

Opioid Response Network

Care and Management of the Patient with Chronic Pain & Opioid Dependence (CPOD)

Craig J. Uthe, MD FAAFP ASAM

May 16, 2024



Opioid
Response
Network



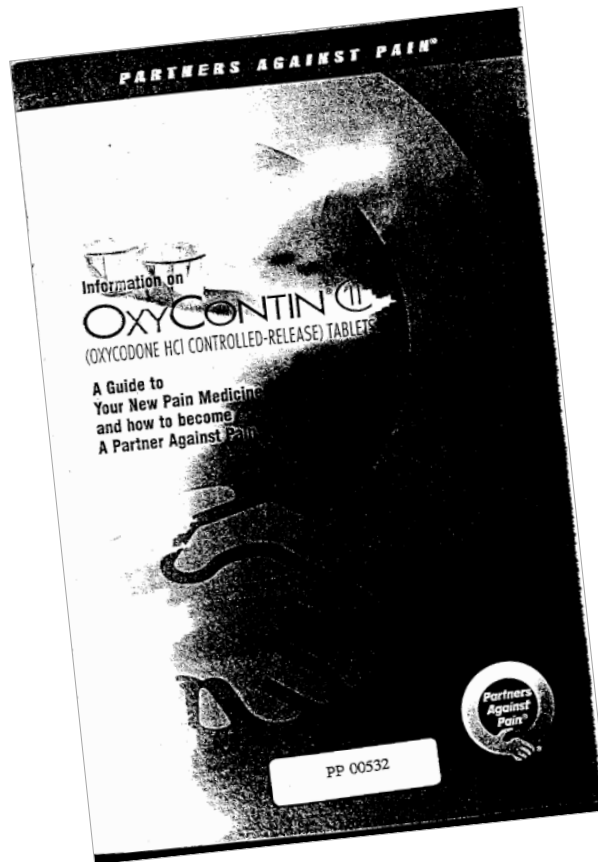
The Opioid Crisis: Four Major Themes

1. Prevent unintended opioid overdose deaths
2. Provide appropriate opioid use disorder services
3. Provide adequate pain relief... using opioids
4. Mitigate misuse/abuse of prescribed opioids




The Opioid Crisis: Four Major Themes

The Opioid Epidemic – 1990s



doctor. It may mean that your regular dose of OxyContin® (oxycodone HCl controlled-release) Tablets needs to be increased. It's a good idea to keep a diary of how many times a day you use your rescue medication and what caused the pain. Also, remember that increasing pain does not necessarily mean your condition is getting worse. Sometimes other treatments for disease may cause pain. Sometimes it's caused by factors totally unrelated to the disease. Regular communication with your doctor will help keep your questions answered and put your fears to rest.



Remember: When your doctor prescribes medication for breakthrough pain:


- Be sure that you understand how to use it.
- Use your breakthrough doses only as your doctor has instructed.
- Write down how many times you take it every day. Your doctor can use this information to decide when to adjust your regular dose of OxyContin® Tablets.
- Do not use your OxyContin® Tablets for your breakthrough pain.

PP 00539

Will it be easy to take OxyContin® Tablets?

OxyContin® Tablets are small (see actual size below) which makes them easy to swallow. They are also color-coded according to their strength. This is helpful for you and your physician.

OxyContin® Tablet Strengths



OxyContin® 80 mg and 160 mg Tablets for use only in opioid-tolerant patients requiring daily oxycodone equivalent dosages of 160 mg and 320 mg respectively.

Aren't opioid pain medications like OxyContin® Tablets "addicting?" Even my family is concerned about this.

Drug addiction means using a drug to get "high" rather than to relieve pain. You are taking opioid pain medication for medical purposes. The medical purposes are clear and the effects are beneficial, not harmful. If you or your family have concerns about addiction, please talk to your doctor or another member of your healthcare team. This fear should not stand in the way of relief from your pain.

What are the most important things to remember while I'm taking OxyContin® Tablets for my pain?

The single most important thing for you to remember is that you are the authority on your pain. Nobody else feels it for you so nobody else can describe how much it hurts, or when it feels better. Your healthcare team is there to help, but they need your help, too. Be sure to talk to them, ask them questions, tell them how you feel — whether that is better or worse. Together you can be Partners Against Pain®.

Additional Reminders

Make sure you always have enough medication.

OxyContin® Tablets require a written prescription, so your doctor cannot call it into your pharmacy. Call or see your doctor at least one week before you run out of medication. Ask a family member to help you keep track if necessary.

PP 00540



The Opioid Crisis: Four Major Themes

The Opioid Epidemic – 1990s

FREEDOM FROM PAIN!

Extra strength pain relief free of extra prescribing restrictions.

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

Excellent patient acceptance. In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.*

| Parameter | Hydrocodone | Vicodin ES |
|---------------|-------------|------------|
| Hydrocodone | S | S |
| Codeine | XX | XX |
| Aspirin | XX | XX |
| Acetaminophen | XX | XX |

The heritage of VICODIN^{ES} over a billion doses prescribed.¹

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra-strength pain relief from a single dose.
- The 1st RXISM frequently prescribed medication in America²

vicodin^{ES}

Hydrocodone bitartrate 7.5mg (Habit-forming) and acetaminophen 750mg

Tablet for tablet, the most potent analgesic you can phone in.

Maintain control of your patient's therapy.

Rx Specify
Do not substitute

vicodin^{ES}

Hydrocodone bitartrate 7.5mg (Habit-forming) and acetaminophen 750mg

It's your prescription – not a suggestion.

PHARMACOLOGICAL: In the overall pharmacological group... VICODIN ES... [Small text continues with detailed pharmacological information]

When you know NSAIDs or acetaminophen will not be enough...

OxyContin[®] q12h

Controlled-release oxycodone tablets

- Rapid onset of analgesia within 46 minutes^{1,2}
- Full 12 hours of pain relief^{1,2}
- No risk of acetaminophen or ASA toxicity^{1,2}

Increasing pain

Step 1
• ASA
• Acetaminophen

Step 2
• Oxycodone
• ASA

Step 3
• Oxycodone
• Oxycodone/ASA
• Oxycodone

The Only Step 2 and Step 3 q12h Analgesic

World Health Organization Pain Ladder (Adapted)³

OxyContin[®] q12h 10 mg, 20 mg, 40 mg, 80 mg
Small, color-coded tablets

One to Start and Stay With...
Easy to Dose, Easy to Titrate

For the relief of moderate to severe pain requiring the prolonged use of an opioid, OxyContin[®] q12h is a controlled-release formulation of oxycodone that provides long-lasting pain relief with a low risk of addiction, abuse, and misuse. OxyContin[®] q12h is not intended for the treatment of acute pain, pain associated with surgery, or pain associated with the initial management of an acute injury. OxyContin[®] q12h is not intended for the treatment of chronic pain, or pain associated with cancer, or pain associated with the initial management of an acute injury. OxyContin[®] q12h is not intended for the treatment of chronic pain, or pain associated with cancer, or pain associated with the initial management of an acute injury. OxyContin[®] q12h is not intended for the treatment of chronic pain, or pain associated with cancer, or pain associated with the initial management of an acute injury.

Purified Oxycodone
Controlled-release oxycodone tablets



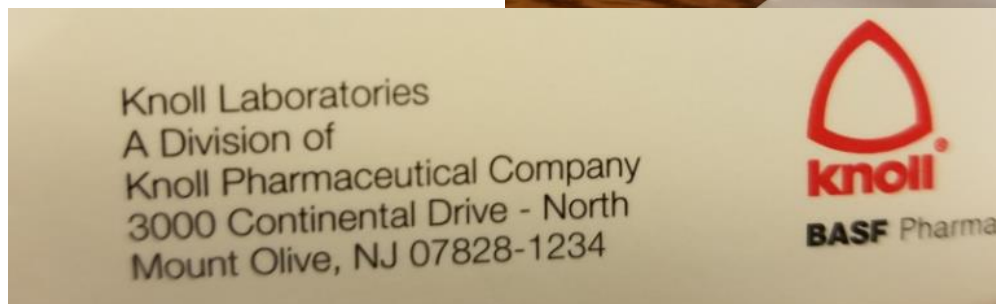
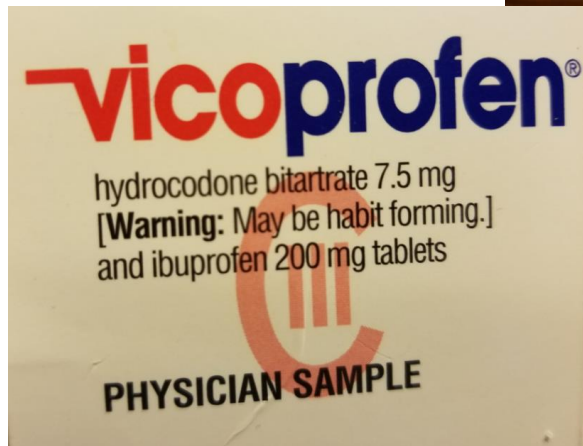
The Opioid Crisis: Four Major Themes

The Opioid Epidemic – 1990s



The Opioid Crisis: Four Major Themes

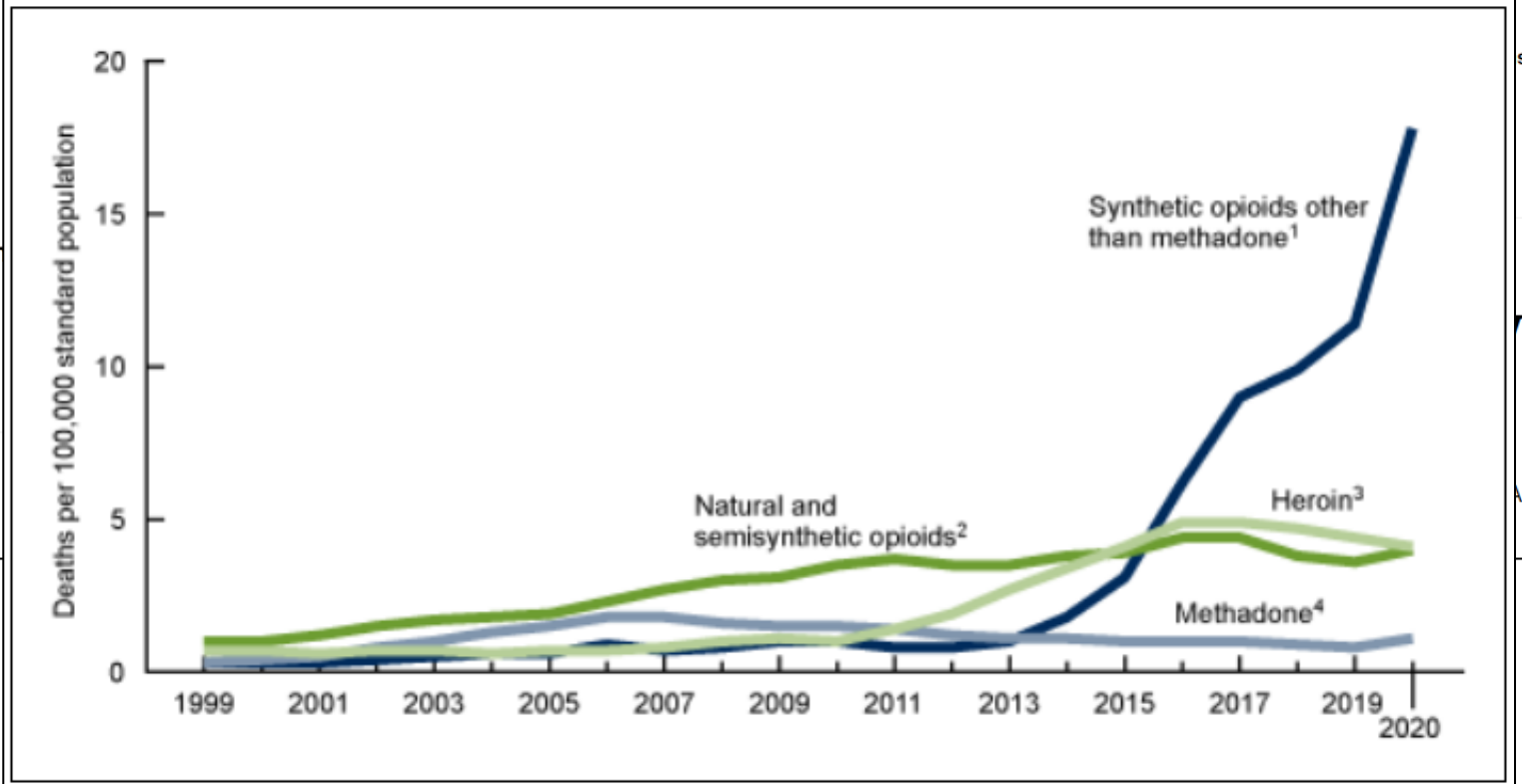
The Opioid Epidemic – 1990s



The Opioid Crisis: Four Major Themes

The Opioid Epidemic – 2020s

Figure 4. Age-adjusted rates of drug overdose deaths involving opioids, by type of opioid: United States, 1999–2020



Drug Enforcement Administration

Headquarters
@DEAHQ



The Opioid Crisis: Four Major Themes

1. Prevent unintended opioid overdose deaths
2. Provide appropriate opioid use disorder services
3. Provide adequate pain relief... using opioids
4. Mitigate misuse/abuse of prescribed opioids



Chronic Pain and Opioid Dependence (CPOD)

OBJECTIVES:

1. Be able to identify the three health conditions that merit attention at every encounter for the patient with chronic pain & opioid dependence (CPOD)
2. Know how to establish a plan of action that includes a benefit-risk assessment with a timeline for the patient with chronic pain & opioid dependence (CPOD)
3. Be familiar with different treatment strategies for patients with different pain scenarios: acute pain, post-op pain, and chronic pain.



Chronic Pain and Opioid Dependence (CPOD)



Words Matter Terms to Use and Avoid When Talking About Addiction

Avoid using the terms...

- Addict*
- User*
- Substance or drug abuser*
- Junkie*
- Alcoholic*
- Drunk*
- Substance dependence*
- Former addict*
- Reformed addict*

Terms to avoid, terms to use, and why

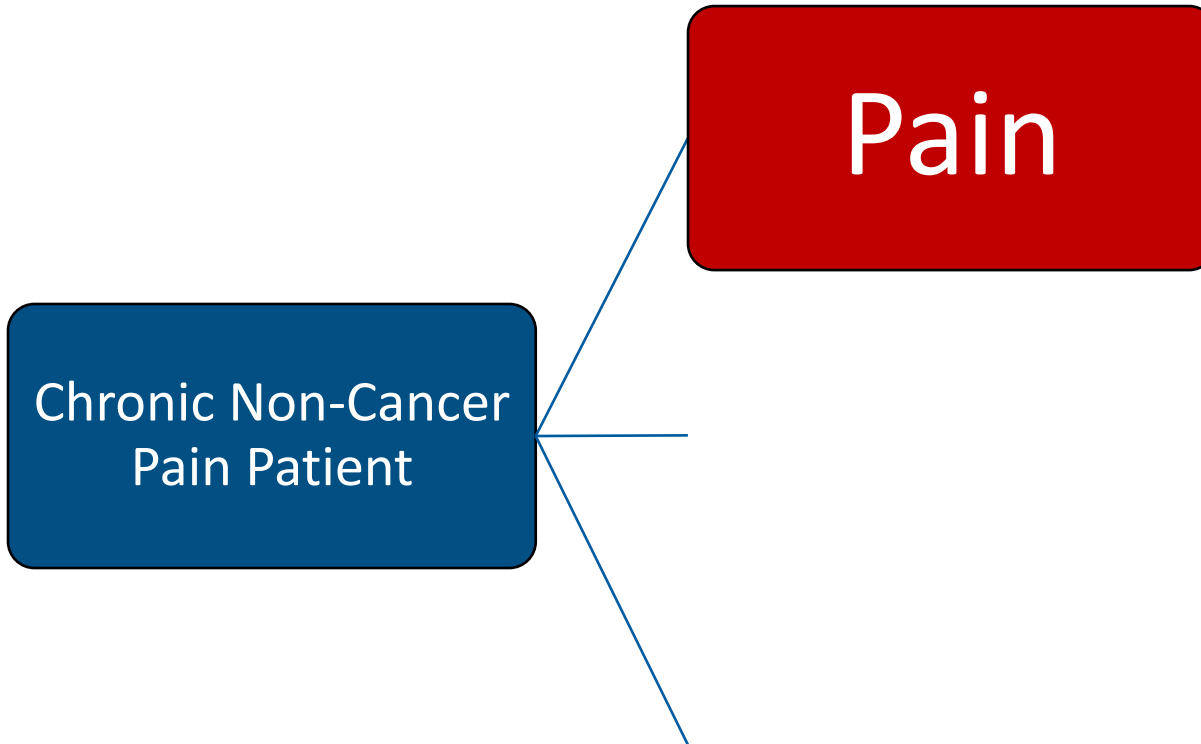
Consider using these recommended terms to reduce stigma and negative bias when talking about addiction.

| Instead of... | Use... | Because... |
|---|---|---|
| Addict | <ul style="list-style-type: none"> Person with opioid use disorder | <ul style="list-style-type: none"> Person-first language. |
| User | | |
| Substance Junkie | <ul style="list-style-type: none"> Person with opioid use disorder (OUD)/SUD or person with opioid addiction | <ul style="list-style-type: none"> that a person "has" a problem is an "is" the problem.⁷ and elicit negative attitudes, and |
| Alcoholic | | |
| Drunk | | |
| Substance Former a Reformed | <ul style="list-style-type: none"> Patient | |
| Addicted | <ul style="list-style-type: none"> Person in recovery or long-term recovery | <ul style="list-style-type: none"> born with addiction is a behavioral simply born withdrawal syndrome. language can reduce |
| Habit | <ul style="list-style-type: none"> Unhealthy, harmful, or hazardous alcohol use Person with alcohol use disorder | <ul style="list-style-type: none"> as that a person is substances or can determine the seriousness |
| Abuse | <ul style="list-style-type: none"> For illicit drugs: <ul style="list-style-type: none"> Use | <ul style="list-style-type: none"> The term "abuse" was found to have a high association with negative punishment.⁸ prescription related to their use as person to whom they consumption outside is misuse. |
| Opioid substitution Replacement therapy | <ul style="list-style-type: none"> Opioid agonist therapy Medication treatment for OUD Pharmacotherapy | <ul style="list-style-type: none"> It is a misconception that medications merely "substitute" one drug or "one addiction" for another.⁶ |
| Clean | <ul style="list-style-type: none"> For toxicology screen results: <ul style="list-style-type: none"> Testing negative For non-toxicology purposes: <ul style="list-style-type: none"> Being in remission or recovery Abstinent from drugs Not drinking or taking drugs Not currently or actively using drugs | <ul style="list-style-type: none"> Consider the motivation and intent of misuse (e.g., level, reasons) to determine whether the specific instance suggests SUD. Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.⁹ Set an example with your own language when treating patients who might use stigmatizing slang. Use of such terms may evoke negative and punitive implicit cognitions.⁷ |
| Dirty | <ul style="list-style-type: none"> For toxicology screen results: <ul style="list-style-type: none"> Testing positive For non-toxicology purposes: <ul style="list-style-type: none"> Person who uses drugs | <ul style="list-style-type: none"> Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.⁹ May decrease patients' sense of hope and self-efficacy for change.⁷ |

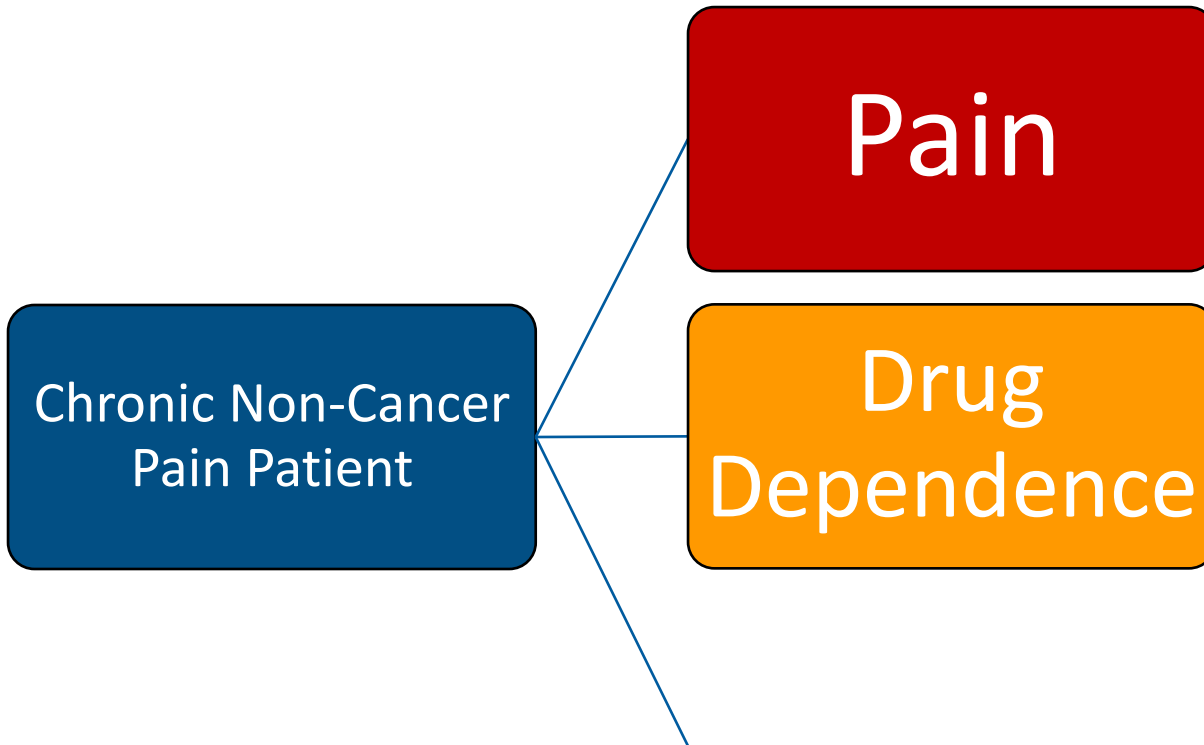
• Person with chronic pain & opioid dependence (CPOD)



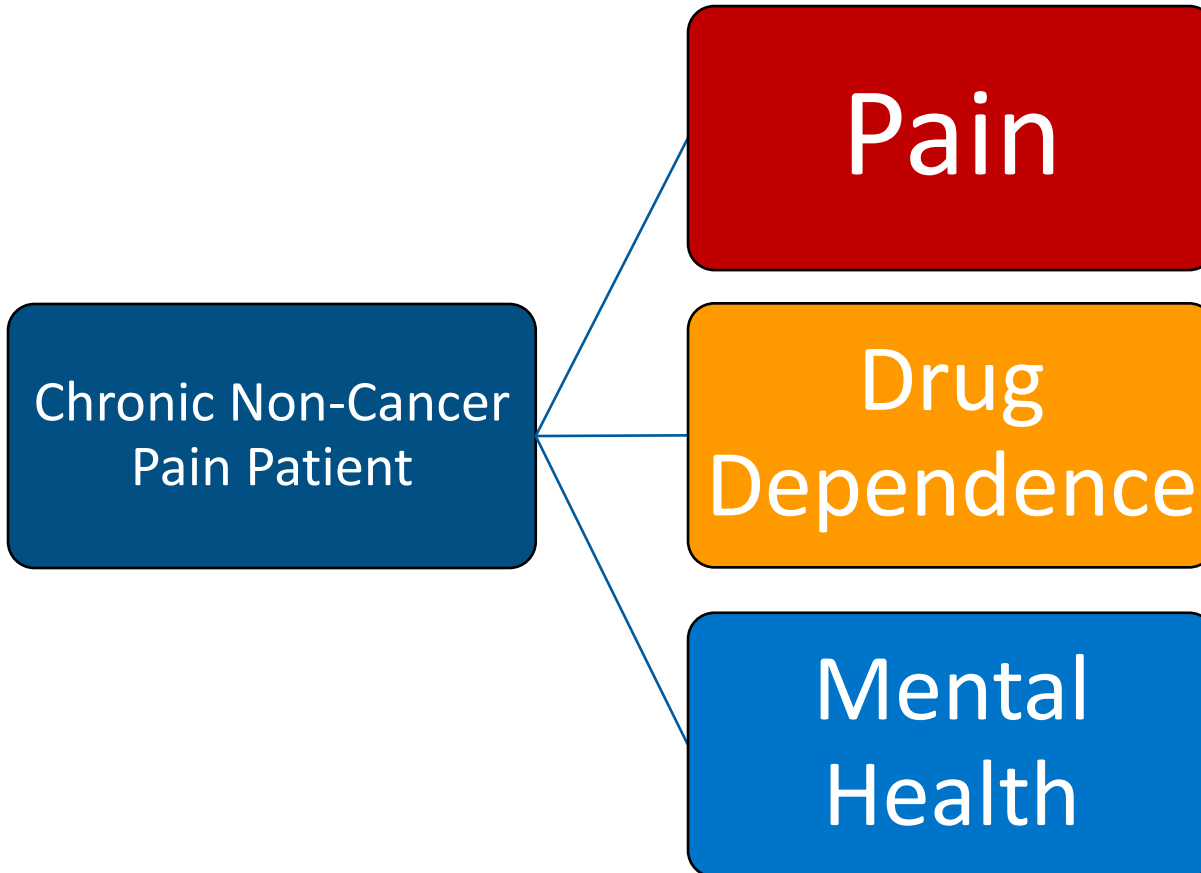
Chronic Pain and Opioid Dependence (CPOD)



Chronic Pain and Opioid Dependence (CPOD)



Chronic Pain and Opioid Dependence (CPOD)



Chronic Pain and Opioid Dependence (CPOD)



Pain

Chronic Non-Cancer
Pain Patient

Chronic Pain is ongoing or recurrent pain, lasting beyond the usual course of acute illness or injury healing, ***more than 3 to 6 months***, and which adversely affects the individual's well-being.

Another definition for chronic or persistent pain is ***pain that continues when it should not.***



Chronic Pain and Opioid Dependence (CPOD)

THREE MAIN TYPES OF PATHOPHYSIOLOGY can be considered to result in chronic pain¹

Pain related to *damage of somatic or visceral tissue*, due to trauma or inflammation

NOCICEPTIVE PAIN

Examples:

Rheumatoid arthritis,
osteoarthritis,
gout

Pain related to *damage of peripheral or central nerves*

NEUROPATHIC PAIN

Examples:

Painful diabetic peripheral neuropathy, postherpetic neuralgia

Pain *without identifiable nerve or tissue damage*, hypothesized to result from persistent neuronal dysregulation—may be called

SENSORY HYPERSENSITIVITY

Example:

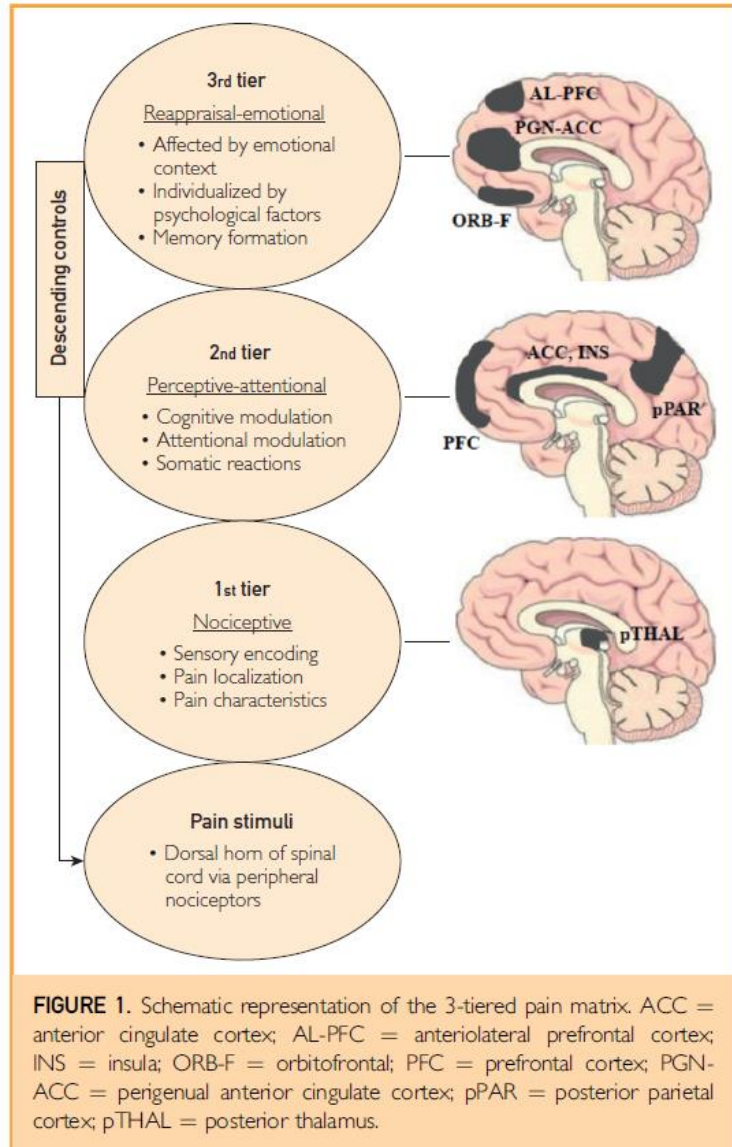
Fibromyalgia

More than 1 type of pain may be present in a given patient

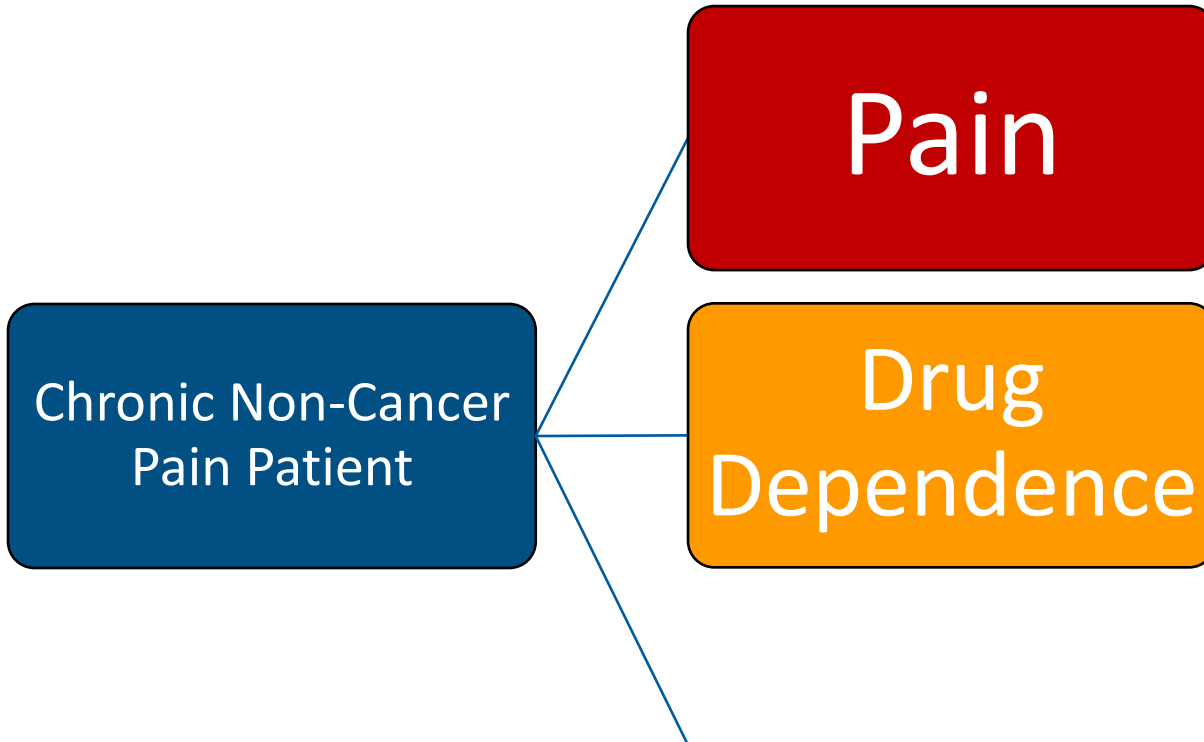


Chronic Pain and Opioid Dependence (CPOD)

The 3-tiered pain matrix:



Chronic Pain and Opioid Dependence (CPOD)



Calculating total daily opioid dosage in MMED

Natural (Opiates):

- **Morphine**
- Codeine

Semi-Synthetics (Opioids):

- Hydrocodone
- Hydromorphone
- Oxycodone
- Oxymorphone
- Buprenorphine
- Heroin

Synthetics (Narcotics):

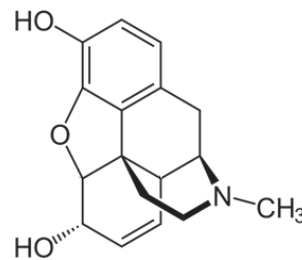
- Meperidine
- Methadone
- Fentanyl
- Tramadol



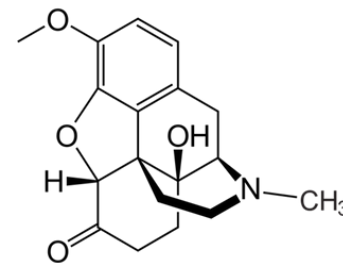
Calculating total daily opioid dosage in MMED

| OPIOID (doses in mg/day except where noted) | CONVERSION FACTOR |
|---|-------------------|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr.) | 2.4 |
| Hydrocodone | 1 |
| Hydromorphone | 4 |
| Methadone | |
| 1 – 20 mg/day | 4 |
| 21 – 40 mg /day | 8 |
| 41 – 60 mg/day | 10 |
| ≥ 61 – 80 mg/day | 12 |
| Morphine | 1 |
| Oxycodone | 1.5 |
| Oxymorphone | 3 |

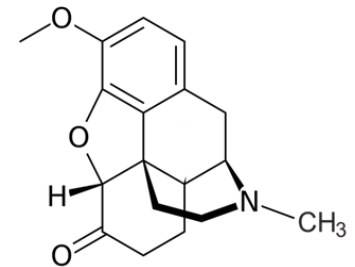
Morphine Milligram Equivalents (MME)
Morphine is the **standard** from which all other opioids are measured.



Morphine



Oxycodone



Hydrocodone



Calculating total daily opioid dosage in MMED

Hydrocodone : Morphine (1:1)

(Lortab, Norco, Vicodin)

Hydrocodone 5 mg = a
Morphine 5 mg (5 MME)

Hydrocodone 7.5mg =
Morphine 7.5mg (7.5 MME)

Hydrocodone 10 mg =
Morphine 10 mg (10 MME)

Hydromorphone : Morphine (4:1)

(Dilaudid, Exalgo)

Hydromorphone 2 mg =
Morphine 8 mg (8 MME)

Hydromorphone 4mg =
Morphine 16 mg (6 MME)

Hydromorphone 8 mg =
Morphine 32 mg (32 MME)

Hydromorphone 16 mg =
Morphine 64 mg (64 MME)

| OPIOID (doses in mg/day except where noted) | CONVERSION FACTOR |
|---|-------------------|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr.) | 2.4 |
| Hydrocodone | 1 |
| Hydromorphone | 4 |
| Methadone | |
| 1 – 20 mg/day | 4 |
| 21 – 40 mg /day | 8 |
| 41 – 60 mg/day | 10 |
| ≥ 61 – 80 mg/day | 12 |
| Morphine | 1 |
| Oxycodone | 1.5 |
| Oxymorphone | 3 |

Oxycodone : Morphine (1.5:1) *(OxyContin, OxyIR, Percocet, Percodan)*

Oxycodone 5 mg =
Morphine 7.5 mg (7.5 MME)

Oxycodone 7.5mg =
Morphine 11.25mg (11.25 MME)

Oxycodone 10 mg =
Morphine 15 mg (15 MME)

Oxycodone 20 mg =
Morphine 30 mg (30 MME)



Morphine Milligram Equivalents per Day (MMED)

Calculating total daily opioid dosage in MMED

OPIOID (doses in mg/day except where noted)

Codeine

Promethazine HCl and Codeine Phosphate Oral Solution



Rx Only

WARNING: ULTRA-RAPID METABOLISM OF CODEINE AND OTHER RISK FACTORS FOR LIFE-THREATENING RESPIRATORY DEPRESSION IN CHILDREN and RISKS FROM CONCOMITANT USE WITH BENZODIAZEPINES OR OTHER CNS DEPRESSANTS

Ultra-Rapid Metabolism of Codeine and Other Risk Factors for Life-Threatening Respiratory Depression in Children

Life-threatening respiratory depression and death have occurred in children who received codeine. Most of the reported cases occurred following tonsillectomy and/or adenoidectomy, and many of the children had evidence of being an ultra-rapid metabolizer of codeine due to a CYP2D6 polymorphism. Promethazine HCl and Codeine Phosphate Oral Solution is contraindicated in children younger than 12 years of age and in children younger than 18 years of age following tonsillectomy and/or adenoidectomy (see

41 – 60 mg/day

≥ 61 – 80 mg/day

Morphine

Oxycodone

Oxymorphone

Postmarketing cases of respiratory depression, including fatalities have been reported with use of promethazine in pediatric patients. Children may be particularly sensitive to the additive respiratory depressant effects when promethazine is combined with other respiratory depressants, including codeine. (See WARNINGS – Promethazine and Respiratory Depression in Children).

Risks from Concomitant Use with Benzodiazepines or Other CNS Depressants

Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death (see WARNINGS, PRECAUTIONS - Drug Interactions). Avoid use of opioid cough medications in patients taking benzodiazepines, other CNS depressants, or alcohol.

(MME)

approximately equivalent Morphine Milligram Medicine.

Morphine Milligram Equivalents per Day (MMED)



Identifying & Defining Opioid Use Disorders

The DSM-5 states the following:

DSM-5 **Substance Use Disorder**: (11 Criteria)

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (**tolerance**).
11. Development of **withdrawal** symptoms, which can be relieved by taking more of the substance.

The
dur
diag

Sym
trea
stim

Indiv
trea
med
bas

An a
OPI

wal

der.

ne



Identifying & Defining Opioid Use Disorders

The DSM-5 states the following:

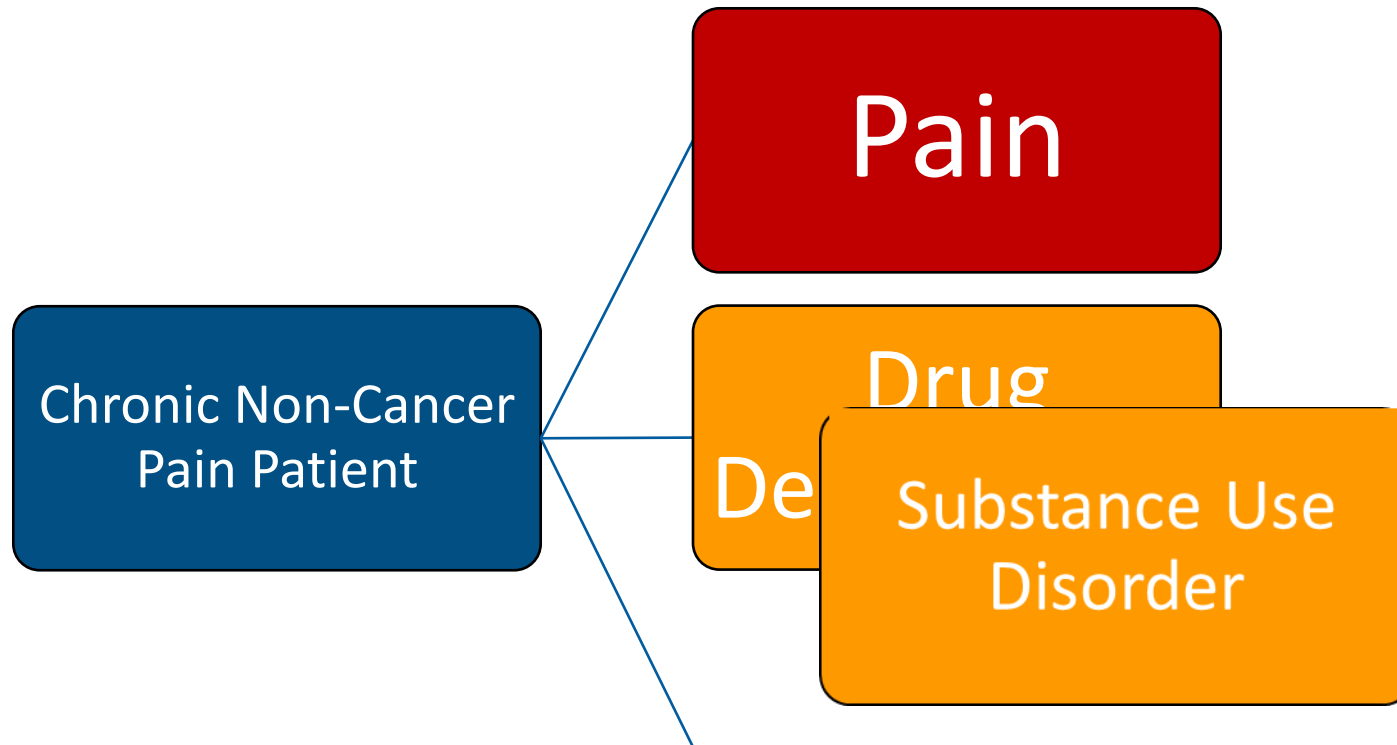
*The appearance of normal, expected **pharmacological tolerance and withdrawal** during the course of medical treatment has been known to lead to an erroneous diagnosis of “addiction,” even when these were the only symptoms present.*

Symptoms of tolerance and withdrawal occurring during appropriate medical treatment with prescribed medications (e.g., opioid analgesics, sedatives, stimulants) are specifically **not** counted when diagnosing a substance use disorder. Individuals whose *only* symptoms are those that occur as a result of medical treatment (i.e., **tolerance** and **withdrawal** as part of medical care when the medications are taken as prescribed) should not receive a diagnosis *solely* on the basis of these symptoms.

An appropriate definition of their medical condition under these circumstances is **OPIOID DEPENDENCE** and should be included in the patient’s problem list.



Identifying & Defining Opioid Use Disorders



However, prescription medications may be used inappropriately (misused, abused).

Substance Use Disorder can be correctly diagnosed when other characteristics and symptoms are present, as noted in the eleven characteristics of Substance Use Disorder as defined in the DSM-5.



Identifying & Defining Opioid Use Disorders

DSM-5 Substance Use Disorder: (11 Criteria)

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.



Identifying & Defining Opioid Use Disorders

DSM-5 **Substance Use Disorder**: (11 Criteria)

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.

An ***Opioid Use Disorder (SUD)*** can be correctly diagnosed when **other symptoms, characteristics, & behaviors** are present among the eleven criteria of Substance Use Disorder DSM-5 in addition to tolerance and withdrawal .

Users (may) substitute one drug for another, trying to regulate their use by finding a new substance that allows for better control: Xanax for alcohol, Ritalin for cocaine, methadone for heroin.

5. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.



Identifying & Defining Opioid Use Disorders

DSM-5 **Substance Use Disorder**: (11 Criteria)

1. Taking the substance in **larger amounts** or for longer than you're meant to.
2. Wanting to **cut down or stop using** the substance but not managing to.
3. **Spending a lot of time getting, using, or recovering** from use of the substance.
4. **Cravings and urges** to use the substance.
5. Not managing to do what you should at work, home, or school because of

There are 11 criteria for determining SUD with 4 groupings:

- **1 – 4. Impaired Control.**
- **5 – 7. Social Problems.**
- **8 – 9. Risky Use.**
- **10 – 11. Physical Dependence.**

6. Co
7. Giv
- of s
8. Us
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.



Identifying & Defining Opioid Use Disorders

DSM-5 **Substance Use Disorder**: (11 Criteria)

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should **at work, home, or school** because of substance use.
6. Continuing to use, even when it **causes problems in relationships**.
7. Giving up important **social, occupational, or recreational activities** because of substance use.
8. Using substances again and again, even when it puts you in danger.

9. Conti
 10. Need
 11. Deve
- of th

There are 11 criteria for determining SUD with 4 groupings:

- **1 – 4. Impaired Control.**
- **5 – 7. Social Problems.**
- **8 – 9. Risky Use.**
- **10 – 11. Physical Dependence.**



Identifying & Defining Opioid Use Disorders

DSM-5 Substance Use Disorder: (11 Criteria)

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.

4. Craving

There are 11 criteria for determining SUD with 4 groupings:

5. No

• 1 – 4. **Impaired Control.**

of

sub

• 5 – 7. **Social Problems.**

6. Co

• 8 – 9. **Risky Use.**

7. Giv

• 10 – 11. **Physical Dependence.**

use

of substance use.

8. Using substances again and again, even **when it puts you in danger.**
9. **Continuing to use, even when you know you have a physical or psychological problem** that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.



Identifying & Defining Opioid Use Disorders

DSM-5 Substance Use Disorder: (11 Criteria)

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been avoided by stopping.
10. Needing more of the substance to get the same effect.
11. Development of withdrawal symptoms when you stop or reduce use of the substance.

Severity of Substance Use Disorders:

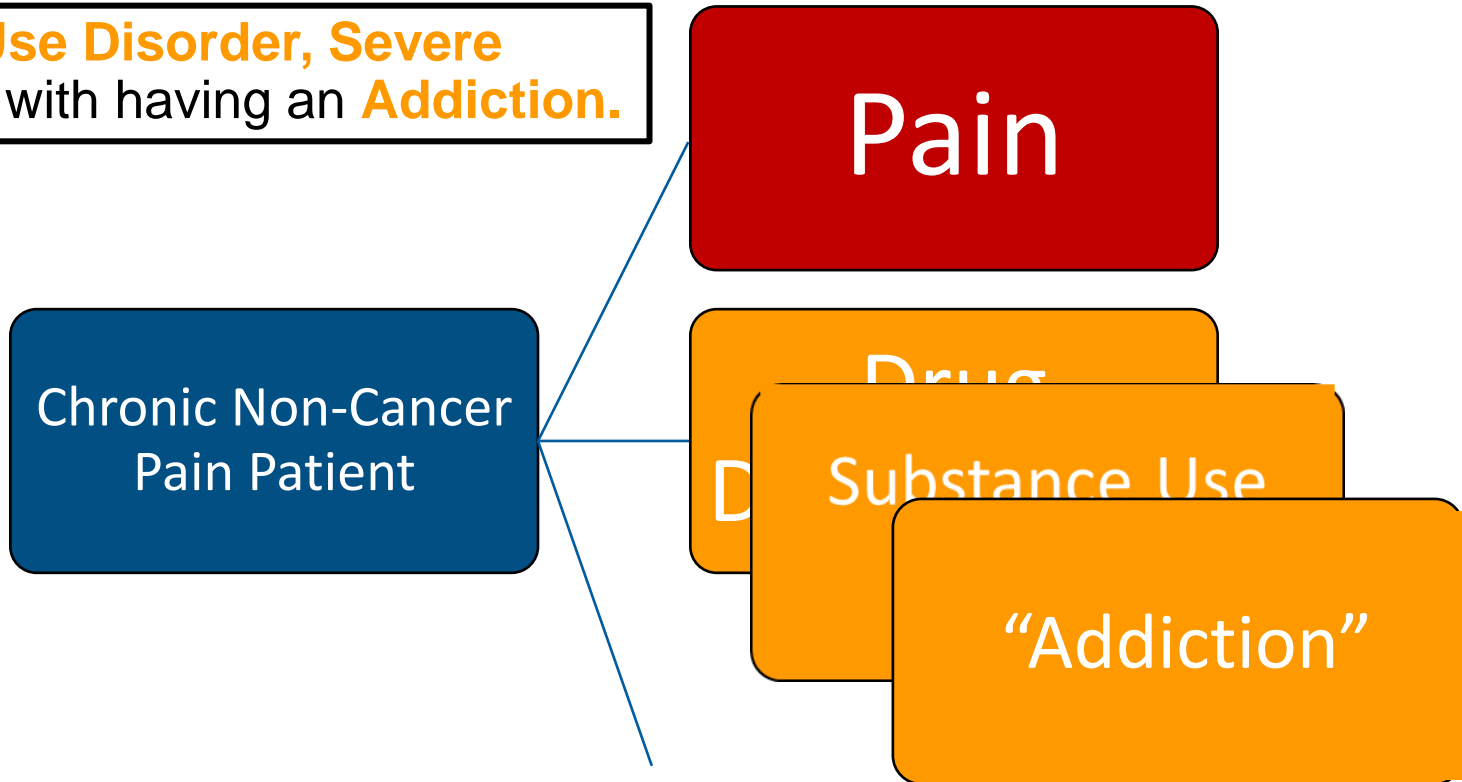
- **Mild:** Presence of **2-3** symptoms
- **Moderate:** Presence of **4-5** symptoms
- **Severe:** Presence of **6 or more** symptoms

more



Identifying & Defining Opioid Use Disorders

A **Substance Use Disorder, Severe** is synonymous with having an **Addiction**.



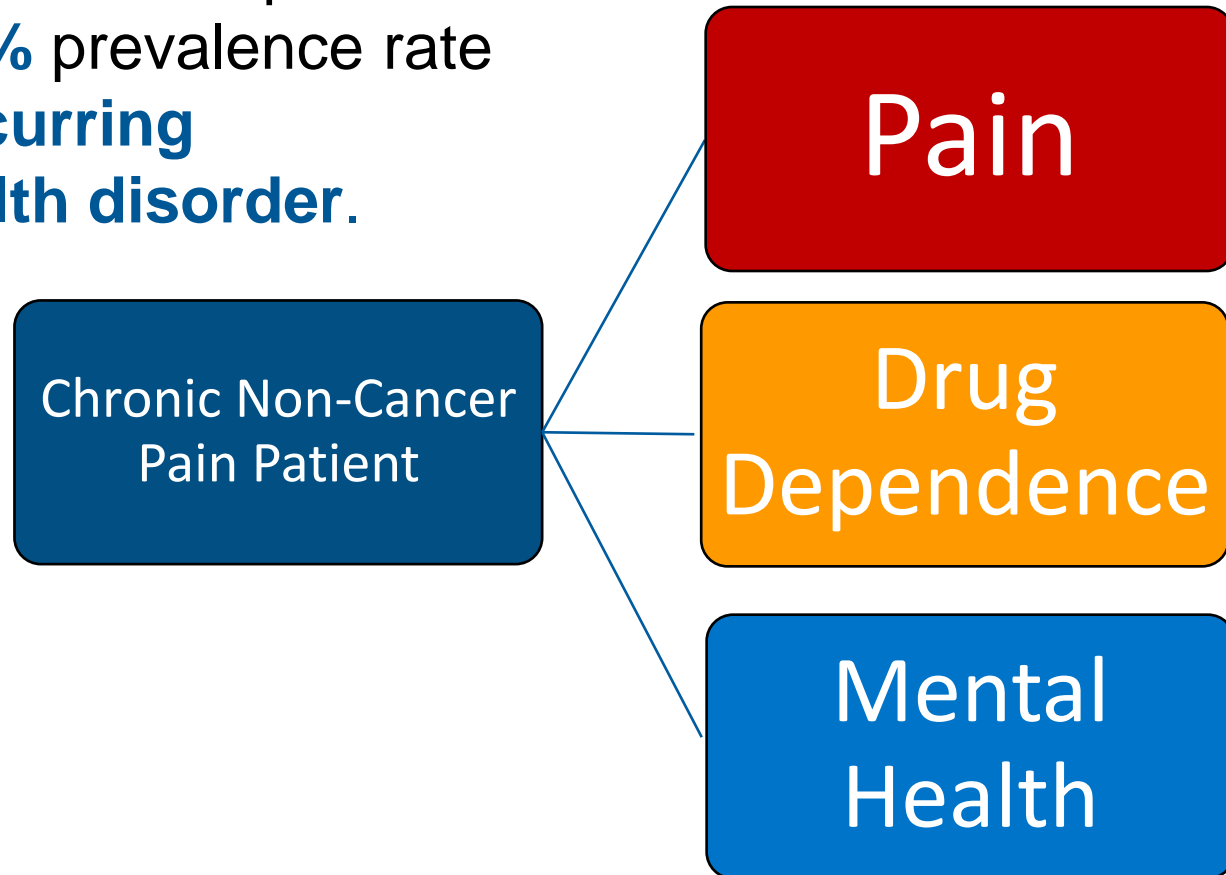
Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug **seeking** and **use**, despite **harmful consequences**.

It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors.



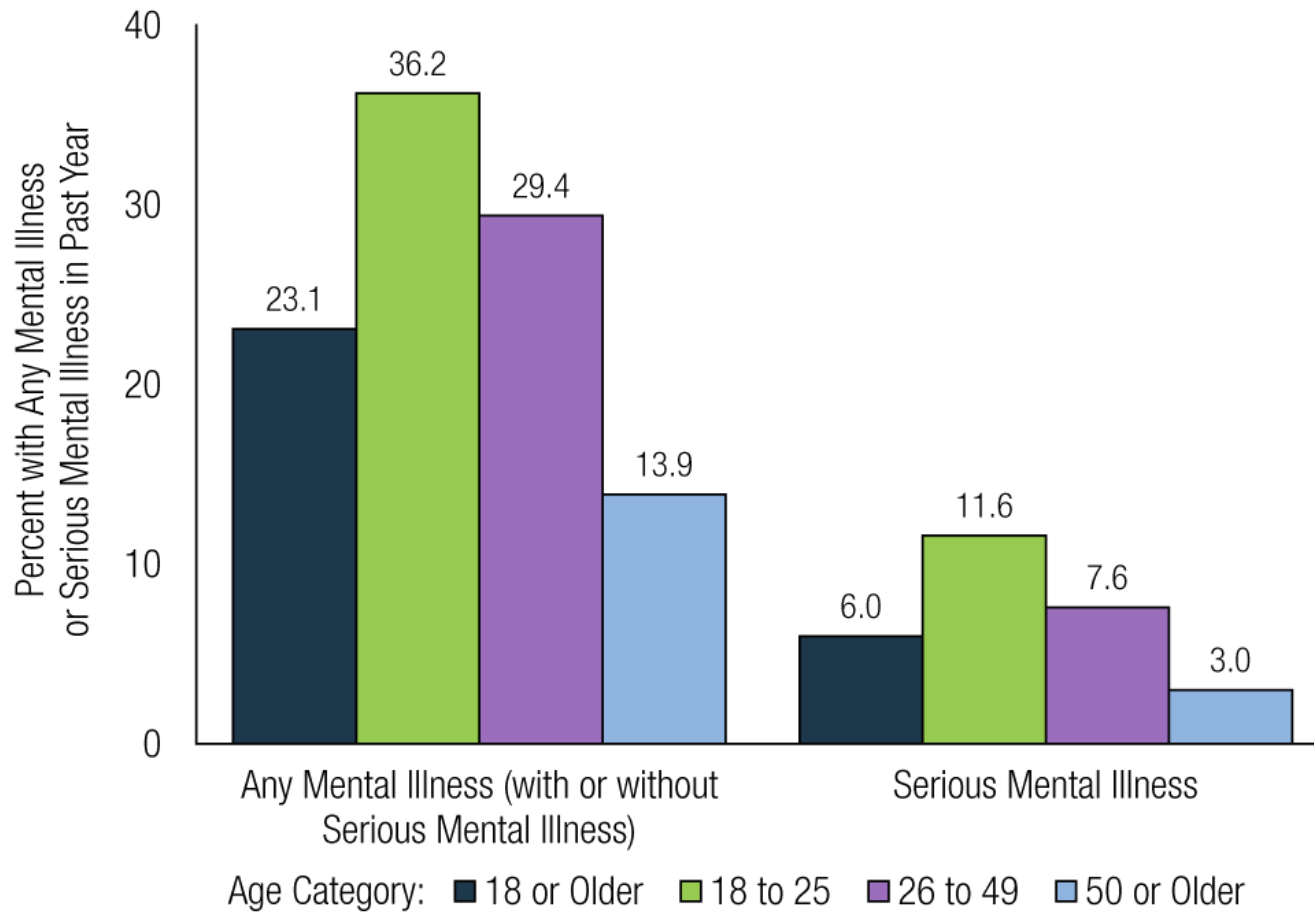
Chronic Pain and Opioid Dependence (CPOD)

Patients with chronic pain have a **>50%** prevalence rate for a **co-occurring mental health disorder**.



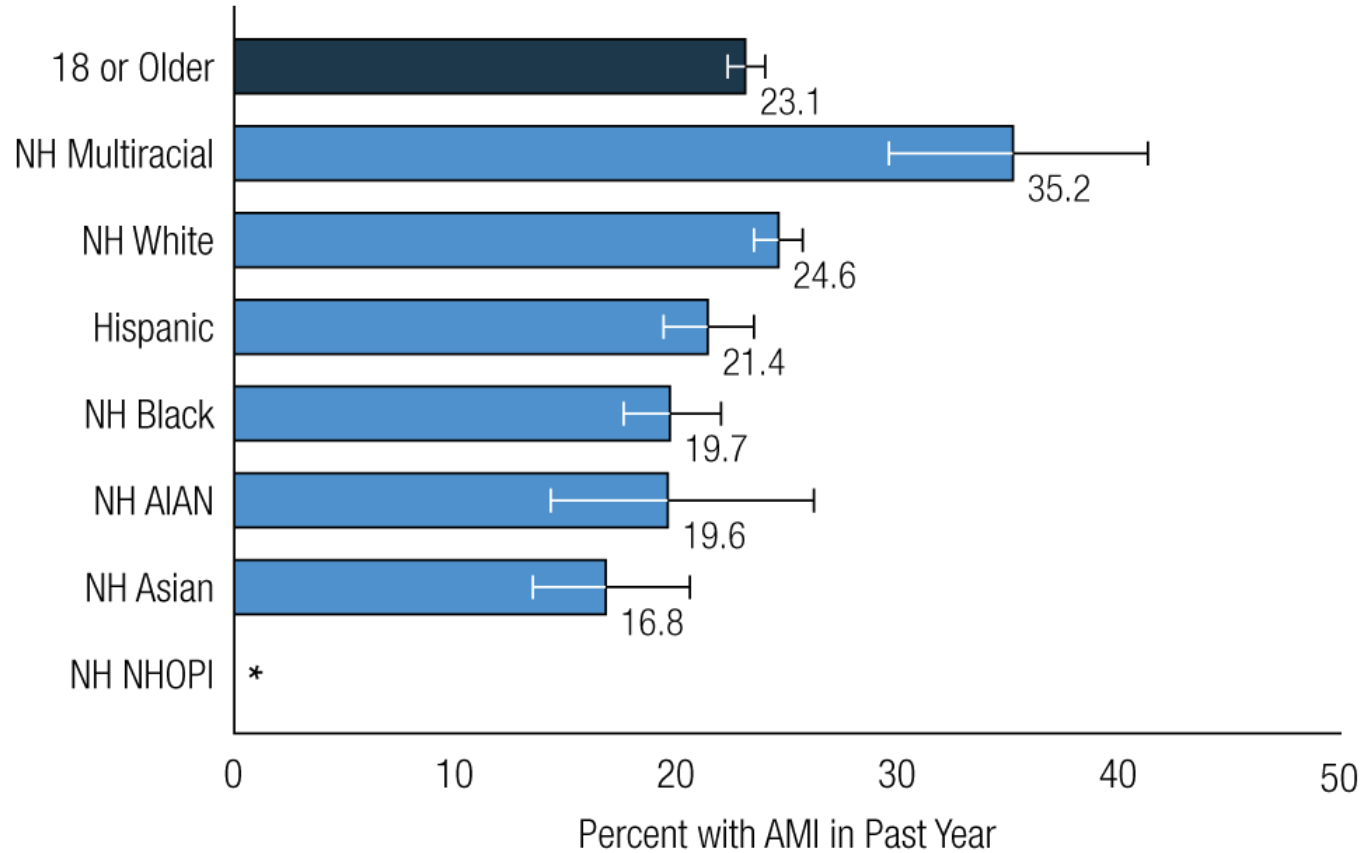
Any Mental Illness or Serious Mental Illness in the Past Year: Among Adults Aged 18 or Older; 2022

NNR.41



Any Mental Illness (AMI) in the Past Year: Among Adults Aged 18 or Older; by Race/Ethnicity, 2022

NNR.42



* Low precision; no estimate reported.

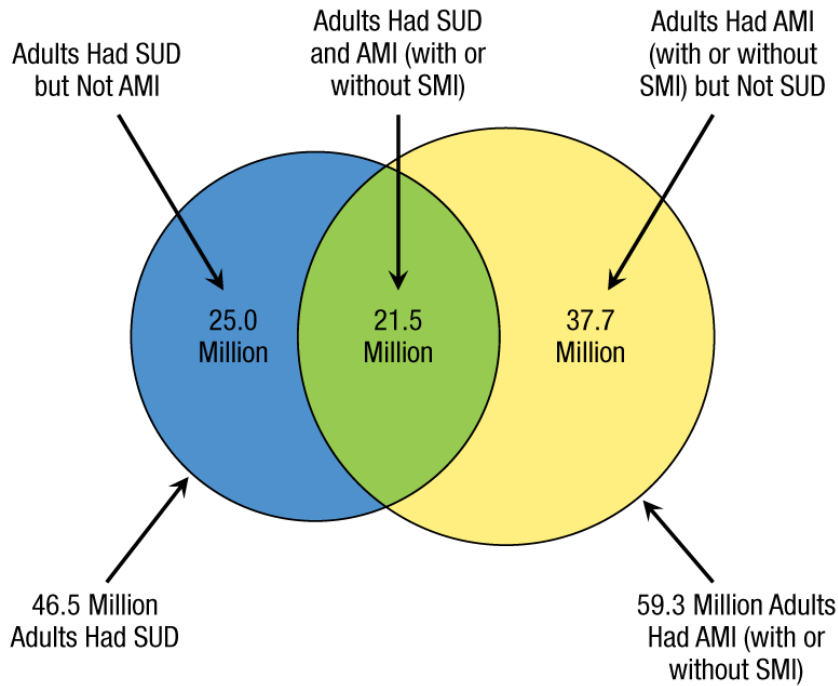
AIAN = American Indian or Alaska Native; Black = Black or African American; Hispanic = Hispanic or Latino; NH = Not Hispanic or Latino; NHOPI = Native Hawaiian or Other Pacific Islander.

Note: Error bars were calculated as 99 percent confidence intervals. Wider error bars indicate less precise estimates. Large apparent differences between groups may not be statistically significant.

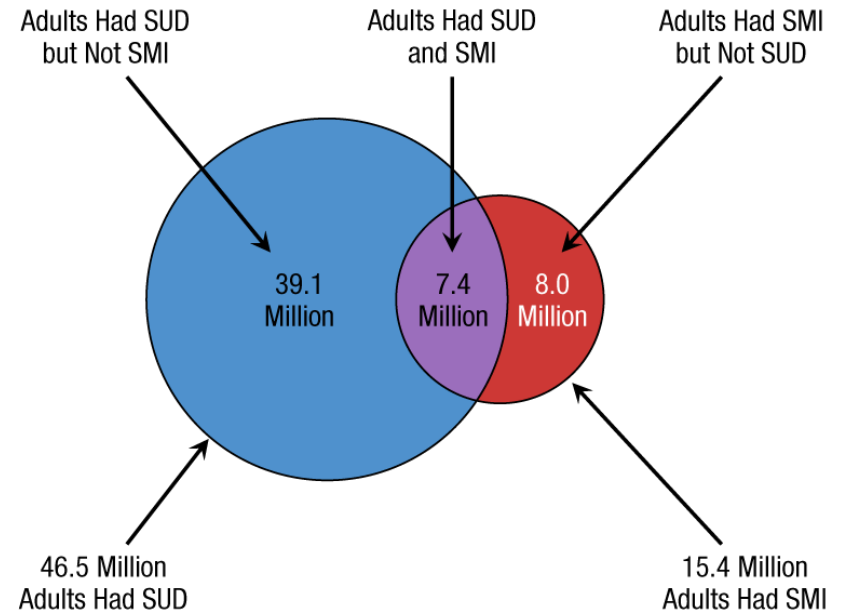


Any Mental Illness (AMI), Serious Mental Illness (SMI), or Substance Use Disorder (SUD) in the Past Year: Among Adults Aged 18 or Older; 2022

NNR.45



84.2 Million Adults Had Either SUD or AMI (with or without SMI)



54.4 Million Adults Had Either SUD or SMI



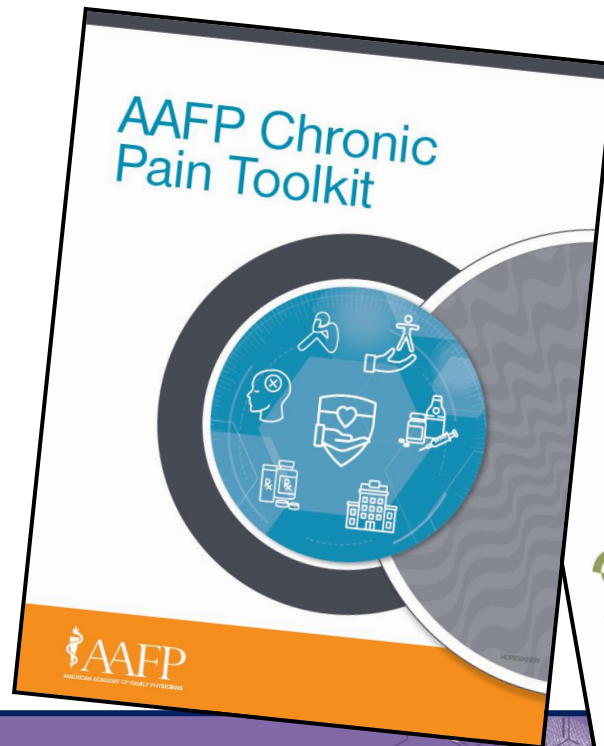
Chronic Pain and Opioid Dependence (CPOD)

OBJECTIVES:

1. Be able to identify the three health conditions that merit attention at every encounter for the patient with chronic pain & opioid dependence (CPOD)
2. Know how to establish a plan of action that includes a benefit-risk assessment with a timeline for the patient with chronic pain & opioid dependence (CPOD)
3. Be familiar with different treatment strategies for patients with different pain scenarios: acute pain, post-op pain, and chronic pain.



Chronic Pain and Opioid Dependence (CPOD) – Treatment Strategy



CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ACPA – Stanford Resource Guide To Chronic Pain Management An Integrated Guide to Comprehensive Pain Therapies



11937 W. 119th Street, Suite 216
Overland Park, KS 66213
T: 913-991-4740
F: 913-991-4740
E: acpa@theacpa.org
W: [American Chronic Pain Association](http://AmericanChronicPainAssociation.com)



1070 Arastradero Road, Suite 200
Palo Alto, CA 94304
T: 650-724-9143
F: 650-725-9642
E: painmedicine@stanford.edu
W: [Stanford Division of Pain Medicine](http://StanfordDivisionofPainMedicine.com)
X/Twitter: @StanfordPain

Copyright 2024 American Chronic Pain Association, Inc., and Stanford University Division of Pain Medicine
All rights reserved. No portion of this book may be reproduced without permission of the American Chronic Pain Association, Inc., and Stanford University Division of Pain Medicine

https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/cpm-toolkit.pdf

https://www.acpanow.com/uploads/9/9/8/3/99838302/acpa_stanford_resource_guide_2024.pdf

https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf



Chronic Pain and Opioid Dependence (CPOD) – Treatment Strategy

Note: What should be included in the encounter problem list?

Chronic Non-Cancer Pain Patient

Pain

100%

Drug Dependence

100%

Mental Health

50%

Pay close attention to the *first thing* the patient states at their CPOD visit.



Chronic Pain and Opioid Dependence (CPOD) – Treatment Strategy

PLAN OF ACTION:

For **CHRONIC PHYSICAL PAIN** COMPONENT OF CARE:

Further diagnostic workup as a result of today's evaluation includes ***

Outcome goal: ***

Timeline for review: ***

For **OPIOID DEPENDENCE** COMPONENT OF CARE:

Medication review: {opioid list:47657}

Risk/Benefit Management Plan:

Identified Benefits: ***

Identified Risks: {medication side effects:51001} {opiateadverse:44248}

Opioid prescribing recommendations: ***

Non-opioid resources recommendations: {Opioid Alternatives:37648}

Outcome goal: ***

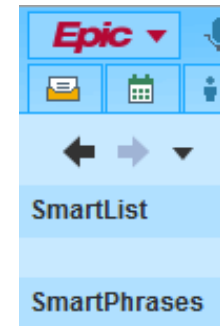
Timeline for review: ***

For **MENTAL HEALTH** COMPONENT OF CARE:

For {Mental Health History:43162}, recommend ***

Outcome goal: ***

Timeline for review: ***



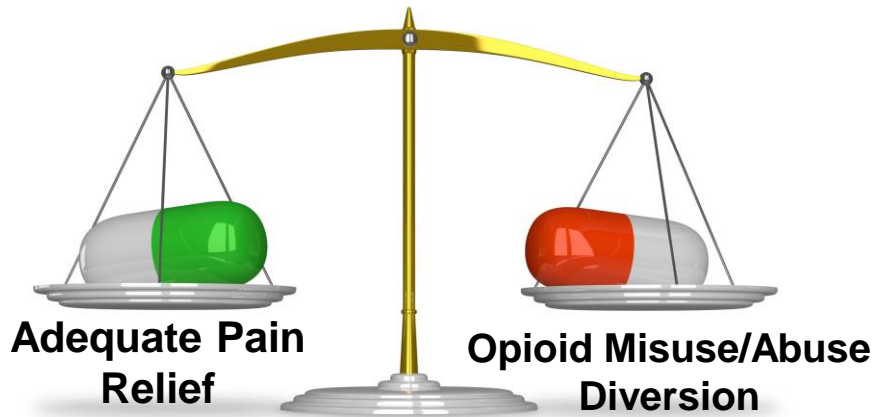
**EPIC SmartPhrase –
CPOD3PLAN [953852]**

In every encounter, address **risks and benefits** of opioids and document how this influenced your decision in the **plan of action**.

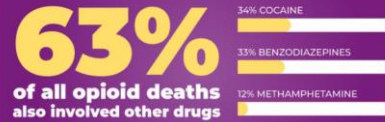
Document the **timeline** for your current plan and determine **follow-up date**.



Chronic Opioid Use - Benefits vs Risks



Dosages at or above 50 MME/day increase risks for overdose by at least



ODU's State Prescription Drug Overdose Reporting System (ODORS), 11 states, January-June 2018. MMWR cdc.gov

Opioid Alternatives

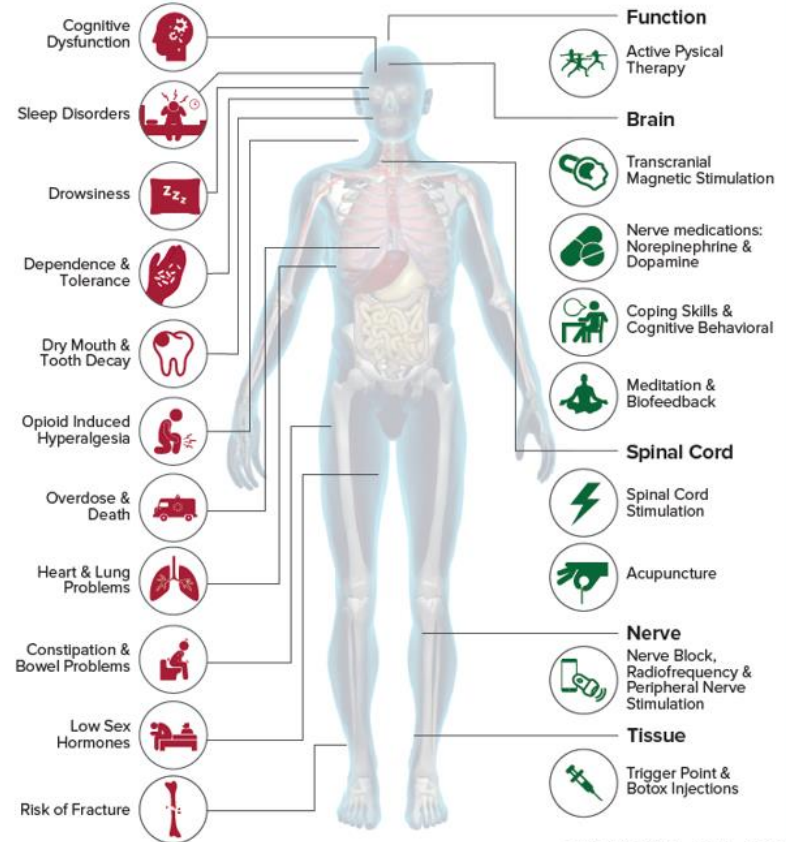
Dr Ming Kao
@pain.tools

Opioids are not the solution

Every day 44 people in the US die from overdose of prescription painkillers and many more become addicted.

Treating pain at the source

Pain specialists can help you find various targeted treatments aimed at the brain, spinal cord, nerves, and tissue.

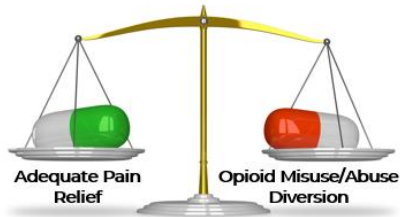


© 2016, 2017, 2018 Ming-Chih Kao, PhD, MD



Chronic Pain and Opioid Dependence (CPOD) – Treatment Strategy

A **Substance Use Disorder, Severe** is synonymous with having an **Addiction**.



Chronic Non-Cancer Pain Patient

Pain

Drug

Substance Use

“Addiction”

Continue Chronic Opioid Prescribing?

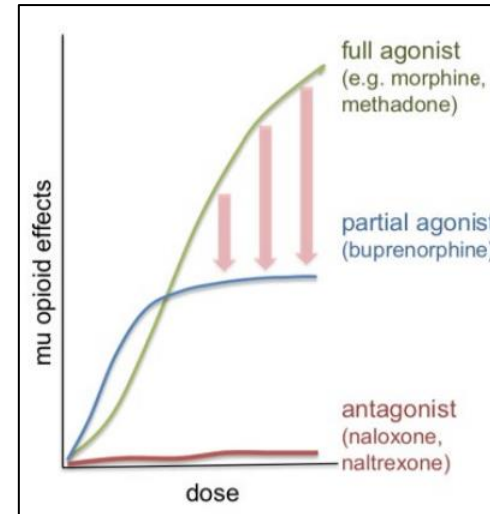
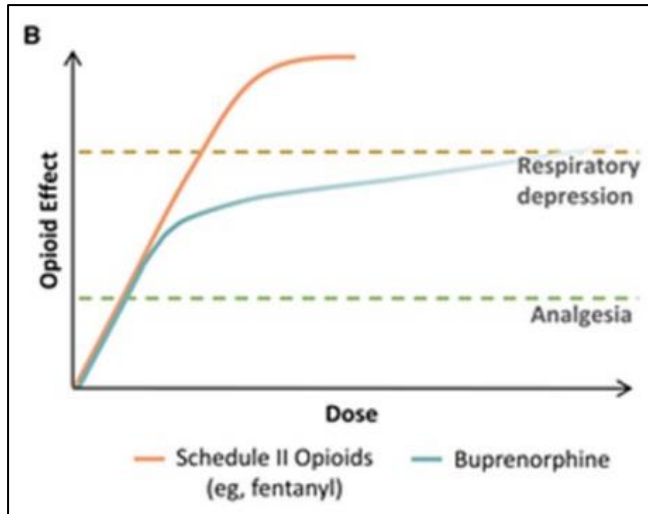
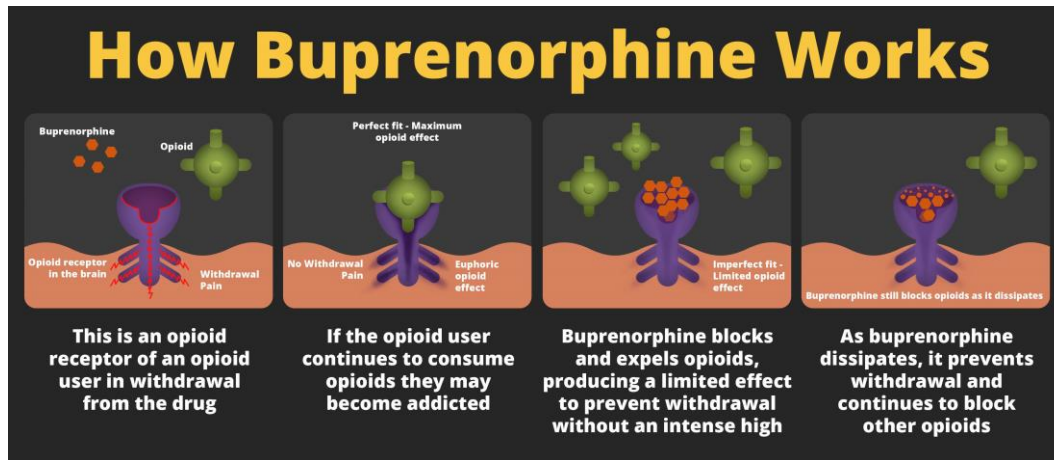
or switch to

Medication for Opioid Use Disorder *(MOUD) ?

*MOUD = methadone, buprenorphine, naltrexone



Chronic Pain and Opioid Dependence (CPOD) – Treatment Strategy



Chronic Pain and Opioid Dependence (CPOD) – Treatment Strategy

When should MOUD be considered as a treatment option?

Buprenorphine *Partial opioid agonist*

- When high risk for unintended opioid overdose death
- With increasing Morphine Milligram Equivalent per Day (MMED)
Consider for MMED \geq 90 in healthy individuals
Consider for MMED \geq 50 in individuals with co-morbidities

Methadone *Full opioid agonist*

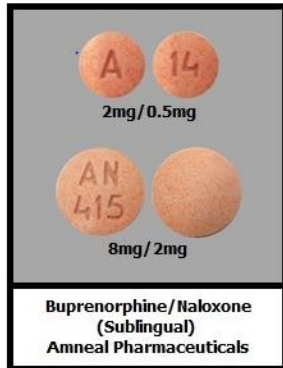
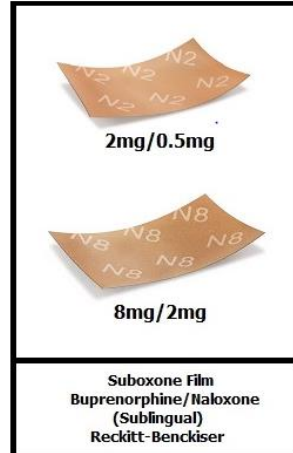
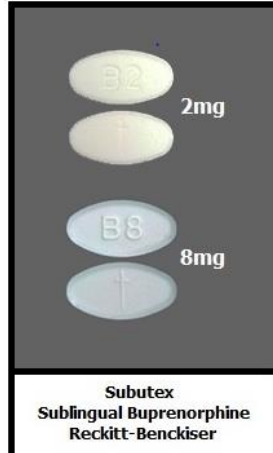
- When long-term risk of opioid side effects exceeds the benefits
- of long-term opioid

Naltrexone *Full opioid antagonist*

- With increasing DSM-5 criteria OUD classification
Opioid Use Disorder, Moderate and
Opioid Use Disorder, Severe



Chronic Pain and Opioid Dependence (CPOD) – Treatment Strategy



Buprenorphine:

- Semi-synthetic partial opioid agonist
- 2002: Opioid Replacement Therapy for persons addicted to opioids
- Much higher affinity for brain μ receptor
- Some significant euphoria – first few doses
- Some “upper”-like effect
- Some addicts take to prevent extremely uncomfortable symptoms of withdrawal
- Will cause “precipitated withdrawal” in person with notable opioid in system



Naloxone and Naltrexone



FREE NARCAN
Distribution Event

Narcan saves lives.
So can you.

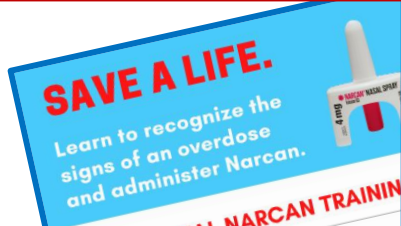
April 15th, 2022
3:30 - 5:30 P.M.
72nd and Portland
Transfer Station

Anyone
can carry Narcan.

Join this free
community event to
receive Narcan nasal spray
and learn about reversing
opioid overdose.

Questions? Contact
CAmato@tpchd.org

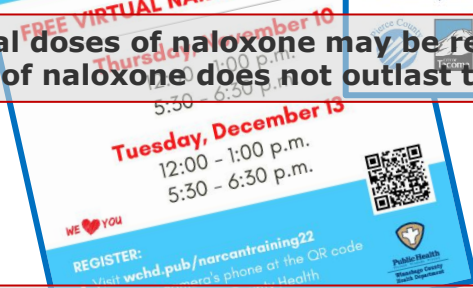
Naloxone can trip severe & unpleasant withdrawal symptoms.



SAVE A LIFE.
Learn to recognize the
signs of an overdose
and administer Narcan.

FREE VIRTUAL NARCAN TRAINING

Several doses of naloxone may be required to reverse an overdose. The reversal effect of naloxone does not outlast the sedating effect of many opioids.



Thursday, November 10
12:00 - 1:00 p.m.
5:30 - 6:30 p.m.

Tuesday, December 13
12:00 - 1:00 p.m.
5:30 - 6:30 p.m.

WE ♥ YOU

REGISTER:
Visit wehd.pub/narcantraining22
or call your community's phone at the QR code

Public Health
Westchester County
Health Department



PREVENT OVERDOSE DEATHS

ABOUT 10 NEW YORKERS DIE FROM DRUG OVERDOSE EVERY DAY

**SAVE A LIFE
CARRY NALOXONE**

YOU CAN SAVE A LIFE WITH NALOXONE
An emergency medicine that prevents
overdose death from prescription
painkillers and heroin.

AVAILABLE WITHOUT PRESCRIPTION

Naloxone should be made available to pts & those around them...

- ≥ 100 morphine milligram equivalents (MME) total for acute pain
- ≥ 50 MME daily for chronic pain.

Note: Naloxone is the “rescue drug” and Naltrexone is the MOUD drug



The Opioid Crisis: Four Major Themes

1. Prevent unintended opioid overdose deaths
2. Provide appropriate opioid use disorder services
3. Provide adequate pain relief... using opioids
4. Mitigate misuse/abuse of prescribed opioids



Acute Pain, Post-Op Pain, and Prescription Pain Reliever Misuse

OBJECTIVES:

1. Be able to identify the three health conditions that merit attention at every encounter for the patient with chronic pain & opioid dependence (CPOD)
2. Know how to establish a plan of action that includes a benefit-risk assessment with a timeline for the patient with chronic pain & opioid dependence (CPOD)
3. Be familiar with different treatment strategies for patients with different pain scenarios: acute pain, post-op pain, and chronic pain.



Acute Pain, Post-Op Pain, and Prescription Pain Reliever Misuse

Chronic Pain: measure opioids in total MMEs per day.

Recommend < 50 MME/day in total Rx

Acute Pain: measure opioids in total MMEs per prescription.

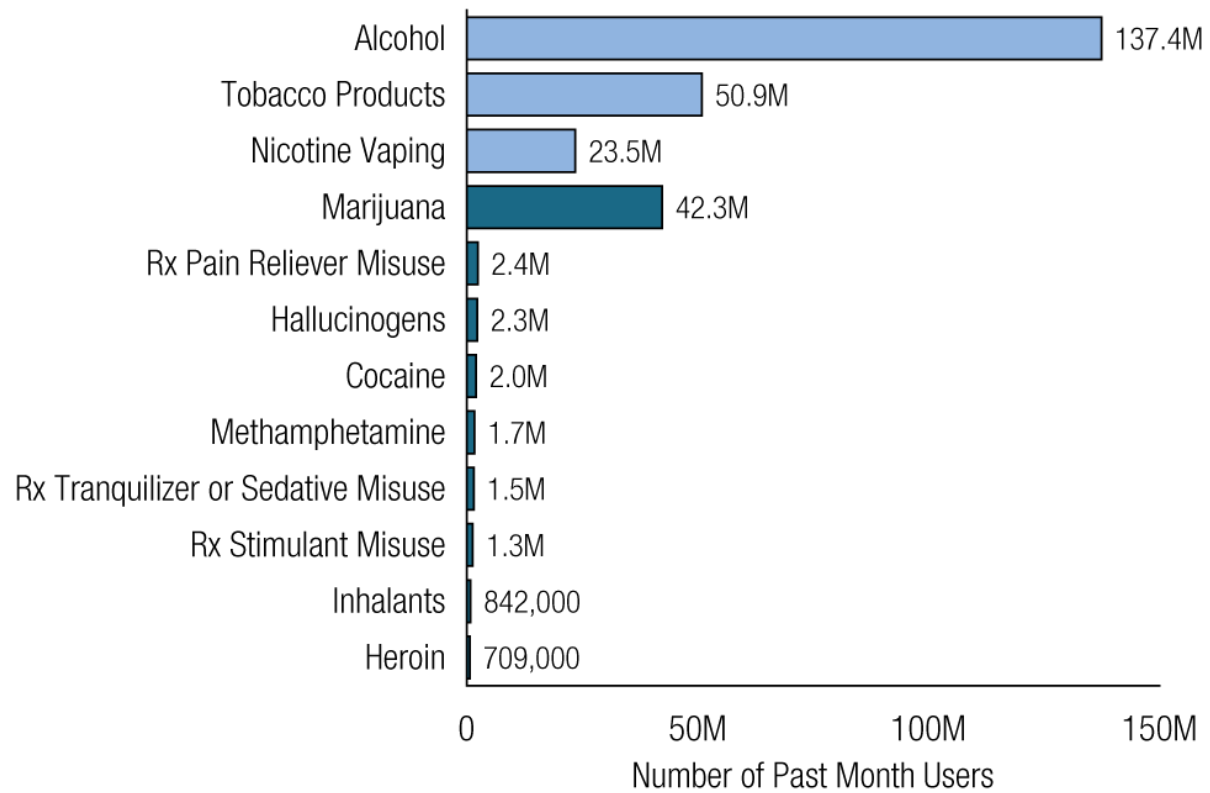
Recommend ≤ 100 MME in total prescription (Rx)

Post-op Pain: measure opioids in total MMEs per prescription based upon a tiered system for severity of pain.

*Recommend ≤100 MME total Rx in Tier 1 surgeries;
≤200 MME total Rx in Tier 2 surgeries*



Past Month Substance Use: Among People Aged 12 or Older; 2022



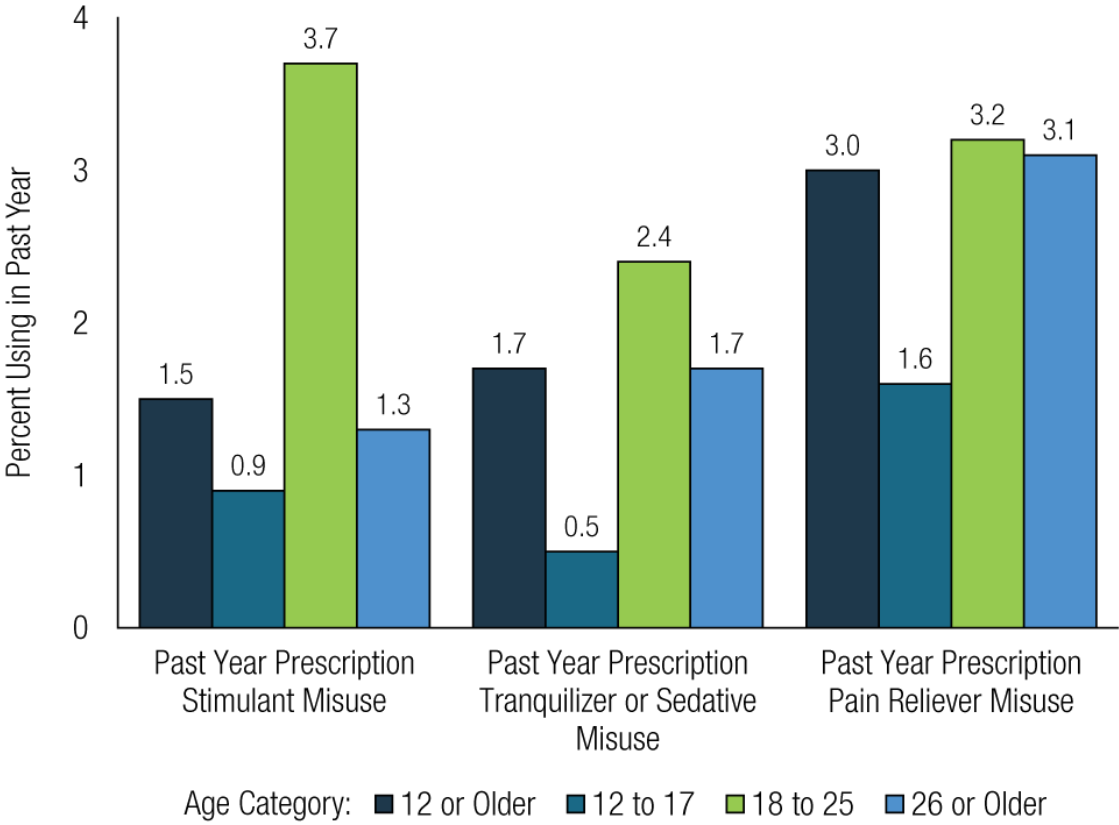
Rx = prescription.

Note: The estimated numbers of current users of different substances are not mutually exclusive because people could have used more than one type of substance in the past month.



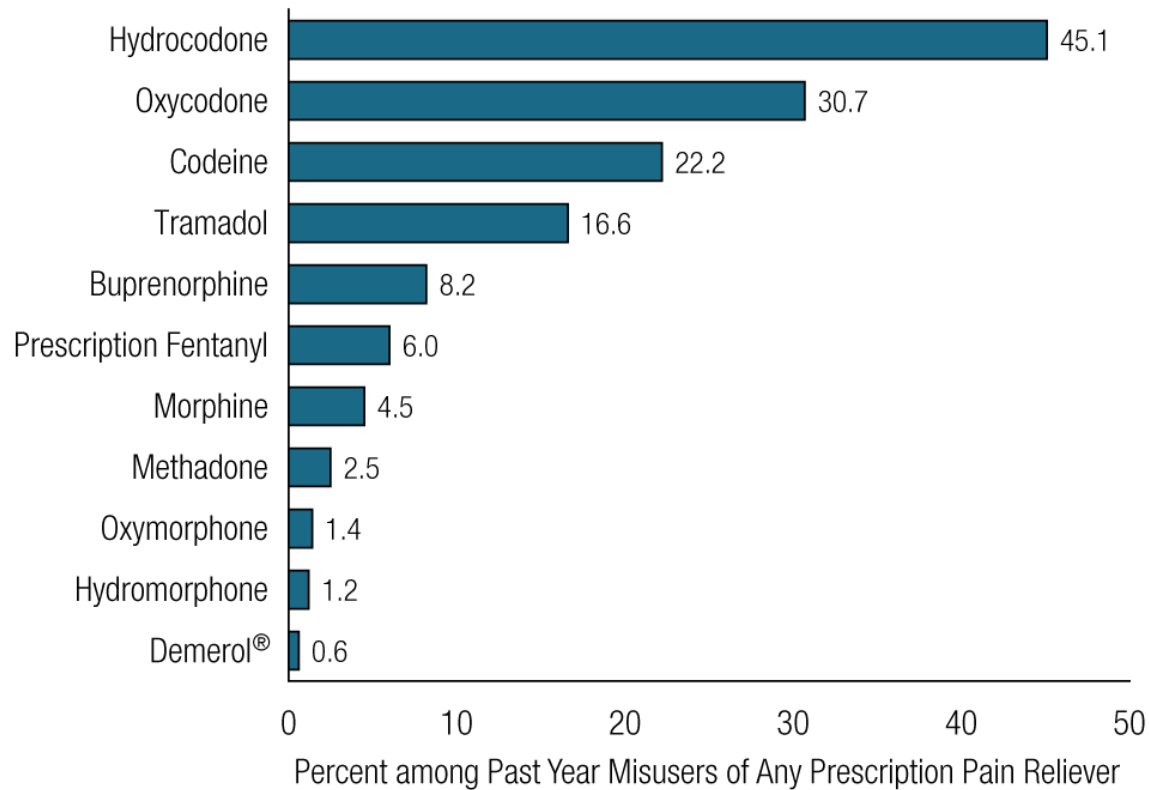
Past Year Prescription Stimulant Misuse, Past Year Prescription Tranquilizer or Sedative Misuse, or Past Year Prescription Pain Reliever Misuse: Among People Aged 12 or Older; 2022

NNR.20



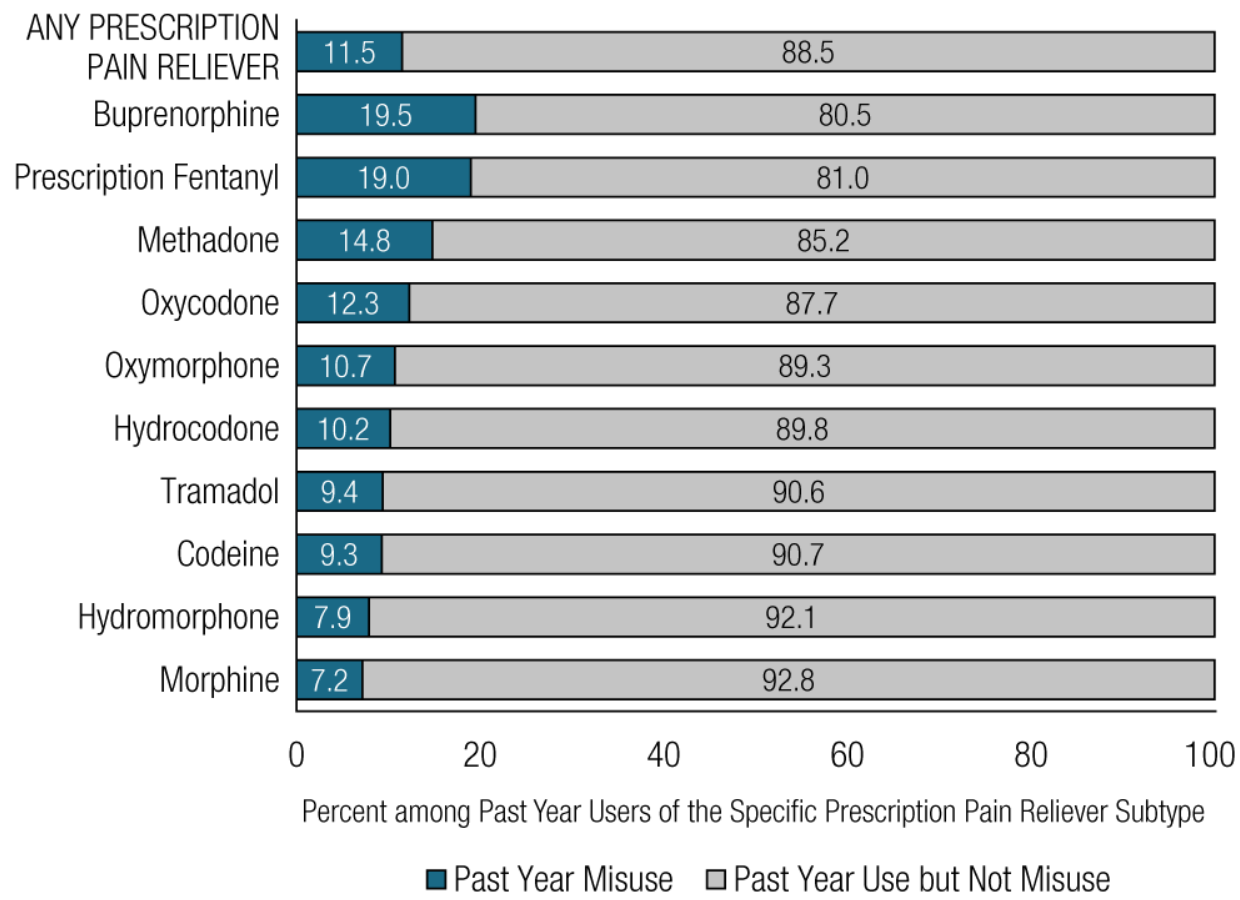
Past Year Prescription Pain Reliever Subtype Misuse: Among People Aged 12 or Older Who Misused Any Prescription Pain Reliever in the Past Year; 2022

NNR.21



Past Year Prescription Pain Reliever Subtype Misuse: Among All Past Year Users of Prescription Pain Reliever Subtypes Aged 12 or Older; 2022

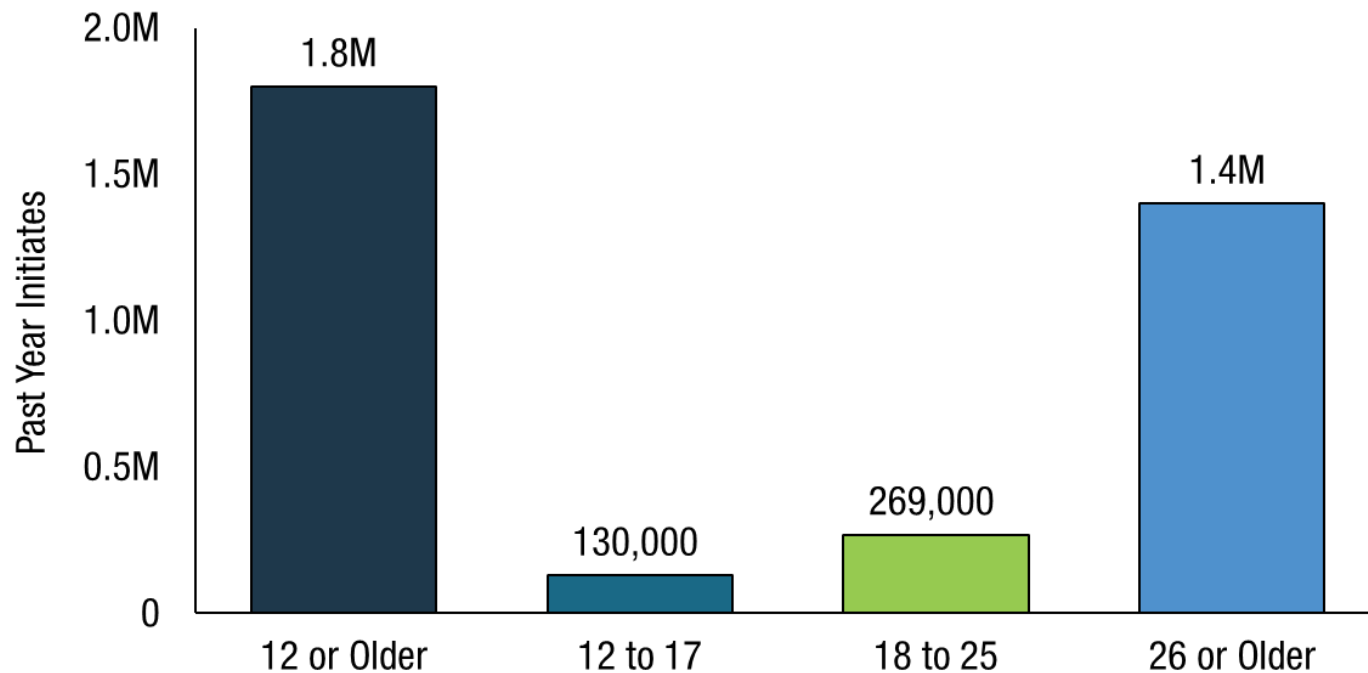
NNR.22



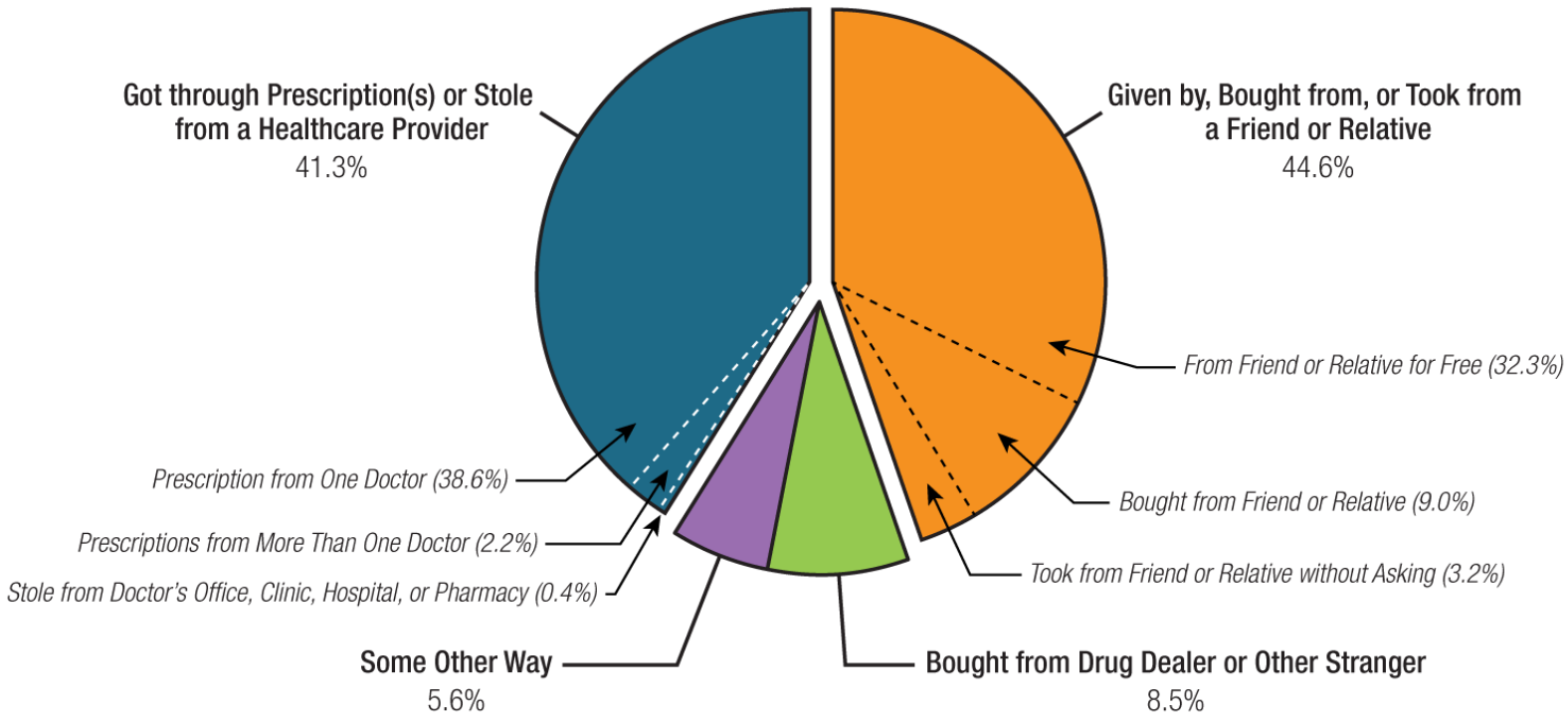
Note: Estimates for Demerol® are not shown due to low precision.



Past Year Prescription Pain Reliever Misuse Initiates: Among People Aged 12 or Older; 2021



Source where Prescription Pain Relievers Were Obtained for Most Recent Misuse: Among People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year; 2022



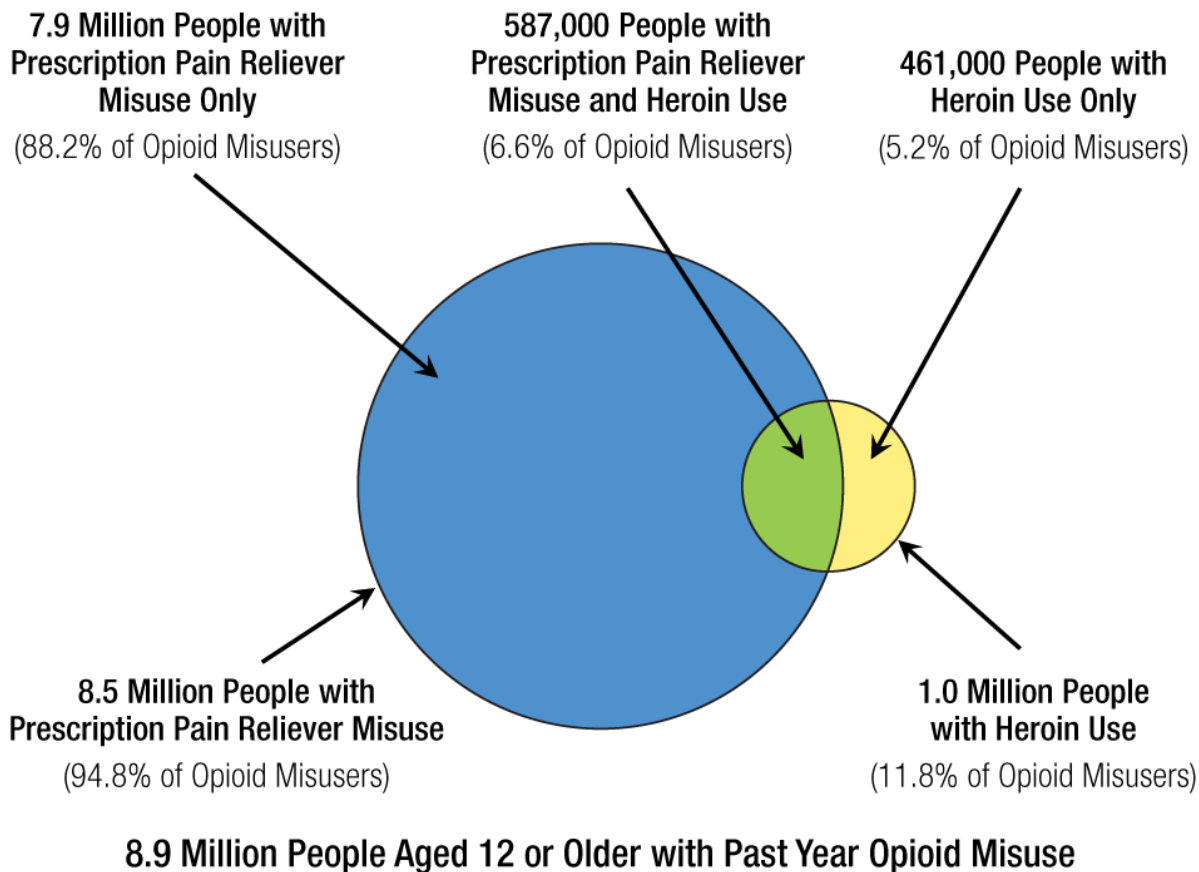
8.5 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year

Note: Respondents with unknown data for the Source for Most Recent Misuse or who reported Some Other Way but did not specify a valid way were excluded.
Note: The percentages may not add to 100 percent due to rounding.



Type of Past Year Opioid Misuse: Among Past Year Opioid Misusers Aged 12 or Older; 2022

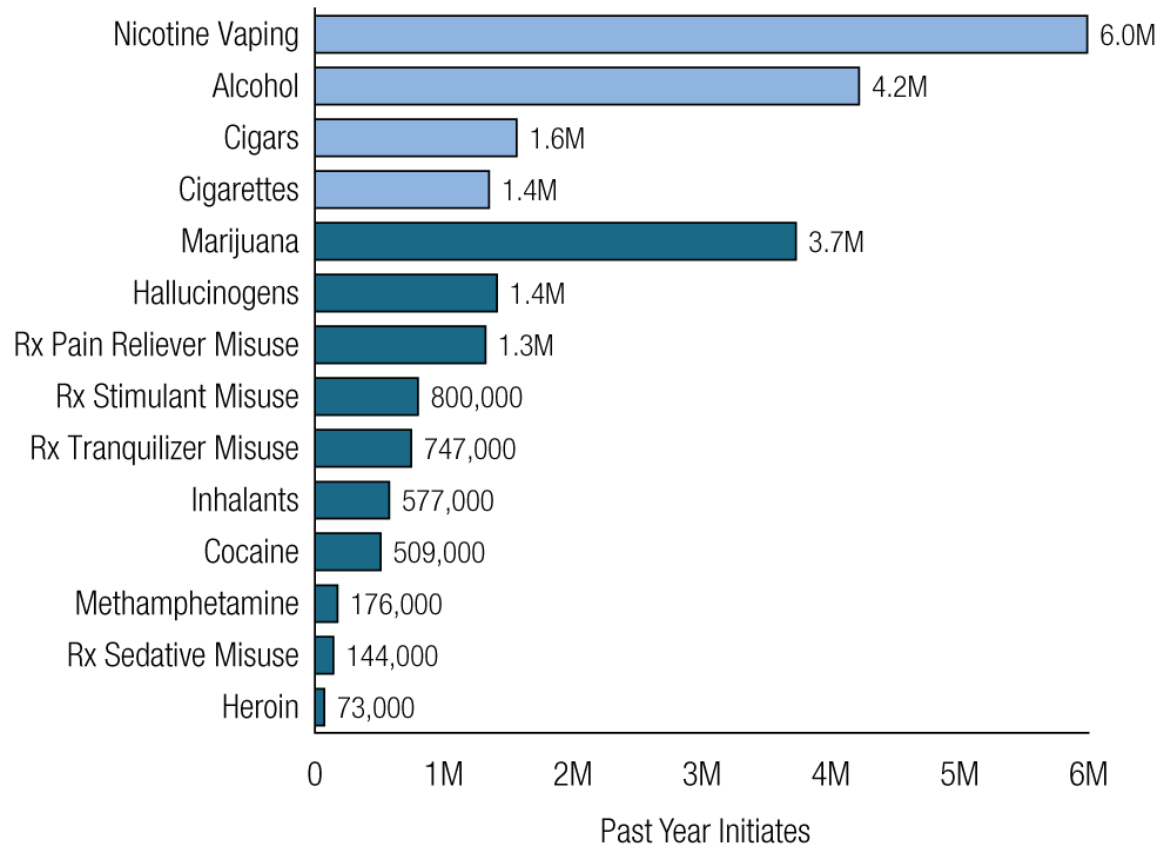
NNR.24



Note: These estimates do not include illegally made fentanyl.

Past Year Initiates of Substances: Among People Aged 12 or Older; 2022

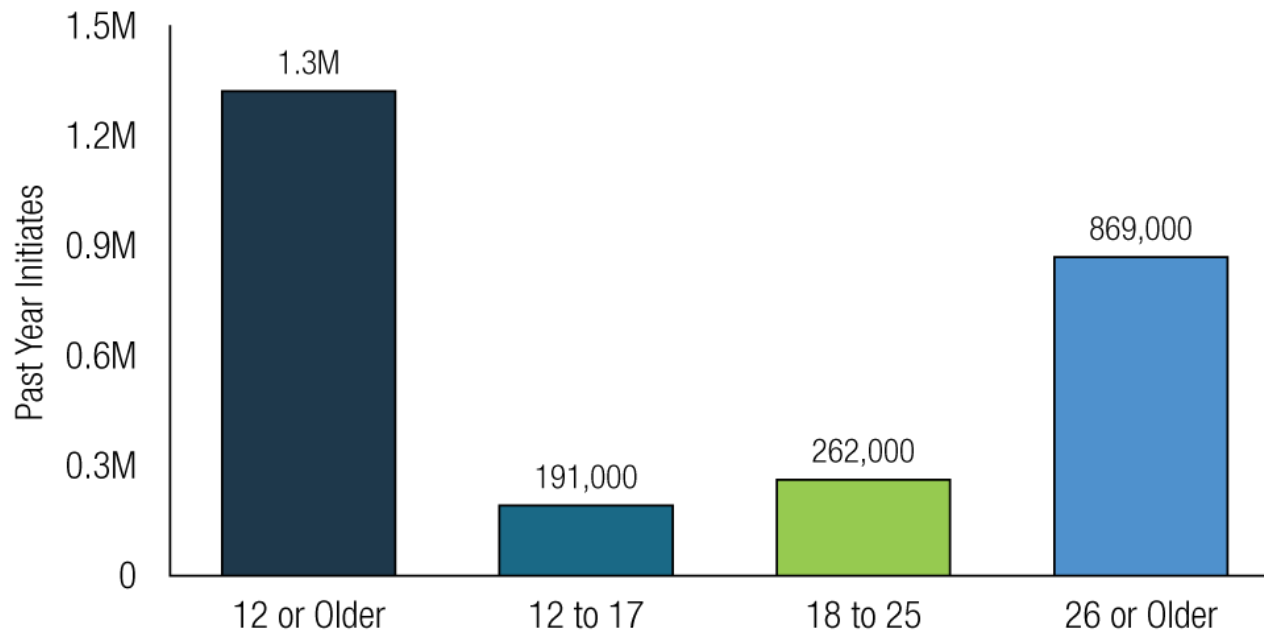
NNR.26



Rx = prescription.

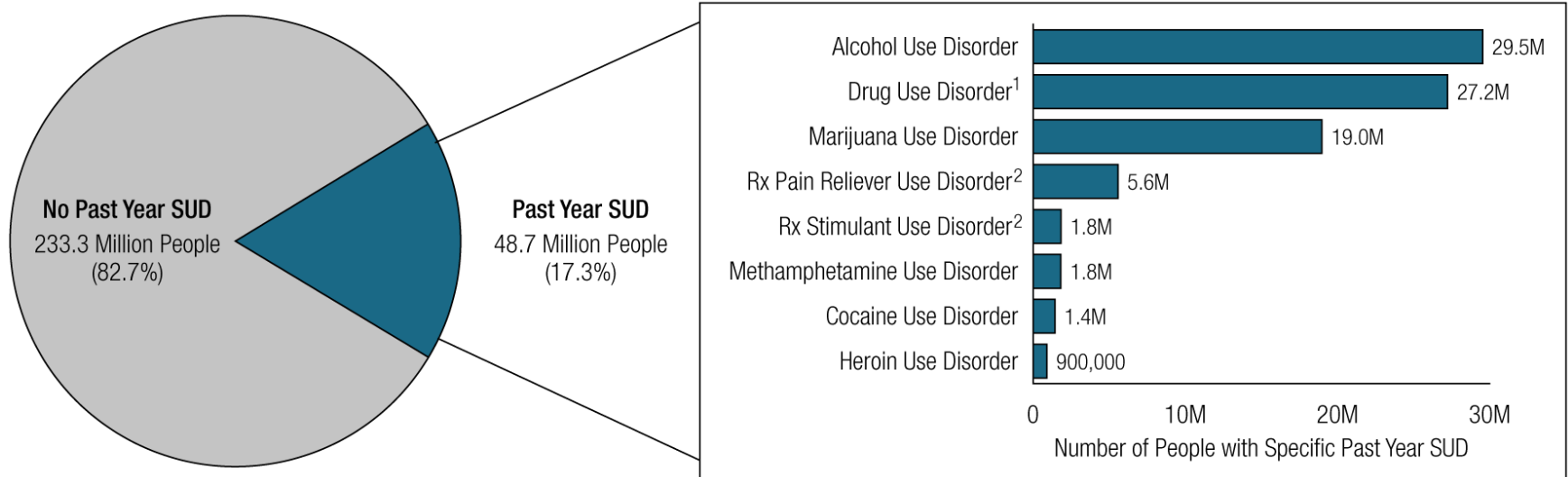
Past Year Prescription Pain Reliever Misuse Initiates: Among People Aged 12 or Older; 2022

NNR.29



Past Year Substance Use Disorder (SUD): Among People Aged 12 or Older; 2022

NNR.31



Rx = prescription.

Note: The estimated numbers of people with SUDs are not mutually exclusive because people could have use disorders for more than one substance.

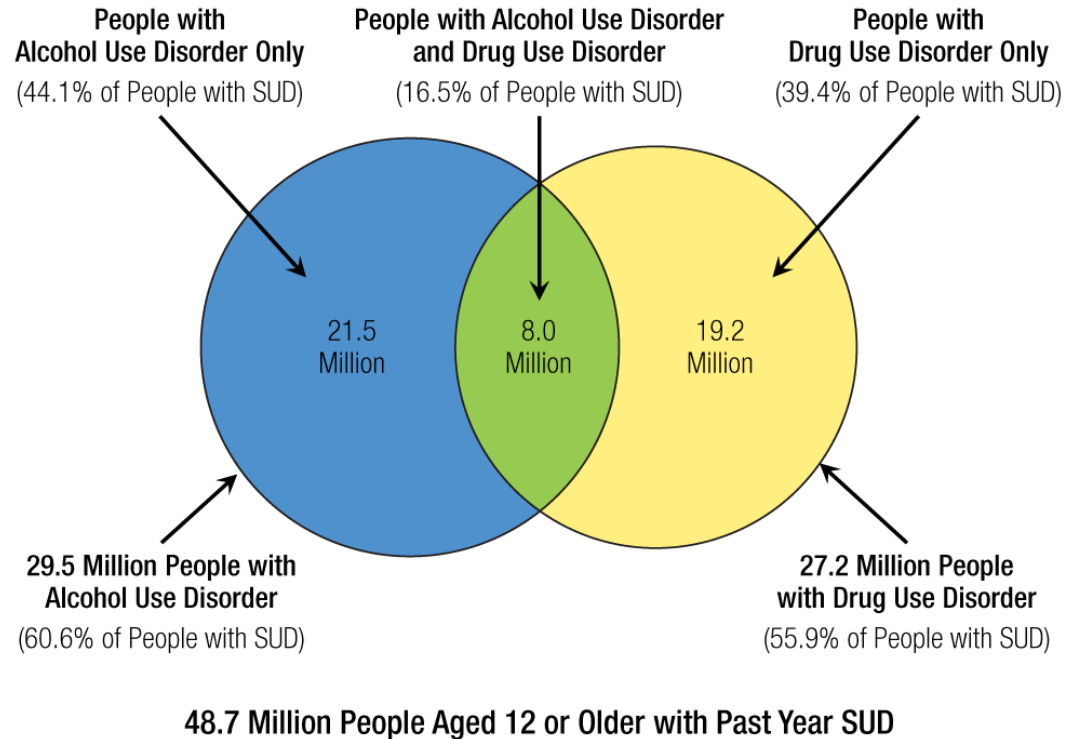
¹ Includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives).

² Includes data from all past year users of the specific prescription drug.



Alcohol Use Disorder or Drug Use Disorder in the Past Year: Among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD); 2022

NNR.32

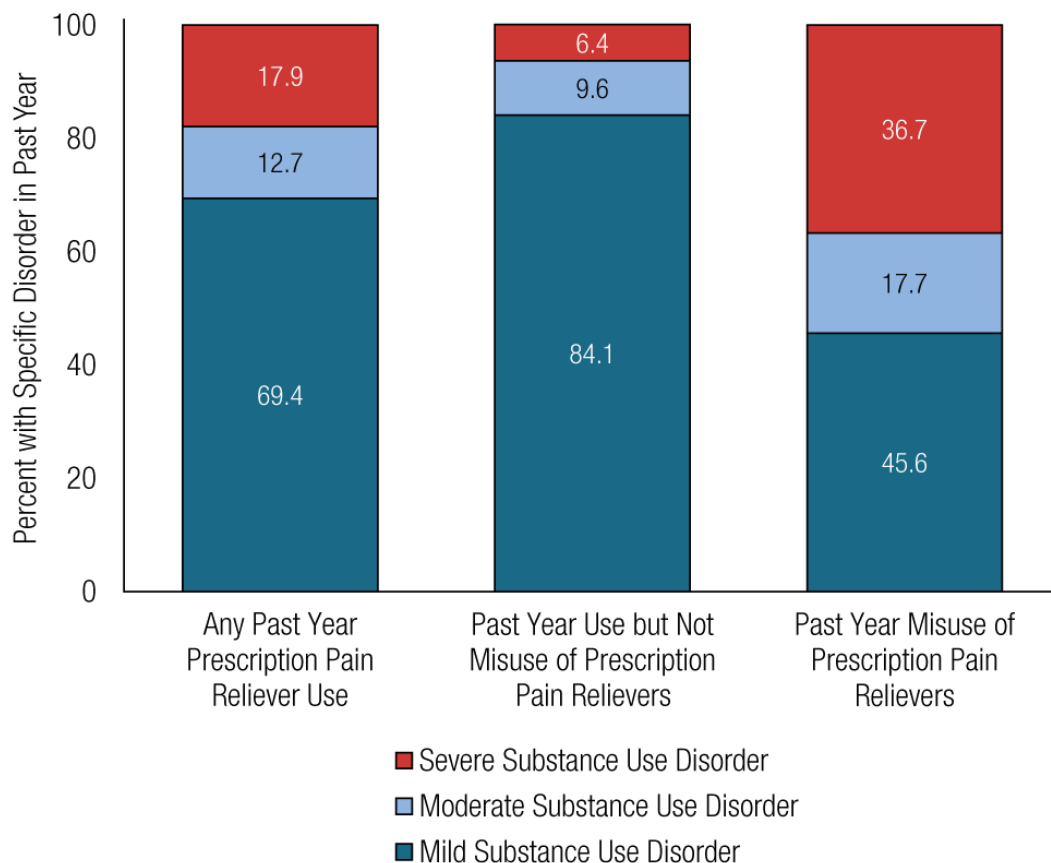


Note: Drug Use Disorder includes data from all past year users of marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, or sedatives).



Prescription Pain Reliever Use Disorder Severity Level in the Past Year: Among People Aged 12 or Older with a Prescription Pain Reliever Use Disorder; 2022

NNR.37



Note: The percentages may not add to 100 percent due to rounding.

Note: The number of criteria for pain reliever use disorder differed for people who misused prescription pain relievers in the past year or who used but did not misuse them. Regardless of the total number of criteria used for classifying people as having a prescription pain reliever use disorder, people who meet two or three criteria are considered to have a "mild" disorder, those who meet four or five criteria are considered to have a "moderate" disorder, and those who meet six or more criteria are considered to have a "severe" disorder.



Acute Pain vs Chronic Pain

Table C. Management Considerations Based on Pain Type: Acute vs. Chronic Pain

| Characteristics | Acute Pain | Chronic Pain |
|---|--|---|
| Duration | Normal healing duration; <3-6 months | Prolonged duration >6 months |
| Function | Physiologic (protective) | Pathologic (non-protective) |
| Cause | Acute illness, injury, trauma, surgery or other medical procedure | Injury, chronic illness, cancer, may have no indefinable pathology |
| Characteristics | Usually nociceptive; sharp, localized, sudden/gradual onset | Usually a combination of nociceptive and neuropathic, dull, aching, generalized, persistent |
| Treatment options (non-inclusive list no in any particular order) | Nonsteroidal anti-inflammatory drugs (NSAIDS), acetaminophen, opioids, nerve blocks, ketamine, muscle relaxants, pain-reducing modalities (e.g., immobilization, heat/cold, and elevation), graded exercise of the affected body area, physical therapy. Opioids are not recommended for acute low back pain. | Non-opioid analgesics, physical therapy, cognitive behavioral therapy, rehabilitation, exercise, integrative medical therapies (e.g., yoga, relaxation, tai chi, massage, and acupuncture), opioids on a case-by-case basis |
| Goals of treatment | Pain Resolution + Resolve underlying cause: <ul style="list-style-type: none"> - Facilitate recovery - Reduce pain - Minimize side effects - Prevent chronic pain | Pain Control + Restore function: <ul style="list-style-type: none"> - Restore function (physical, emotional, social) - Decrease pain (e.g., treat underlying cause, minimize medication use) - Correct secondary consequences (e.g., maladaptive behavior) |



Acute Pain, Post-Op Pain, and Prescription Pain Reliever Misuse

Chronic Pain: measure opioids in total MMEs per day.

Recommend < 50 MME/day in total Rx

Acute Pain: measure opioids in total MMEs per prescription.

Recommend ≤ 100 MME in total prescription (Rx)

Post-op Pain: measure opioids in total MMEs per prescription based upon a tiered system for severity of pain.

*Recommend ≤100 MME total Rx in Tier 1 surgeries;
≤200 MME total Rx in Tier 2 surgeries*



Acute Pain, Post-Op Pain, and Prescription Pain Reliever Misuse

| Surgical Grouping: Gynecology Procedure Description | # procedures | # Rx | % Rx | Benchmark (2018 25th Percentile MME) MAX | 2018 Mean MME | Minimum/ Maximum MME |
|---|--------------|------|------|---|---------------------|----------------------------|
| Colporrhaphy | 43 | 26 | 60% | 100 | 144 | 30-450 |
| Conization Of Cervix | 231 | 28 | 12% | 55 | 86 | 30-225 |
| Endometrial Ablation | 30 | 10 | 33% | 45 | 72 | 23-160 |
| Excision of Ovary/Ovarian Duct | 218 | 184 | 84% | 90 | 128 | 25-300 |
| Hysterectomies | 1003 | 846 | 84% | 113 | 158 | 25-440 |
| Hysteroscopy with Treatment | 535 | 285 | 53% | 50 | 78 | 15-270 |
| Incision and Drainage of Bartholin's Gland Abscess | 55 | 8 | 15% | 63 | 93 | 45-150 |
| Ligation of Fallopian Tube | 277 | 185 | 67% | 113 | 172 | 38-1200 |
| Removal of Ovary/Ovarian Duct | 329 | 275 | 84% | 75 | 133 | 23-1800 |
| Stress Incontinence Repair | 122 | 103 | 84% | 75 | 106 | 25-240 |
| Cesarean Section** | | | | 100 | | |
| Vaginal Delivery ** | | | | 0 | | |

** Benchmark derived from literature and expert opinion.

(Bateman, 2017, Emerson 2017, Osmundson, 2018, Prabhu, 2017, Prabhu, 2018)

| Surgical Grouping: Orthopedic Procedure Description | # procedures | # Rx | % Rx | Benchmark (2018 25th Percentile MME) MAX | 2018 Mean MME | Minimum/ Maximum MME |
|---|--------------|------|------|---|---------------------|----------------------------|
| Bilateral Knee Replacement Surgery | 33 | 24 | 73% | 300 | 392 | 90-1050 |
| Carpal Tunnel Surgery | 888 | 670 | 75% | 50 | 105 | 15-1800 |
| Joint Replacements (Hip) | 766 | 600 | 78% | 240 | 335 | 50-1500 |
| Joint Replacements (Knee Revision) | 58 | 41 | 71% | 320 | 443 | 140-1200 |
| Joint Replacements (Knee) | 1136 | 945 | 83% | 300 | 411 | 75-2250 |
| Other Knee Arthroscopy with Treatment | 379 | 340 | 90% | 150 | 197 | 38-1350 |
| Other Open Surgery of The Knee | 184 | 161 | 88% | 280 | 361 | 90-1050 |
| Scopes (Knee Ligament Repair) | 314 | 297 | 95% | 225 | 304 | 70-675 |
| Scopes (Knee Meniscectomy) | 1311 | 1121 | 86% | 100 | 160 | 38-1500 |
| Therapeutic Arthroscopy of The Hip | 138 | 121 | 93% | 225 | 288 | 53-990 |
| Scopes (Rotator Cuff) | 670 | 625 | 92% | 300 | 348 | 30-1250 |
| Scopes (Shoulder) | 508 | 468 | 88% | 225 | 318 | 25-1050 |
| Total Shoulder Replacement | 106 | 89 | 84% | 240 | 332 | 40-1050 |
| Other Knee Arthroscopy with Treatment | 65 | 61 | 94% | 100 | 176 | 50-450 |
| Scopes (Knee Ligament Repair) | 104 | 97 | 93% | 200 | 276 | 60-585 |
| Scopes (Knee Meniscectomy) | 40 | 36 | 90% | 100 | 124 | 38-225 |
| Scopes (Shoulder) | 31 | 29 | 94% | 150 | 252 | 68-750 |
| Therapeutic Arthroscopy of The Hip | 30 | 29 | 97% | 210 | 306 | 150-600 |

Clinical team data analysis is used for best practice clinical guideline strategy regarding acute pain & post-op opioid prescribing recommendations.



Acute Pain, Post-Op Pain, and Prescription Pain Reliever Misuse

Hydrocodone : Morphine (1:1)

(Lortab, Norco, Vicodin)

Hydrocodone 5 mg = a
Morphine 5 mg (5 MME)

Hydrocodone 7.5mg =
Morphine 7.5mg (7.5 MME)

Hydrocodone 10 mg =
Morphine 10 mg (10 MME)

Hydromorphone : Morphine (4:1)

(Dilaudid, Exalgo)

Hydromorphone 2 mg =
Morphine 8 mg (8 MME)

Hydromorphone 4mg =
Morphine 16 mg (6 MME)

Hydromorphone 8 mg =
Morphine 32 mg (32 MME)

Hydromorphone 16 mg =
Morphine 64 mg (64 MME)

| OPIOID (doses in mg/day except where noted) | CONVERSION FACTOR |
|---|-------------------|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr.) | 2.4 |
| Hydrocodone | 1 |
| Hydromorphone | 4 |
| Methadone | |
| 1 – 20 mg/day | 4 |
| 21 – 40 mg /day | 8 |
| 41 – 60 mg/day | 10 |
| ≥ 61 – 80 mg/day | 12 |
| Morphine | 1 |
| Oxycodone | 1.5 |
| Oxymorphone | 3 |

Oxycodone : Morphine (1.5:1)

(OxyContin, OxyIR, Percocet, Percodan)

Oxycodone 5 mg =
Morphine 7.5 mg (7.5 MME)

Oxycodone 7.5mg =
Morphine 11.25mg (11.25 MME)

Oxycodone 10 mg =
Morphine 15 mg (15 MME)

Oxycodone 20 mg =
Morphine 30 mg (30 MME)



Morphine Milligram Equivalents per Day (MMED)

The Opioid Crisis: Four Major Themes

1. Prevent unintended opioid overdose deaths
2. Provide appropriate opioid use disorder services
3. Provide adequate pain relief... using opioids
4. Mitigate misuse/abuse of prescribed opioids

Questions and Comments...

