





Association of Pain Program Directors: 2016

Bryan Hoelzer M.D.
President-elect: Association of Pain Program Directors






Disclosures

- None


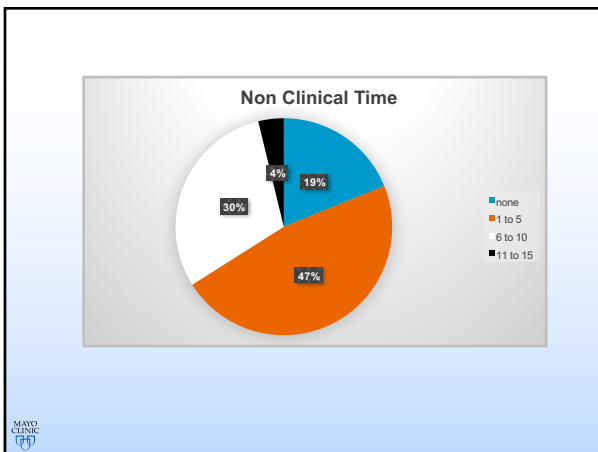



Objectives

- Review the 2017 match
- Review the Pain Medicine ACGME Program requirements for Medical Knowledge competencies
- List the Medical Knowledge Competencies. IV.A.5.b) to IV.A.5.b).(4).(n)
- Identify area where Program Directors have weaknesses in their Curriculum
- Introduce the website content being developed by the APPD
- Simulation is Pain Fellowship training





Year	Programs	Positions	Filled	% not matched	%US Grad	US FMG	Osteo	Inter'l
2014	82	261	256	36	73	8	9	10
2015	84	286	286	27	69	9	14	7
2016	90	305	303	37	71	10	14	5
2017	93	316	309	23	70	9	15	6

Future Directions of APPD?

- Ranked as Very Important
- Access to Educational Content (70%)



Introducing a Pain Medicine Fellowship Educational Resource:

The Association of Pain Program Directors' New Website

Scott Brancolini, MD, MPH

Assistant Professor
 Program Director, Pain Medicine Fellowship
 Board Member, APPD
 University of Pittsburgh Medical Center
 Department of Anesthesiology/Pain Medicine Division
 SAAA – 11/11/16
 AASPD Pain Medicine Fellowship Breakout Session

ACGME Competencies

- Practice Based Learning and Improvement
- Systems Based Practice
- Professionalism
- Interpersonal Skill and Communication
- Patient Care
- **Medical Knowledge**

Pain Medicine ACGME Medical Knowledge Competencies

- https://www.acgme.org/Portals/o/PFAssets/ProgramRequirements/530_pain_medicine_2016_1-YR.pdf
- **IV.A.5.b) Medical Knowledge**
- **Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.**

Dear Colleagues, Don't Worry.

- I promise I will not read aloud all of the following items.
- Hang on for a few slides, my point is coming soon!

ACGME Pain Medicine Competencies

- IV.A.5.b).(1) assessment of pain
- IV.A.5.b).(1).(a) anatomy, physiology and pharmacology of pain transmission and modulation
- IV.A.5.b).(1).(b) natural history of various musculoskeletal pain disorders
- IV.A.5.b).(1).(c) general principles of pain evaluation and management including neurological exam, musculoskeletal exam, psychological assessment
- IV.A.5.b).(1).(d) indicators and interpretation of electro-diagnostic studies: X-Rays, MRI, CT, and clinical nerve function studies
- IV.A.5.b).(1).(e) pain measurement in humans, both experimental and clinical

ACGME Pain Medicine Competencies

- IV.A.5.b).(1).(f) psychosocial aspects of pain, including cultural and cross-cultural considerations
- IV.A.5.b).(1).(g) taxonomy of pain syndromes
- IV.A.5.b).(1).(h) pain of spinal origin, including radicular pain, zygapophysial joint disease, and discogenic pain
- IV.A.5.b).(1).(i) myofascial pain
- IV.A.5.b).(1).(j) neuropathic pain

ACGME Pain Medicine Competencies

- IV.A.5.b.(1).(k) headache and orofacial pain
- IV.A.5.b.(1).(l) rheumatological aspects of pain
- IV.A.5.b.(1).(m) complex regional pain syndrome
- IV.A.5.b.(1).(n) visceral pain
- IV.A.5.b.(1).(o) urogenital pain
- IV.A.5.b.(1).(p) cancer pain, including palliative and hospice care

ACGME Pain Medicine Competencies

- IV.A.5.b.(1).(q) acute pain
- IV.A.5.b.(1).(r) frequent psychiatric and pain co-morbidities, which include substance-related mood, anxiety, somatoform, factitious, and personality disorders
- IV.A.5.b.(1).(s) the effects of pain medications on mental status
- IV.A.5.b.(1).(t) assessment of pain in special populations, including patients with ongoing substance abuse, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired
- IV.A.5.b.(1).(u) functional and disability assessment

ACGME Pain Medicine Competencies

- IV.A.5.b.(2) treatment of pain
- IV.A.5.b.(2).(a) Drug Treatment I: opioids
- IV.A.5.b.(2).(b) Drug Treatment II: antipyretic analgesics
- IV.A.5.b.(2).(c) Drug Treatment III: antidepressants, anticonvulsants, and miscellaneous drugs
- IV.A.5.b.(2).(d) psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy, psychosocial therapies and treatment of psychiatric illness
- IV.A.5.b.(2).(e) prescription drug detoxification concepts
- IV.A.5.b.(2).(f) functional and vocational rehabilitation
- IV.A.5.b.(2).(g) surgical approaches

ACGME Pain Medicine Competencies

- IV.A.5.b.(2).(h) complementary and alternative treatments in pain management
- IV.A.5.b.(2).(i) treatments that comprise multidisciplinary cancer pain care
- IV.A.5.b.(2).(j) strategies to integrate pain management into the treatment model
- IV.A.5.b.(2).(k) hospice and multidimensional treatments that comprise palliative care; and
- IV.A.5.b.(2).(l) treatment of pain in pediatric patients
- IV.A.5.b.(3) general topics, research, and ethics; including

ACGME Pain Medicine Competencies

- IV.A.5.b.(3).(a) epidemiology of pain
- IV.A.5.b.(3).(b) gender issues in pain
- IV.A.5.b.(3).(c) placebo response
- IV.A.5.b.(3).(d) multidisciplinary pain medicine
- IV.A.5.b.(3).(e) organization and management of a pain center
- IV.A.5.b.(3).(f) Continuing Quality Improvement, Utilization Review, and Program Evaluation
- IV.A.5.b.(3).(g) patient and provider safety

ACGME Pain Medicine Competencies

- IV.A.5.b.(3).(h) designing, reporting, and interpreting clinical trials of treatment for pain
- IV.A.5.b.(3).(i) ethical standards in pain management and research
- IV.A.5.b.(3).(j) animal models of pain, ethics of animal experimentation
- IV.A.5.b.(4) interventional pain treatment, including
- IV.A.5.b.(4).(a) selection criteria for a broad range of interventions and an understanding of the risks and potential advantages of these interventions
- IV.A.5.b.(4).(b) airway management skills
- IV.A.5.b.(4).(c) sedation/analgesia

ACGME Pain Medicine Competencies

- IV.A.5.b).(4).(d) fluoroscopic imaging and radiation safety
- IV.A.5.b).(4).(e) pharmacology of local anesthetics and other injectable medications, including radiographic contrast agents and steroid preparations
- IV.A.5.b).(4).(e).(i) This must include treatment of local anesthetic systemic toxicity
- IV.A.5.b).(4).(f) trigger point injections
- IV.A.5.b).(4).(g) peripheral and cranial nerve blocks and ablation
- IV.A.5.b).(4).(h) spinal injections including epidural injections: interlaminar, transforaminal, nerve root sheath injections, and zygapophysial joint injections

ACGME Pain Medicine Competencies

- IV.A.5.b).(4).(i) discography and intradiscal/percutaneous disc treatments
- IV.A.5.b).(4).(j) joint and bursal injections, including sacroiliac, hip, knee, and shoulder joint injections
- IV.A.5.b).(4).(k) sympathetic ganglion blocks
- IV.A.5.b).(4).(l) epidural and intrathecal medication management
- IV.A.5.b).(4).(m) spinal cord stimulation
- IV.A.5.b).(4).(n) intrathecal drug administration systems

THAT'S A LOT OF WORDS.
THAT'S A LOT OF CONTENT.

- Wouldn't it be nice to not have to worry about this?
- We are here to help!

The APPD Website

- <http://www.appdhq.org/>
- New educational content design
 - Lectures comprised to satisfy all ACGME Pain Medicine Medical Knowledge Competencies
 - Maximize fellow education
 - Eliminate concern for not fulfilling ACGME requirements for site visits
 - A joint national effort

The APPD Website

- Thank you to all contributors.
- We request with your kind permission to use some of your slides for the new content.
- It's ok to say no.
- But your cooperation would be great appreciated!
- All credit will be given when your slides are used.

Where we are...

APPD Website- Educational Content Upgrade Project 2016-2017						Key to content
Scott Brumfield, MD, MPH, Program Director, Assistant Professor, CPAC Pain Medicine Fellowship						Lectures completed
http://www.acgme.org/Portals/0/PDFs/ProgramRequirements/2016_pain_medicine_program_4_18.pdf						No content
						Block but lacking content
						Block - some fully partial content, not yet started
# ACGME Medical Knowledge Competency	Content Module Content	Content Number?	Author			Block/complete
1. Anatomy, physiology and pharmacology of pain transmission/Pathology of Cervical and Lumbar Spine and neck/Head	Cervical Anatomy Spinal Cord Introduction Sympathetic Ganglion Blocks Intrathecal Pain	Mean 40427	Huckler			Done
2. Natural history of various musculoskeletal pain disorders: mechanical pain, and trigger point injections	Myofascial Pain	No	Argente, Argente, Bransford			Done
3. General principles of pain evaluation and management including nonpharmacologic, musculoskeletal, chronic, psychological assessment	Lumbar Spine Intervention	No	Bransford, Walcutt			Done
4. Indications and interpretation of electrodiagnostic studies: Pathology of Cervical and Lumbar Spine, EMG, CE, and clinical neurophysiology	Cervical Anatomy	Mean 40427	Bransford, Walcutt			Done
5. Pain measurement in animals and humans, both experimental/Animal Models of Pain and clinical, placebo response	Yes - for human models and placebo		Bransford, Walcutt			Animal portion completed.
6. Psychological aspects of pain, including cultural and cross-cultural considerations	Psychology in Chronic Pain	Yes - ongoing content and cross-cultural considerations	Bransford, Pothman			Psychology portion completed.

Taxonomy of pain syndromes	Nothing specific	No	Essential	Done
Pain of spinal origin, including radicular pain, myofascial pain disorders, and neuropathic pain	Spinal Diagnosis, Lumbar Spine Interventions	More detail?	Essential, Moderate, Weak	Done
Neurospinal pain & Post-Surgical Numb Pain	Neurospinal Pain, Post-Surgical Numb Pain	No	Essential, Moderate, Weak	Done
Headache and orofacial pain	Headache and Facial Pain, Temporomandibular Joint	No	Essential, Weak	Done
Rheumatological aspects of pain	Nothing	Yes	Essential	done
Complex Regional Pain Syndrome	CRPS 1 & 2	No	Essential	done
Visceral Pain	Thoracic and Abdominal Pain	Yes	Essential - abdominal pain	
Chronic Pain	Thoracic and Abdominal Pain	Yes, need longitudinal pain research	Essential	
Cancer Pain including Palliative and hospice care, and end-of-life care	Cancer Epidemiology, Cancer Pain Interventions	Yes, need palliative, hospice, and end-of-life care research	Essential - cancer related	
Acute pain	Nothing	Yes	Essential	done
Emergent psychiatric and pain comorbidities, which include substance use disorders, anxiety, depression, delirium, and personality disorders	Psychiatric Pain, Substance Abuse	Yes, need personality disorder and anxiety content	Essential	
Special populations - Geriatrics and Gender	Geriatric Pain	Yes, gender related	Essential	
Special populations - Opioid Use/Abuse	Substance Abuse	No	Essential	
Special populations - Pediatrics	Nothing	No	Essential, Pediatric	
Special populations - Physically disabled and cognitively impaired	Nothing	Yes	Essential	
Functional and disability assessment	Nothing	Yes	Essential	
Opoids	Opoids, Medication	No	Essential	
NSAIDs and Acetaminophen	Long-Term Opioid Therapy for CNMP	Yes	Essential	
Antidepressants	Neurobiology of Chronic Pain, SSRIs, SNRIs, and Opioids	No	Essential - additional antidepressant	
Anticonvulsants	Nothing	Yes	Essential	Done
Psychological and psychiatric approaches to treatment including cognitive behavioral therapy, psychosocial therapies and treatment of psychiatric illness	Psychology in Chronic Pain, Pain Psychology	Yes, nothing more specific about psychologic treatments	Essential	
Prevention drug utilization strategies	Nothing	Yes	Essential	
Functional and vocational rehabilitation	Nothing	Yes	Essential	
Surgical Approaches	Basic Surgical Skills	Yes, more information and procedures	Essential - necessary/surgical skills	
Complementary and alternative treatments in pain	Nothing	Yes	Essential	

Organization and management of a pain center and interdisciplinary pain medicine	Nothing	Yes		
Other: pain management, research, and clinical epidemiology	Nothing	Yes		
Pharmacology imaging and radiation safety	Radiology of Cervical and Lumbar Spine	Yes - radiation safety	Essential - Fluoroscopy images	
Local Anesthetics and treatment of toxicity	Cervical Spine Anatomy	Yes	Essential	Done
Radiofrequency contrast agents and steroid preparation	Nothing	Yes	Essential before	
Spinal Injection: IDE, TENS, Nerve root Block, Zygoparal	Lumbar Spine Intervention	Yes, TENS, zygoparal	Essential, Research before on all other	
Diagnosis and interventional/percutaneous disc treatment	Cervicalization of Interventional Pain Procedures	Yes, per disc needed	Essential	
Joint and neural injections, including cervical, hip, knee, and lumbar spine intervention		Yes, need hip, knee, shoulder details	Done - Most details reviewed	
Sympathetic ganglion blocks	Sympathetic Ganglion Blocks			
Epidural and intrathecal medication management, intrathecal IDE, Part 1, IDE, Part 2, IDE, Opioid delivery systems	Pharmacology, IDU, Transdermal drug	No		
Spinal cord stimulation	Spinal Cord Stimulation	No		


The APPD Website Future

- Key word database
- Resources materials
- Videos of pain procedures
- Audio recorded lectures
- A way to build your CV for promotion
- Possible peer reviewed publication

Thank you!

- Please contact me if you are interested
- Please refer to your handout

• brancolinisa@upmc.edu




Simulation in Pain Medicine Training

Bryan Hoelzer M.D.

Objectives

- Creating a positive learning environment
- Why do simulation
- Picking scenarios
- Set-up tips



Create the Right Environment

- Outline the positive benefits of the exercise
- Emphasize that the point is improvement NOT measurement
- Share the feelings you have had during simulation exercises



Why do Simulation?



What are my fellows **thinking** and how will they **respond** in critical situations?



Critical Skills Taught in Simulation

Critical event recognition	Crisis management
Teamwork	Patient care handoffs
ACLS algorithm	Empathetic listening
Vital sign pattern recognition	Closed-loop communication
Communication skills	Group dynamics



Picking Scenarios



Possible Simulation Scenarios


Total spinal following a stellate ganglion injection	Pneumothorax following a stellate ganglion block
Seizure following a stellate ganglion injection	Bradycardia and Vasovagal reaction during a cervical injection
Seizure following a TAP block	Progressing epidural hematoma
Lost airway during sedation	Recognition of anterior spinal syndrome during a transforaminal injection
Pneumothorax following intercostal blocks	Inadvertent pocket fill during an intrathecal pump refill
Severe pain on injection	Non-compliant (moving) patient during injection
Equipment (fluoroscopy) failure during procedure	



Possible Difficult Conversation Scenarios	
Disclosing a wrong-sided procedure	Discussing a procedural complication with a patient or family member
Discussing end-of-life issues with a terminal patient	Utilizing a translator
Discontinuing opioid therapy in a combative patient	Discussing an unexpected finding during a toxicology screening
Patient consent	Neuritis following radiofrequency ablation


Scenario examples

- Tape



Scenario Examples

- Wro



Set up Tips

Scenarios

- Base them on what makes you uncomfortable
 - Think about difficult situations you have encountered
- Keep them fairly simple
 - Try to focus on one concept

Environment

- Make it as close to the real thing as possible
- Don't over think the details
- Be a part of the scenario

Debriefing

- Start with open ended questions
 - How did that feel?
 - What went well?
 - What was difficult?
- Let other learners provide feedback
 - Gives a team sense to the simulation
- Always find and emphasize the positives



Simulation Room



<p>Standardized Patient Script <i>20-26-17-17-17</i></p> <p>Scenario title: Telling a patient a procedure was performed on the wrong side.</p> <p>Target audience: Pain Medicine Fellows (PF)</p> <p>Scenario brief synopsis: The PF will have just completed a cervical suboccipital injection (dosing correct in the neck). This is a procedure done at C2-3 and C3-4 to treat patients in the neck when a nerve root is being treated. The PF will notice that the head side was on the wrong side. The PF will notice in the situation that the procedure was performed on the wrong side.</p> <p>Feedback: The PF will notice the technician came to talk with the patient. It will be clear that the procedure was done on the wrong side.</p> <p>Facilitator point: The scenario will end once the PF has seen the algorithm and has answered all questions from the patient.</p> <p>Objectives learner need to achieve:</p> <ul style="list-style-type: none"> • PF will explain the mistake to the wrong side. • PF will describe when the patient can expect when a sensory neural pain. • PF will reassure the patient that they will not personally be re-embolizing the wrong side. • PF will listen to the patient's concerns. <p>Setting in a simulated: outpatient surgical center.</p> <p>Age/Gender of SP: age 30-70. Gender does not matter.</p> <p>Chief Complaint (Problem): lower right sided neck and hand pain.</p> <p>Social History: No tobacco or alcohol use.</p>	<p>Behavior: The SP will express frustration over the complication and have extensive questions about the progress of the complication. They will be fairly understanding and even mention possible fix with:</p> <p>Afternoon (what you need the actor to portray verbally):</p> <p>How did this happen? Did I not have enough percent during the wrong side? I've heard of these types of things happening elsewhere but I would not expect it at Mayo. May neck and hand are much more right on the wrong side. How long will this last? Will I have to get the fix? When can I get the correct side done? I want to file a complaint? I've never seen one the wrong side will be better in looking how this happened.</p> <p>Overall: the SP will be open that the wrong side was done. Their concern will focus on their area. +1) What damage has been done to the wrong side? +2) When can the correct side be done? +3) What is going to fix this? They will be disappointed for the mistake and be even more frustrated by the fact that they will have to take more off work to get the correct side done.</p> <p>History of present illness (if applicable): N/A</p>
--	--



Thank You!

Bryan Hoelzer M.D.
 Mayo Clinic
 Hoelzer.bryan@mayo.edu