Body System: Pain		
Session Topic: Acute Pain Management		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Knowledge gaps with regard to diagnosing acute pain conditions. • Knowledge gaps with regard to managing acute pain conditions • Knowledge gaps with regard to developing collaborative treatment plans, use of expanded pharmacologic therapies that include non-opioid medications and novel protocolized uses of opioids , documentation of medical decision making, and an algorithmic way to identify potential "drug-seeking" patients in the management of acute pain conditions • Knowledge and practice gaps with regard to prescription, counseling, and monitoring of opioid medications resulting in extreme societal costs in disability and death from addiction and unintentional	1. Identify and use evidence-based criteria to diagnose acute pain conditions like low back pain, migraine headaches, neck pain, face pain, and acute postsurgical pain. 2. Identify and use standardized/validated tools and algorithms to manage acute pain conditions. 3. Identify and use standardized collaborative instruments, WHO ladder, non-opioid analgesics guide, documenting medical thinking tool, and identifying "drug-seeking patients" tool. 4. Establish standards for acknowledging patient complaints of pain, including documentation, and treatment effectiveness evaluation. 5. Know and understand the entities of CPSP and acute postoperative pain and the modern principles of treating them using a standardized tool.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

overdose • Knowledge gaps regarding acknowledging and understanding that patients with acute pain are not faking it • Knowledge gaps regarding the association between chronic postsurgical pain (CPSP) and antecedent inadequate acute postoperative pain		

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge		Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for evidence-based criteria to diagnose acute pain conditions like low back pain, migraine headaches, neck pain, face pain, and acute postsurgical pain
- Provide recommendations for standardized/validated tools and algorithms to manage acute pain conditions
- Provide recommendations for standardized collaborative instruments, WHO ladder, non-opioid analgesics guide, documenting medical thinking tool, and identifying "drug-seeking patients" tool
- Provide recommendations for standardized methods of prescribing, counseling, and monitoring patients that require opioids for acute pain to reduce the risk of adverse outcomes
- Provide recommendations for identifying and eliminating specific practices of "blowing patients off" like failure to acknowledge pain, failure to document pain, failure to assess treatment effectiveness, failure to follow guidelines, and failure to meet patient

expectations
- Provide an overview of the entities of CPSP and acute postoperative pain and the modern principles of treating them using a standardized tool

*Note – the scope of this topic should include non-opioid prescription drug management of pain conditions (If you can't use opioids for non-cancer pain management, then what can you use, WHO guidelines, NSAIDS – kidney problems and similar contraindications, etc.)

Needs Assessment

According to the National Center for Health Statistics (2006), approximately 76.2 million, one in every four Americans, have suffered from pain that lasts longer than 24 hours and millions more suffer from acute pain.[1] When asked about four common types of pain, respondents of a National Institute of Health Statistics survey indicated that low back pain was the most common (27%), followed by severe headache or migraine pain (15%), neck pain (15%) and facial ache or pain (4%).[2] Data from the 2013 National Ambulatory Medical Care Survey indicates that analgesics are the most (aspirin), seventh (acetaminophen-hydrocodone), twelfth (ibuprofen), and eighteenth (acetaminophen) prescribed drugs at an office visit.[3]

Data from the Centers for Disease Control and Prevention (CDC) reveals that deaths from unintentional drug overdoses in the United States have been rising steeply since the early 1990s and are the second-leading cause of accidental death, with 27,658 such deaths recorded in 2007.[4] That increase has been propelled by a rising number of overdoses of opioids, which caused 11,499 of the deaths in 2007—more than heroin and cocaine combined, and second only to motor vehicle crash deaths among leading causes of unintentional injury death.[5,6] "More than 40 Americans die each day from prescription opioid overdoses; we must act now," said CDC Director Tom Frieden, M.D., M.P.H., in a news release.[7] "Overprescribing opioids -- largely for chronic pain -- is a key driver of America's drug-overdose epidemic. Contributing physician factors include inappropriate prescribing along with inadequate counseling and monitoring, reflecting knowledge, competence, and performance deficits.[8] To improve care, physicians must play a central role by being specific and write pain drug prescriptions with explicit directions. There is also a need to consider alternative agents in patients who don't require opioids.[5,8]

Practice Gaps

Physicians may not be aware of recent advances in the pharmacological management of acute pain that use new preparations and ways to use non-opioid analgesic drugs in perioperative care.[9] Additionally, recent studies suggest that low dose ketamine may be a good alternative non-opioid analgesic for treatment of acute and refractory pain in the emergency department (ED).[10] A review of the literature suggests the following gaps with regard to pain management in the emergency department (ED):[11] failure to acknowledge pain, failure to assess initial pain, failure to have pain management guidelines in ED, failure to document pain and to assess treatment adequacy, and failure to meet patient's expectations. The barriers that preclude emergency physicians from proper pain management include ethnic and racial bias, gender bias, age bias, inadequate knowledge and formal training in acute pain management, opiophobia, the ED, and the ED culture.

Another area to consider is with respect to chronic postsurgical pain (CPSP). One of the most striking predictive factors of CPSP is the intensity of acute postoperative pain. Patients suffering intense postoperative pain are more prone than others to develop CPSP. However, surveys indicate that the efficacy of the treatment of acute postoperative pain revealed that the treatment remains inadequate.[12]

Physicians may improve their care of patients with acute pain by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[13,14]

- Acetaminophen is the first-line treatment for most mild to moderate acute pain.
- Ibuprofen and naproxen (Naprosyn) are good, first-line NSAIDs for mild to moderate acute pain based on effectiveness, adverse effect profile, cost, and over-the-counter availability.
- Cyclooxygenase-2 selective NSAIDs are second-line medications for mild to moderate pain based on their similar effectiveness to nonselective NSAIDs and greater costs.
- Celecoxib (Celebrex) alone and an NSAID plus a proton pump inhibitor have the same probability of causing gastrointestinal complications in those at high risk.
- Full opioid agonists may be used if opioids combined with acetaminophen or NSAIDs are insufficient to control moderate to severe pain.
- Tramadol (Ultram) is less effective than hydrocodone/acetaminophen and is a second-line medication for the treatment of moderate to severe pain.
- There may be a small but clinically significant benefit to adding caffeine to analgesic therapy for various types of acute pain. More research is needed to determine the optimal dosing. (Strength of Recommendation: B, based on inconsistent or limited-quality patient-oriented evidence.)

Choosing Wisely Recommendation(s):

- Don’t prescribe opioids for treatment of chronic or acute pain for workers who perform safety-sensitive jobs such as operating motor vehicles, forklifts, cranes, or other heavy equipment. (American College of Occupational and Environmental Medicine)[15]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Pharmacologic Therapy for Acute Pain[14]
- Thinking on paper: documenting decision making[16]
- Engaging Patients in Collaborative Care Plans[17]
- A systematic approach to identifying drug-seeking patients[18]

- The Use of Symptom Diaries in Outpatient Care[19]
- Health Coaching: Teaching Patients to Fish[20]
- Medication adherence: we didn't ask and they didn't tell[21]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[22]
- Familydoctor.org - Pain Relievers: Understanding Your OTC Options (patient education)[23]
- Familydoctor.org - Pain Control After Surgery: Pain Medicines (patient education)[24]

References

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7. Centers for Disease Control and Prevention. CDC Releases Guideline for Prescribing Opioids for Chronic Pain. *CDC Newsroom Releases* 2016;
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11. Motov SM, Khan ANGA. Problems and barriers of pain management in the emergency department: Are we ever going to get better? *Journal of pain research.* 2009;2:5-11.
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