene in particular ways at incisive moments (Miller and Rollnick, 1991, pp. 51-52).

The clinician practices motivational interviewing with *five general principles* in mind:

1. Express empathy through reflective listening.
2. Develop discrepancy between clients' goals or values and their current behavior.
3. Avoid argument and direct confrontation.
4. Adjust to client resistance rather than opposing it directly.
5. Support self-efficacy and optimism

**Empathic** motivational interviewing establishes a safe and open environment that is conducive to examining issues and eliciting personal reasons and methods for change. A fundamental component of motivational interviewing is understanding each client's unique perspective, feelings, and values. Your attitude should be one of acceptance, but not necessarily approval or agreement, recognizing that ambivalence about change is to be expected. Motivational interviewing is most successful when a trusting relationship is established between you and your client. An empathic style:

- Communicates respect for and acceptance of clients and their feelings
- Encourages a nonjudgmental, collaborative relationship
- Allows you to be a supportive and knowledgeable consultant
- Sincerely compliments rather than denigrates
- Listens rather than tells
- Gently persuades, with the understanding that the decision to change is the client's
- Provides support throughout the recovery process

Another strategy to motivate change is to **develop discrepancy** between clients' goals or values and their current behavior. Your task is to help focus your client's attention on how current behavior differs from ideal or desired behavior. Discrepancy is initially highlighted by raising your clients' awareness of the negative personal, familial, or community consequences of a problem behavior and helping them confront the substance use that contributed to the consequences.

- Developing awareness of consequences helps clients examine their behavior.
- A discrepancy between present behavior and important goals motivates change.
- The client should present the arguments for change

You may occasionally be **tempted to argue** with a client who is unsure about changing or unwilling to change, especially if the client is hostile, defiant, or provocative. However, trying to convince a client that a problem exists or that change is needed could precipitate even more resistance. If you try to prove a point, the client predictably takes the opposite side. Arguments with the client can rapidly degenerate into a power struggle and do not enhance motivation for beneficial change.

**Resistance** is a legitimate concern for the clinician because it is predictive of poor treatment outcomes and lack of involvement in the therapeutic process. One view of resistance is that the client is behaving defiantly. Another, perhaps more constructive, viewpoint is that resistance is a signal that the client views the situation differently. This requires you to understand your client's perspective and proceed from there. Resistance is a signal to you to change direction or listen more carefully. Resistance actually offers you an opportunity to respond in a new, perhaps surprising, way and to take advantage of the situation without being confrontational.

Many patients do not have a well-developed sense of **self-efficacy** and find it difficult to believe that they can begin or maintain behavioral change. Improving self-efficacy requires eliciting and supporting hope, optimism, and the feasibility of accomplishing change. This requires you to recognize the client's strengths and bring these to the forefront whenever possible. Unless a client believes change is possible, the perceived discrepancy between the desire for change and feelings of hopelessness about accomplishing change is likely to result in rationalizations or denial in order to reduce discomfort. Because self-efficacy is a critical component of behavior change, it is crucial that you as the clinician also believe in your clients' capacity to reach their goals.

Self-efficacy in a nutshell:

- Belief in the possibility of change is an important motivator.
- The client is responsible for choosing and carrying out personal change.
- There is hope in the range of alternative approaches available

**Harm reduction** strategies include offering:

- take-home naloxone
- safe injection strategies
- an open-door policy of they ever want to be treated – return to the ED!
- offer pregnancy, Hep C and HIV screening
- ask about food or shelter insecurity
- all patients should be referred to comprehensive outpatient medication-based OUD treatment

References:

- Maimonides Specific Resources and Treatment Map
- [MQI Safer Injection Guide](https://drive.google.com/file/d/1371sBEYLAfvovFbC5PoZ2r-AtsS9DK-d/view) - <https://drive.google.com/file/d/1371sBEYLAfvovFbC5PoZ2r-AtsS9DK-d/view>
- Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1999. (Treatment Improvement Protocol (TIP) Series, No. 35.) Chapter 3—Motivational Interviewing as a Counseling Style. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK64964/>

# Emergency Care During an Opioid Addiction Epidemic

in withdrawal  
desires treatment for opioid addiction

exclusions from ED buprenorphine initiation on methadone  
on high dose (usually prescribed) opioids  
very intoxicated (with other substances)  
buprenorphine allergy

verifying adequate withdrawal is crucial  
*if inadequate withdrawal, buprenorphine will precipitate withdrawal*  
plug COWS into your favorite medical calculator  
COWS should be  $\geq 8$ , the higher the better

you do not need to be x-waivered to treat withdrawal with buprenorphine in the ED

buprenorphine 4-8 mg sublingual  
the higher the COWS, the larger the bup dose  
if unsure of withdrawal symptoms or borderline COWS, dose 2 mg q2h

observe in ED for 30-60 minutes  
provide sandwich

optional testing during buprenorphine initiation  
HCG, urine tox, LFTs, Hep C, HIV

if waived doc present, can d/c with prescription

if expected delay in accessing buprenorphine ( $\geq 24$ h), consider high dose initiation in consultation with addiction specialist

advise on dangers of etoh/benzo use while on bup

**refer to bup-capable provider/clinic**  
the smaller the ED buprenorphine dose, the tighter the followup has to be, esp if no Rx

## buprenorphine Rx

buprenorphine/naloxone 8/2 mg sublingual tabs  
1 tab SL bid—can dispense 6 to 14 tabs

if concern for suboxone abuse/diversion, can skip Rx or ↓ Rx  
(though suboxone safer than street opioids)

alternatively, **patient can return to ED** while awaiting followup: on days 2 and 3 dose 16 mg SL  
x-waiver not required to dose in ED on days 2&3  
however cannot continue beyond 3 days by law

in withdrawal  
does not desire treatment

consider buprenorphine initiation anyway  
alternative: methadone 10 mg IM  
can use non-opioid Rx but much less effective  
clonidine, NSAID, antiemetic, antidiarrheal  
haloperidol, ketamine

refer to ongoing addiction care

harm reduction (see box)

not in withdrawal  
does not desire treatment

engage, encourage to move to treatment

refer to ongoing addiction care

## Harm Reduction for all opioid misusers

all patients at high risk for OD should receive  
take home naloxone  
high risk for OD: prior OD, use of illicit opioids, high daily dose ( $>50$  MME), concurrent use of sedatives, recent period of abstinence, uses alone

if IVDU, encourage safe injection practices and refer to local needle exchange/safe injection site  
Do you lick your needles?  
Do you cut your heroin with sterile water?  
Do you discard your cotton after every use?  
Do you inject with other people around?  
Do you do a tester shot to make sure a new batch isn't too strong?

open door policy: if unwilling to be treated for addiction now, return anytime, we're here 24/7

not in withdrawal  
desires treatment for opioid addiction

if waived doc present, can prescribe buprenorphine for home initiation

alternatives:  
return to ED when withdrawing  
hold in ED to await withdrawal

refer to bup-capable provider/clinic

## Priorities for Emergency Care

### Prevent opioid-naive patients from becoming misusers by your prescription

calculate benefit:harm whenever an opioid prescription is considered, and if opioid Rx, prescribe small # of low dose, lower-risk pills

Immediate Release Morphine Sulfate (MSIR)  
15 mg tabs, 1 tab q4-6h prn pain, disp #9

Willing: **"I have a problem, I need help"**  
aggressive move to treatment  
ED-initiated buprenorphine  
arranged speciality followup

Revealed, unwilling: **"I overdosed"**  
harm reduction (see box)  
supportive stance, open door

Partially revealed: **"I have chronic pain and need meds"**  
avoid opioids in ED or by prescription  
opioid alternatives for pain  
express concern that opioids are causing harm

Unrevealed: **"I have acute pain and need meds"**  
risk stratify with red & yellow flags  
PDMP - move positives to willingness  
if low risk, treat as opioid-naive  
if high risk, treat as partially revealed

reuben j. strayer · @emupdates · [emupdates.com/help](http://emupdates.com/help)

<https://emupdates.com/wp-content/uploads/2018/03/Emergency-Care-in-an-Epidemic.pdf>

PRE-SESSION WORKSHEET

Name:

Date:

Indicate your gender:    Male    Female    Other

1) Based on your past experiences, how does it make you FEEL to interact with ED patients who are or could be misusing opioids?

2) How do you currently counsel patients who receive an opioid prescription?

3) How do you currently manage patients in acute opioid withdrawal?

4) How do you currently manage patients who have been revealed to have an opioid use disorder, but not active withdrawal?

5) How do you currently approach teaching opioid stewardship to trainees (e.g. students, residents, etc.)?

6) What have been your preferred opioids to prescribe for outpatient prescriptions. *Select all that apply:*

- Oxycodone (e.g. Percocet)
- Morphine
- Codeine
- Hydrocodone (e.g. Vicodin)
- Tramadol (e.g. Ultram)
- Hydromorphone (e.g. Dilaudid)

7) Which of the following do you feel are true about buprenorphine (“Bupe”)? *Select all that apply:*

- Getting a DEA X waiver to prescribe Bupe is not worth the effort
- Providing Bupe will result in diversion for the purpose of abuse
- Initiating Bupe in the ED will increase length of stay
- Initiating Bupe is too complicated in an already chaotic and crowded ED
- Patients getting Bupe in the ED will come back to the ED repeatedly

8) Which of the following ED based interventions REDUCE the likelihood of opioid misuse? *Select all that apply:*

- Prescribing buprenorphine to patients with opioid addiction
- Prescribing opioids when feasible non-opioid alternatives exists
- When there are no feasible non-opioid alternatives, limiting the quantity of opioid pills prescribed
- When there are no feasible non-opioid alternatives, preferentially prescribing opioids that cause less euphoria
- Co-prescribing of benzodiazepines
- Avoiding opioids for one-time analgesia in ED patients suffering from severe pain

POST-SESSION WORKSHEET

Name:

Date:

1) Which of the following do you feel are true about buprenorphine (“Bupe”)? *Select all that apply:*

- Getting a DEA X waiver to prescribe Bupe is not worth the effort
- Providing Bupe will result in diversion for the purpose of abuse
- Initiating Bupe in the ED will increase length of stay
- Initiating Bupe is too complicated in an already chaotic and crowded ED
- Patients getting Bupe in the ED will come back to the ED repeatedly

2) Which of the following ED based interventions **REDUCE** the likelihood of opioid misuse? *Select all that apply:*

- Prescribing buprenorphine to patients with opioid addiction
- Prescribing opioids when feasible non-opioid alternatives exists
- When there are no feasible non-opioid alternatives, limiting the quantity of opioid pills prescribed
- When there are no feasible non-opioid alternatives, preferentially prescribing opioids that cause less euphoria
- Co-prescribing of benzodiazepines
- Avoiding opioids for one-time analgesia in ED patients suffering from severe pain

3) Moving forward, please indicate your preferred opioids to prescribe for outpatient prescriptions. *Select all that apply:*

- Oxycodone (e.g. Percocet)
- Morphine
- Codeine
- Hydrocodone (e.g. Vicodin)
- Tramadol (e.g. Ultram)
- Hydromorphone (e.g. Dilaudid)

4) After this session, have your feelings about treating patients who misuse opioids changed (if yes, please describe)

5) How will you improve your approach counseling patients who receive an opioid prescription?

6) How will you improve your approach in managing patients in acute opioid withdrawal?

7) How will you improve your approach in managing patients who have been revealed to have an opioid use disorder, but not active withdrawal?

8) How will you improve your approach in teaching opioid stewardship to your trainees (e.g. residents, students, etc.)?

9) Please provide any suggestion on how we can provide opioid stewardship from a systems-based perspective in our department (e.g. order sets, pain pathways, restricting use of certain medications, create outpatient referral pathways, CDU pathways, leverage ED navigators to screen for OUD, etc.):

## Promoting Opioid Stewardship in the ED

### *Anonymous Post-Course Survey*

How effective was the session in highlighting strategies to promote good prescribing practices?

<input type="radio"/>				
Not at all Effective	Slightly Effective	Moderately Effective	Quite Effective	Extremely Effective

How effective was the session in teaching best practices around education to patients who require a short course of opioids?

<input type="radio"/>				
Not at all Effective	Slightly Effective	Moderately Effective	Quite Effective	Extremely Effective

How effective was the session in highlighting strategies to minimize harm in patients who have an opioid use disorder?

<input type="radio"/>				
Not at all Effective	Slightly Effective	Moderately Effective	Quite Effective	Extremely Effective

How effective was the session in highlighting strategies for buprenorphine use?

<input type="radio"/>				
Not at all Effective	Slightly Effective	Moderately Effective	Quite Effective	Extremely Effective

How effective was the session to improve your motivational interviewing techniques in patients abusing opioids?

<input type="radio"/>				
Not at all Effective	Slightly Effective	Moderately Effective	Quite Effective	Extremely Effective

How effective was the acting of the simulated patient instructors?				
○	○	○	○	○
Not at all Effective	Slightly Effective	Moderately Effective	Quite Effective	Extremely Effective

Good focused feedback reinforces good and gives advice on the bad. Overall, how effective were the SPs in providing feedback?				
○	○	○	○	○
Not at all Effective	Slightly Effective	Moderately Effective	Quite Effective	Extremely Effective

A good debrief enhances knowledge and reflection; provides clear and constructive feedback; and is a dialogue rather than a lecture. Overall, how effective were the faculty instructors in debriefing?				
○	○	○	○	○
Not at all Effective	Slightly Effective	Moderately Effective	Quite Effective	Extremely Effective

<h2 style="margin: 0;">Promoting Opioid Stewardship in the ED</h2> <p style="margin: 0;"><i>Anonymous Post-Course Survey</i></p>
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