
TXOTI Podcast Packet

Podcast Episode

Training the Team: Simulation in SUD Education

Host / Moderator

Lindsey Loera, PharmD

PhARM Program, The University of Texas at Austin College of Pharmacy

Guests

Jane Gray, PhD

The University of Texas at Austin

Brian Fasolka, PhD, RN, CEN

New York University, Rory Meyers College of Nursing

Learning Objectives

- Describe the role of simulation-based learning in interprofessional substance use disorder (SUD) education and training.
- Explain key design elements of effective interprofessional simulation experiences.
- Identify opportunities and challenges in using simulation for opioid and other SUD training.
- Describe practical strategies for developing or enhancing interprofessional simulation experiences in educational and clinical training settings.

The Big Three questions this episode will address for the listener

1. What does simulation-based learning contribute to interprofessional SUD education that other teaching methods do not offer?
2. What are the essential elements of an effective interprofessional simulation for SUD care?
3. What should educators know before implementing simulation-based training in interprofessional education program?

Moderator Questions**Panelist Answer Key**

(JG) Jane Gray, PhD

(BF) Brian Fasolka, PhD, RN, CEN

About simulation learning

What does simulation-based learning allow us to teach that traditional classroom learning cannot?

- (JG) Simulation gives the learner a hook to hang their knowledge on. By providing a realistic scenario to apply the emerging expertise of students in the health professions, they get closer to a real-world clinical scenario. After leading an interprofessional training program for over 10 years, I have seen and heard from learners that experiential exercises are most beneficial to their learning. It is the most frequent piece of feedback on our surveys following didactics/workshops. The other is that interacting with peers from different disciplines is incredibly helpful, at times it has been cited as the most helpful part of our program. And it

makes sense that directly practicing skills, applying new knowledge, in an interprofessional arena, can help people learn so much more than they would listening to new information in a classroom.

- (BF) Simulation-based learning offers multiple benefits for learners in healthcare programs, especially in pre-licensure nursing where most or all of the clinical experiences need to be completed in just 2 or even a 1-year timeframe.
- (BF) The learning in a high-fidelity simulation is often high level – hitting the domains of application, analysis, and synthesis. These domains that can be difficult to reach in a traditional classroom.
- (BF) Simulation offers a way to ensure standardization to all of our students. In a clinical setting we can never ensure that all of our students will have an experience caring for a patient with a particular need or diagnosis. It is even more challenging to ensure students experience those “high-risk, low frequency” events at a clinical setting, and in those circumstances the clinical site is often reluctant to let students do more than observe (for understandable reasons).
- (BF) Simulation offers our students opportunities to lead patient care and make critical decisions, without risking harm to any patients. Our students can learn so much by using their own clinical judgment, including learning from their mistakes. Allowing a student to make a mistake is safe in a simulation. The students are never shamed, but rather learn in an environment with ensured psychological safety.
- (BF) The real-time debriefing in simulation is priceless. Especially, the feedback students receive from standardized patients. I absolutely love it in debriefing when the SP exits their patient role, and gives the student feedback about how they felt as the patient under the student’s care. This level of feedback is so powerful.

Describe the role of simulation-based learning in interprofessional education.

- (JG) Simulation in education isn’t a new concept and is widely implemented in many professions, especially nursing. In fact there are entire journals devoted to simulation education (e.g. Simulation in Healthcare, Clinical Simulation in Nursing) and a professional organization devoted to simulation education (Society for Simulation in Healthcare). More recently there has been attention to providing simulation activities for learners of different professions and it’s proving to be quite effective, there are already meta-analyses demonstrating simulation enhances knowledge, although we have yet to see good data/results in terms of other outcomes (e.g. patient outcomes) (Saragih et al 2024).
- (BF) So often healthcare students learn in silos, and that’s just not how the healthcare system works. As an RN for over 20 years, I have never once worked a clinical shift without collaborating with other healthcare professionals. Yet sometimes students graduate from their nursing program without ever actually speaking to a physician, a pharmacist, or any other non-nursing licensed professional in a clinical setting. Then we wonder why interprofessional collaboration is a challenge for newly licensed nurses.
- (BF) Much of the information our students learn is the same across different types of healthcare programs. What’s different is the role that a specific profession offers to the collaborative team approach. Applying this in a simulation setting, allows different types of healthcare students to learn with each other, while concurrently learning about each other’s roles and expertise.

Essential elements of an effective interprofessional simulation for SUD care

Walk us through your simulation activity: What’s the scenario and what are learners doing?

- (JG) Our simulation follows a 17 year old boy named Sam who had an inpatient admission after an accidental overdose. Sam has a history of anxiety and suffered panic attacks, and received medication (a benzodiazepine) from a friend that ended up containing fentanyl. The learners in the simulation are from a range of health professions, including but not limited to nursing, social work, psychology, pharmacy, medicine, public health. They receive some information orienting them to youth substance use and interprofessional communication in the form of short theory bursts. They also receive some chart notes from Sam's inpatient visit, and later in the simulation, his outpatient notes. They are responsible for developing a plan on the outpatient side for Sam and his family and addressing a challenge that comes in after a few encounters at the outpatient clinic.
- (BF) Learners in our scenario included 6th year pharmacy students and 2nd semester baccalaureate nursing students (enrolled in an upper-division 4 semester professional nursing program). All nursing students were currently enrolled in their psychiatric nursing course. The simulation had 2 phases.
- (BF) Phase 1 was the patient presenting to the ED with continued lower back pain after an MVC 2 weeks prior. The patient had been previously seen in the ED immediately after the MVC and also was evaluated by their PCP for continued low back pain. The patient finished their 10-day supply of oxycodone/acetaminophen 5mg/325mg in just 5 days. The patient was previously prescribed an SNRI for depression, but reported stopping that several years prior.
- (BF) In phase 2, the same patient presents to the ED again 6 months later for chronic low back pain. Patient reports being prescribed oxycodone 10mg from a different PCP after the previous ED visit. The patient states they are out of oxycodone and need a refill. The patient is exhibiting signs of opioid withdrawal. In phase 2 the patient reports that they are now unemployed after having lost their job as an RN due to opioid diversion. The patient also has significant financial stressors as they were the sole income for their family.

What decisions do learners have to make?

- (JG) The learners are from various health professions that can be relevant for a shorter list of clinic "roles" including care coordinator, primary care provider, behavioral health therapist, and psychiatric medication provider. In these roles, the learners contribute to an initial treatment plan. Further along in the simulation, they collaborate to resolve a challenge that comes up in the family and develop a plan for how to address it. They are also responsible for one practice change – a commitment to something they will do differently or learn more about in the future in their clinic role. For example, the behavioral health therapist may commit to further continuing education on youth substance use, and more regular screening of all therapy patients.
- (BF) The nursing and pharmacy students are expected to collaboratively:
 - Complete a comprehensive patient assessment -including the COWS assessment in phase 2
 - Review a simulated prescription monitoring program website
 - Develop a comprehensive plan of care to recommend to the simulated EM physician
 - Provide appropriate patient education to the SP

Where does teamwork show up

- (JG) Mostly captured above, but to add – the learners will receive specific instruction on communicating with psychological safety in interprofessional teams. They will also be asked to

ask one question of another team member. For example, the behavioral health therapist may ask the psychiatric medication provider about the risks and benefits of different medications to manage anxiety.

- (BF) Teamwork shows up throughout the simulation and again during the debriefing. Nursing students and pharmacy students realize that they each have strengths and limitations in this complex situation. For example, the pharmacy students were very familiar with the prescription monitoring programs in New York State.

What makes it feel realistic

- (JG) Our simulation is conducted virtually and does not include a standardized patient. It is entirely focused on a vignette that unfolds throughout the course of a half day activity, with team discussions in breakout rooms. We assembled a team of experts to create the simulation, including the vignette details, the chart notes, and the cheat sheets that we will give to learners to describe their role on the team. The expert panel creating the simulation includes folks who train, conduct research, and work directly with the community. We have been refining the vignette over a series of meetings this spring, and each time pause to ask ourselves from each perspective if the vignette seems realistic. We know that opioid use in adolescents is very rare but increasingly deadly, and that most folks who are misusing opioids obtain them via prescription or from a friend/family member.
- (BF) The simulated scenarios took place in our nursing clinical simulation lab, which provides an environment that is physically realistic appearing. Additionally, our SPs are fantastic actors who completed training specific to this scenario prior to the simulation day.

(BF) Brian Fasolka

- **What was the focus of your team's simulation?**
 - The focus of our simulation was interprofessional, evidenced-based care for the patient experiencing (and at risk for) opioid use (misuse) disorder.
 - While this was not specific outcome of the scenario, having a simulated patient who was also a nurse was an intentional detail added to address the stigmatization often associated with opioid use disorder.
- **What outcomes were you targeting?**
 - Best practices regarding safe prescribing of opioids and use of opioid monitoring systems.
 - Effective interprofessional communication and collaboration.
 - Effective patient education that avoided any profession-specific or stigmatizing language.
- **What did you learn from implementing and studying this simulation?**
 - Findings from this simulation indicate that sim-IPE is an effective teaching strategy to improve teamwork, collaboration, and communication among nursing and pharmacy students.
 - We learned that with the appropriate resources and time, it is possible to organize and successfully implement a sim-IPE even with a large group of students.

(JG) Jane Gray

- **What are you aiming to build with the adolescent opioid use disorder (OUD) simulation?**
 - For my project, we are fortunate to have grant funding to support the project, and the grant is entirely focused on behavioral health workforce development, and specifically building a workforce that is more competent in addressing opioid use in youth. So my primary goal is to achieve this objective. In psychology specifically, our trainees are sorely underprepared to screen for, prevent, and treat substance use generally in youth, and especially opioid use. Creating this simulation, I am also hoping to inspire learners from all professions to lean into collaboration and effective communication with one another. Even with recent efforts to ramp up integrated health, our system still suffers from fragmentation. The more we can instill a value for integrated care early in training, the better off patients will be down the road.
- **What makes this population and scenario important for interprofessional training?**
 - Mostly captured in the response above, but to add – we feel adolescence is so important because most adults who have a substance use disorder began using substances during their teen or young adult years (CDC, 2022). Although there have been some decreases in local drug use in adolescence, accidental deaths with fentanyl detected has jumped from 22 deaths in 2019 to 279 deaths in 2023. According to the Travis County Medical Examiner’s office, 14 teens died from accidental overdose in 2023, a number that has been steadily increasing over the last three years. Furthermore, although the prevalence of Texas students reporting opioid use is relatively low, the average age of first use is shockingly young, at 11 years old (Marchbanks et al, 2024). Texas ranks #2 in the nation as far as children ages 12-17 who reported using illicit drugs (SAMSHA, 2022).
 - In terms of interprofessional training, this issue really requires to whole team. Taking Austin, for example – we are especially underserved when it comes to resources to address substance use in youth. The only treatment options for publicly funded youth are large public mental health organizations that serve a myriad of needs and have long waiting lists. The only specialized substance use treatment program (Phoenix House) lost its funding for direct treatment, although the organization still exists and provides prevention programming. So this issue requires for everyone to be on board, looking out for teens and screening and prevention is crucial. We can’t have learners starting their careers afraid to ask kids these important questions, especially since our treatment options down the road are so scarce.
- **What makes opioid-related harm (especially in the adolescent population) challenging to simulate well**
 - (JG) I think the rarity of opioids makes it hard to simulate, in terms of reaching the target of being realistic. It is also hard to keep the simulation within the limits of competence and prior knowledge of our learners, given that most training programs don’t have a ton of preparation on the topic.

Looking at the simulation you just described, what design choices were most important to making it effective?

- (JG) We are giving a lot of thought to bringing the deliverables within what is realistic and can be successful for a wide range of prior knowledge and experience. For example, we gave a lot of thought to the “escalating scenario” and tried to choose something that would be familiar to them in content (parents disagreeing about treatment plan) and applied to a new content area.

- (BF) Given the large volume of learners, this simulation relied on the assumption that observation can still be a valuable learning strategy in simulation. Half of the learners watched simulcasts of the phase 1 simulation in large classrooms. Then during phase 2, the learners switched. Phase 1 active participants watched phase 2 as a simulcast in a large classroom.
- (BF) This simulation required significant support from faculty from both nursing and pharmacy. Faculty facilitators were needed in the simulcast rooms, and each of the 5 rooms running the simulations.

Was there anything that didn't work the first time around?

- (BF) This simulation required students to complete an online module on opioid use disorder prior to the simulation. However, no mechanism was in place to ensure that every learner completed it prior to their participation in the simulation.

What had to be adjusted after running the simulation?

- (JG) (TBD – we have not launched yet) – but my prior experience with prior simulations was that we had to be very clear and specific with the information given to learners especially in terms of their roles and expectations, and we had to cut the length of the simulation, especially in virtual format.

Practical Strategies

What is one piece of advice you have for educators looking to implement simulation-based learning in their SUD teaching?

- (JG) Bring together an interprofessional team to create the simulation, and leave room for ongoing quality improvement. Bring in student perspective early (e.g. via a student member of the team or research assistant).
- (JG) Having a source of funding helps, particularly to support the time of busy faculty and clinicians who are creating and implementing the activity.
- (JG) Build requirements for participation into courses, training programs, etc to encourage participation from learners. Optional activities are often sorely under-attended.
- (BF) Anyone writing, facilitating, or participating in a simulation-based learning about SUD should be familiar with NIDA terminology guidance. The stigmatization associated with SUD is still so common, including among healthcare professionals. Faculty facilitating this type of simulation need to set an example for learners, and correct any learners who use demeaning or stigmatizing language during a simulation-based learning experience. That being said, it is better to correct that language in simulation rather than in a clinical setting.

Where should programs start if they want to incorporate simulation into their curriculum, whether within a single discipline or across professions?

- (JG) I would start with determining the need/market for such an activity by bringing the idea to colleagues from other disciplines (if it's an interprofessional activity) and seeking funding (or at least determining feasibility with current time and other resources).
- (BF) Programs wishing to incorporate simulation into their curriculum should follow evidence-based guidelines, such as the International Nursing Association for Clinical Simulation and Learning (INACSL)'s *Healthcare Simulation Standards of Best Practice*. It is important to know that planning a high-quality simulation requires a significant amount of planning and preparation and cannot just be implemented overnight.

- (BF) When planning an interprofessional simulation, it is important to know that the logistics and planning become even more complex. Different programs often run on different academic calendars, students might be based on different campuses, and these factors can make logistics a real challenge. IPE programs, such as the one I described, can be very difficult to maintain over time. There are also evidence-based competencies for IPE education; we used the Interprofessional Education Collaborative (IPEC) competencies as the framework for our sim-IPE.

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