Opioid Response Network

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

Craig J. Uthe, MD FAAFP ASAM

May 16, 2024

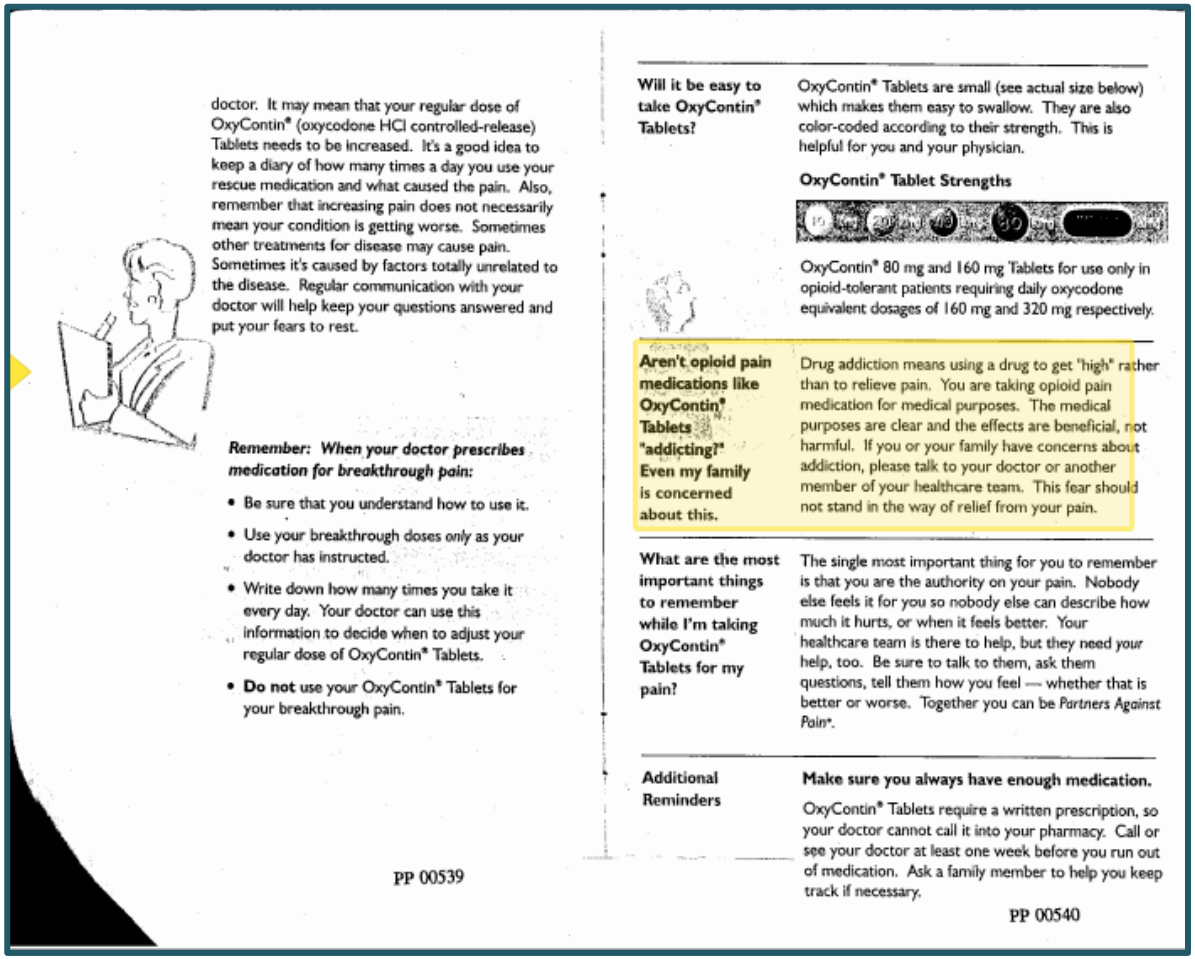
Opioid Response Network

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.

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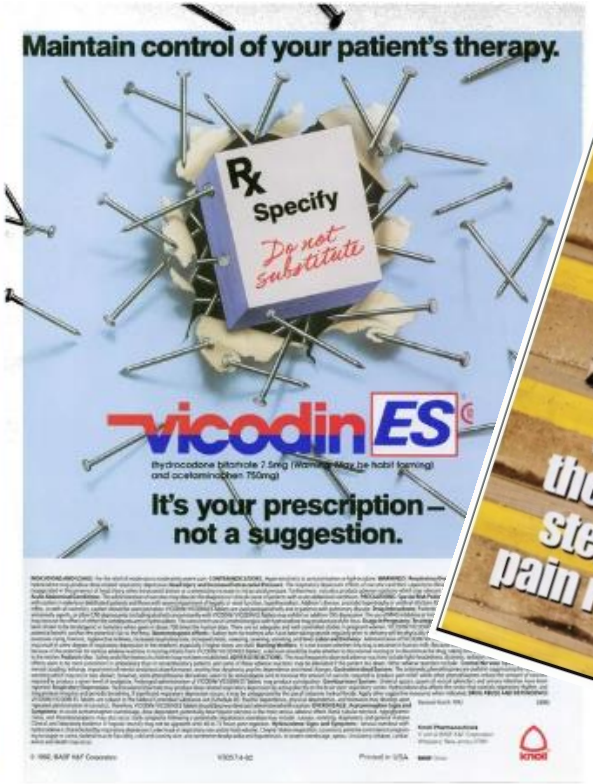
The Opioid Crisis: Four Major Themes

The Opioid Epidemic – 1990s



The Opioid Crisis: Four Major Themes

The Opioid Epidemic – 1990s

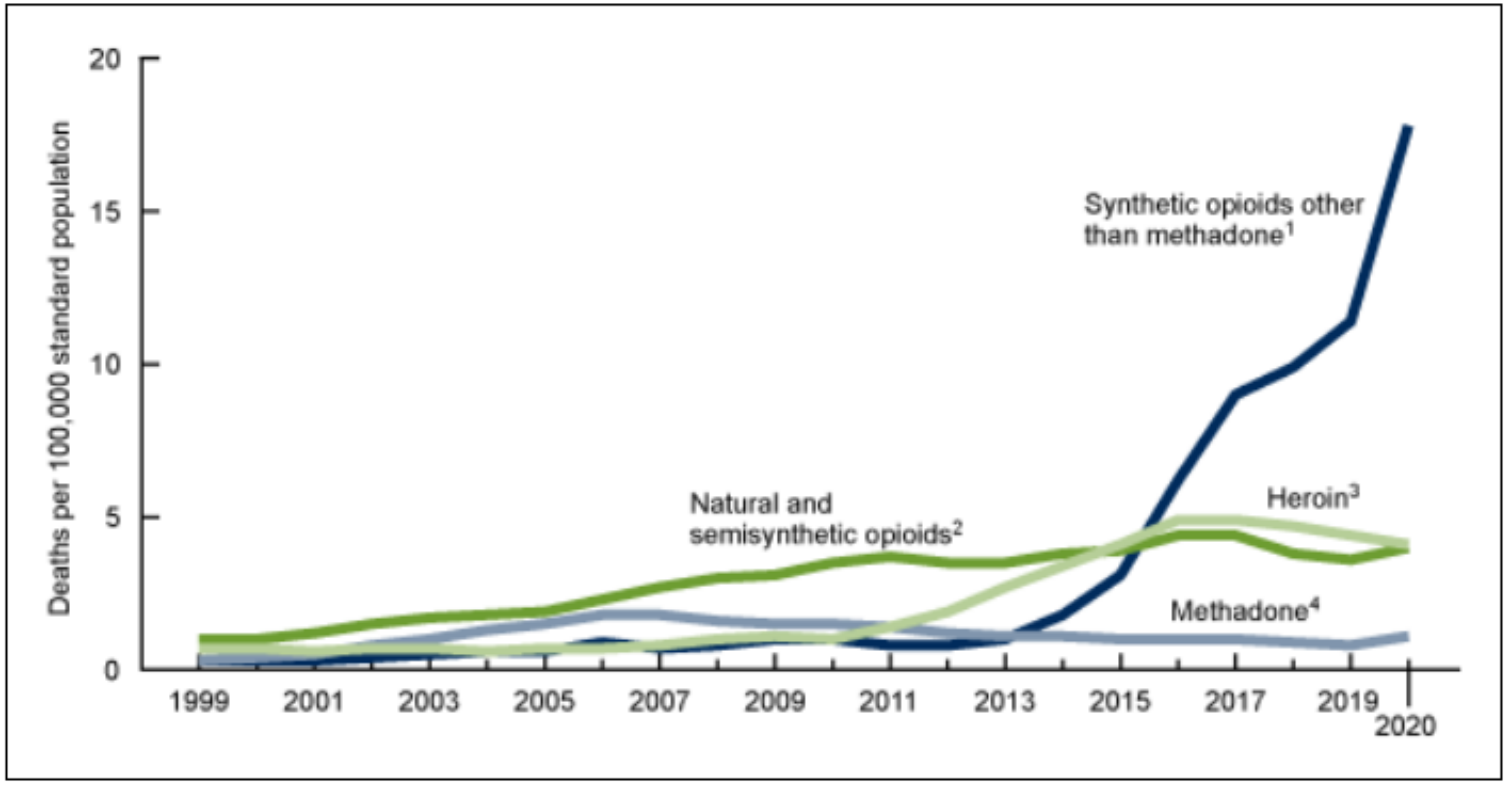
The Opioid Crisis: Four Major Themes

The Opioid Epidemic – 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 Enforcemer
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
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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)

NIDAMED

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 User Substanc Junkie Alcoholic Drunk Substanc Former a Reforme	• Person with opioid use disorder	• Person-first language. …that a person "has" a …an "is" the problem.[7] …d elicit negative …tive attitudes, and
Addicted		…born with addiction …is a behavioral …e simply born …drawal syndrome. …language can reduce
Habit		…s that a person is …ubstances or can …rmine the seriousness
Abuse	For illicit drugs: • Use	• The term "abuse" was found to have a high association with negative …unishment.[8] …prescription …ited to their use as …person to whom they …onsumption outside …is misuse. • Consider the motivation and intent of misuse (e.g., level, reasons) to determine whether the specific instance suggests SUD.
Opioid substitution Replacement therapy	• Opioid agonist therapy • Medication treatment for OUD • Pharmacotherapy	• It is a misconception that medications merely "substitute" one drug or "one addiction" for another.[6]
Clean	For toxicology screen results: • Testing negative For non-toxicology purposes: • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs	• 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	For toxicology screen results: • Testing positive For non-toxicology purposes: • Person who uses drugs	• 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 opioid use disorder (OUD)/SUD or person with opioid addiction
- Patient
- Person in recovery or long-term recovery

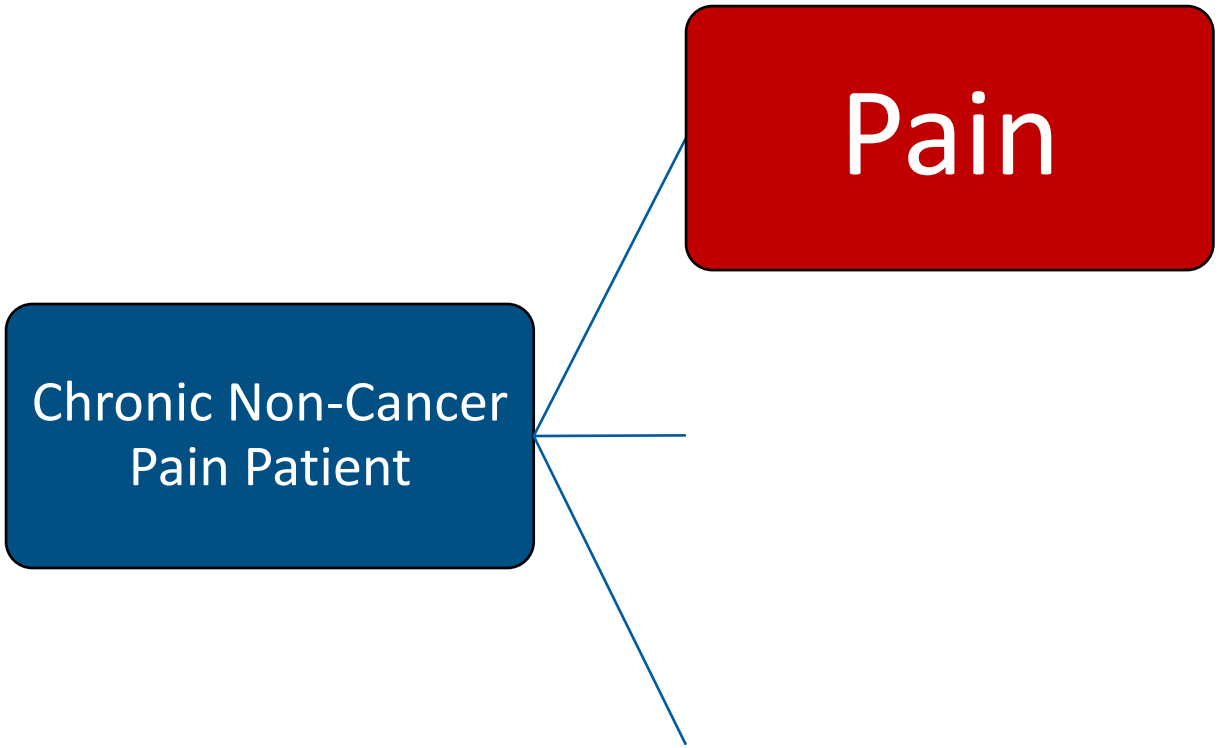
For heavy alcohol use:

- Unhealthy, harmful, or hazardous alcohol use
- Person with alcohol use disorder

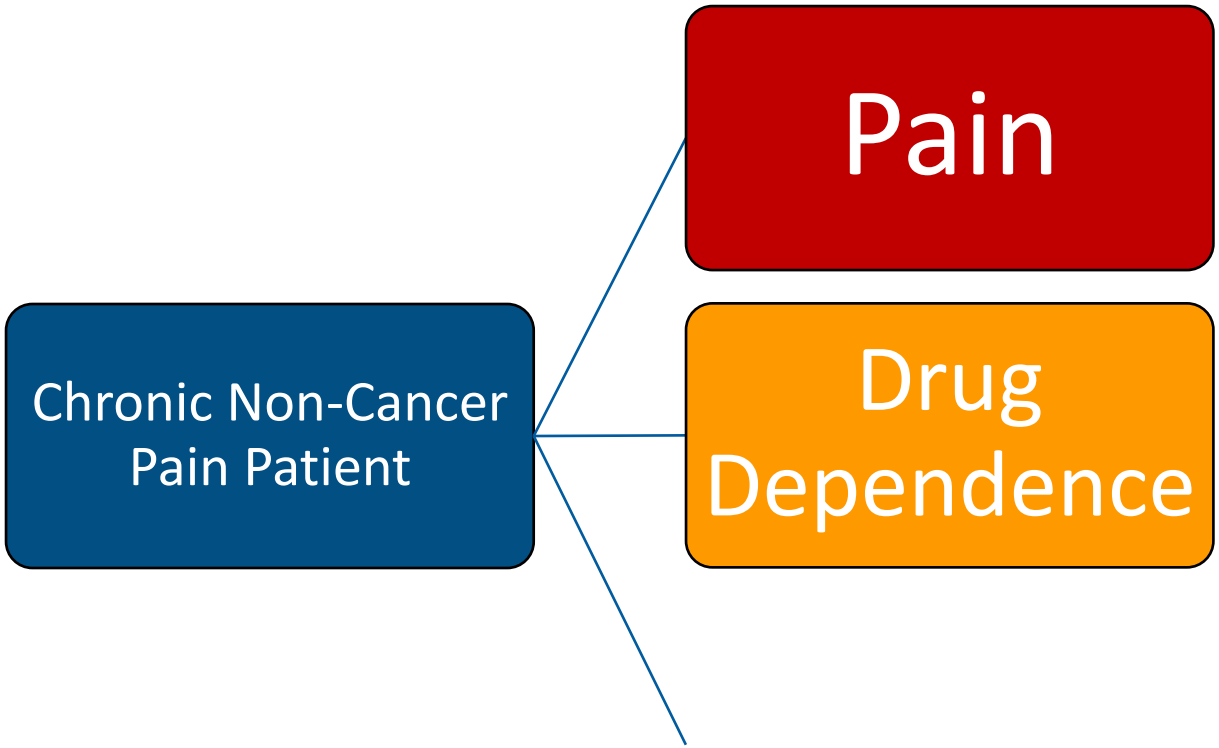
- Person with chronic pain & opioid dependence (CPOD)

https://www.asam.org/docs/default-source/default-document-library/nidamed_wordsmatter3_508.pdf

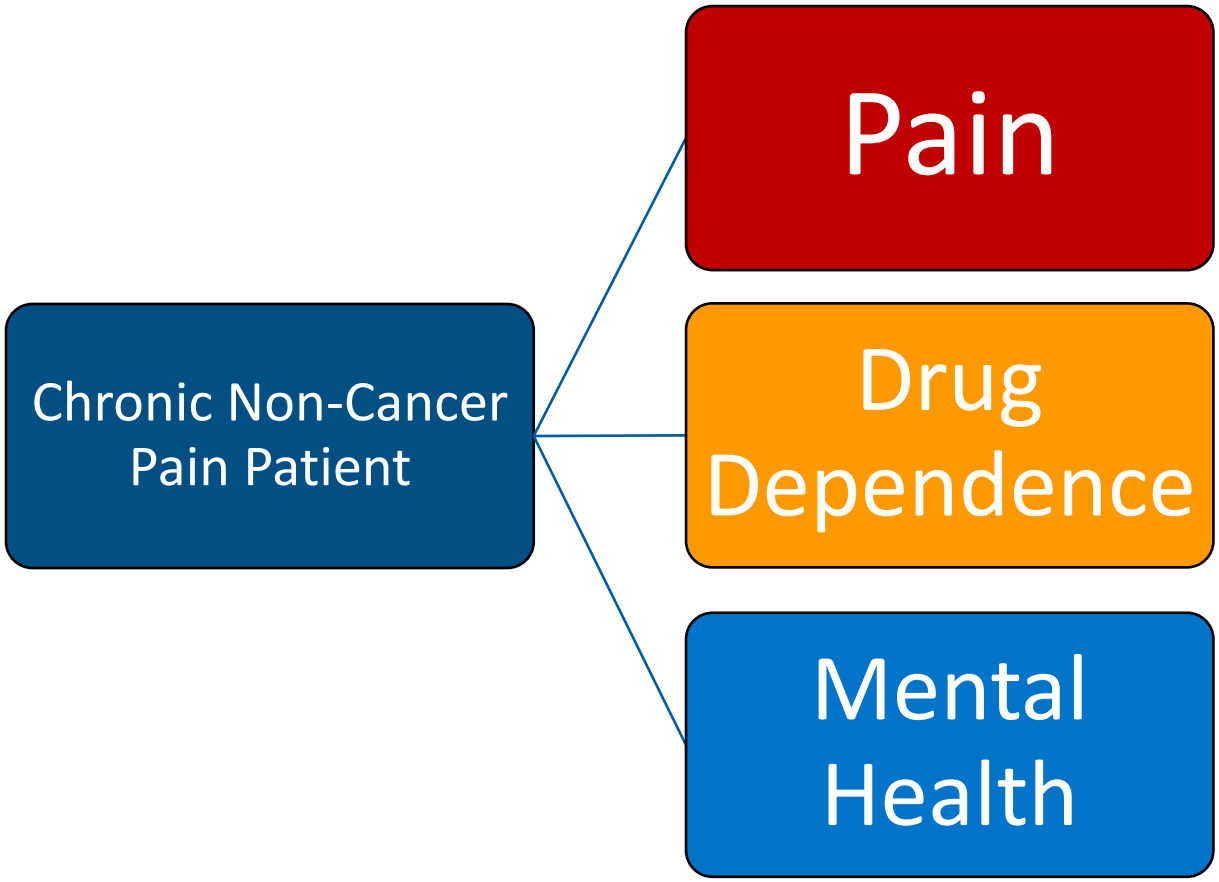
Chronic Pain and Opioid Dependence (CPOD)



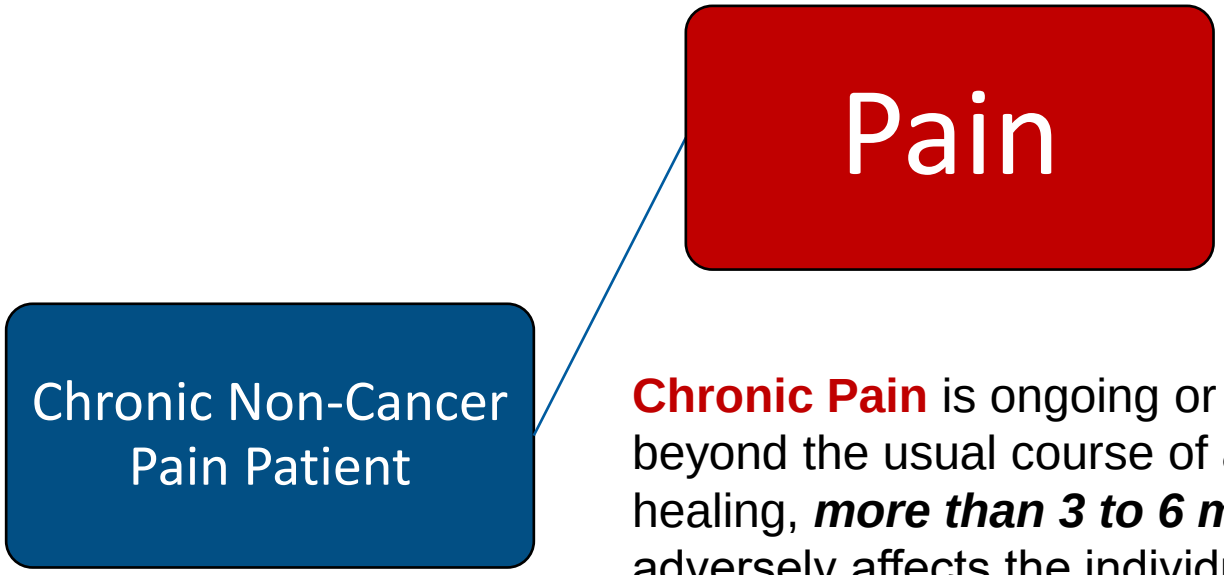
Chronic Pain and Opioid Dependence (CPOD)



Chronic Pain and Opioid Dependence (CPOD)



Chronic Pain and Opioid Dependence (CPOD)



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.***

American Chronic Pain Association (ACPA) - Stanford Resource Guide To Chronic Pain Management: An Integrated Guide to Comprehensive Pain Therapies - 2024 Edition

Chronic Pain and Opioid Dependence (CPOD)

THREE MAIN TYPES OF PATHOPHYSIOLOGY
can be considered to result in chronic pain[1]

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

Chronic Pain and Opioid Dependence (CPOD)

The 3-tiered pain matrix:

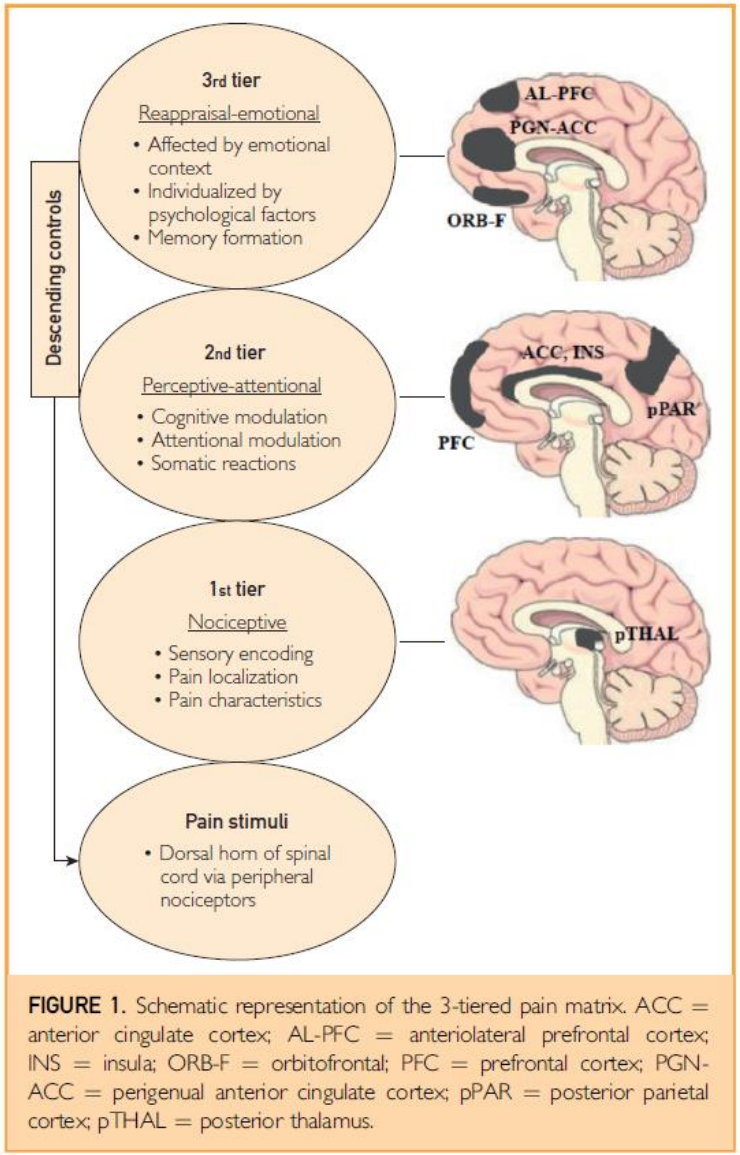
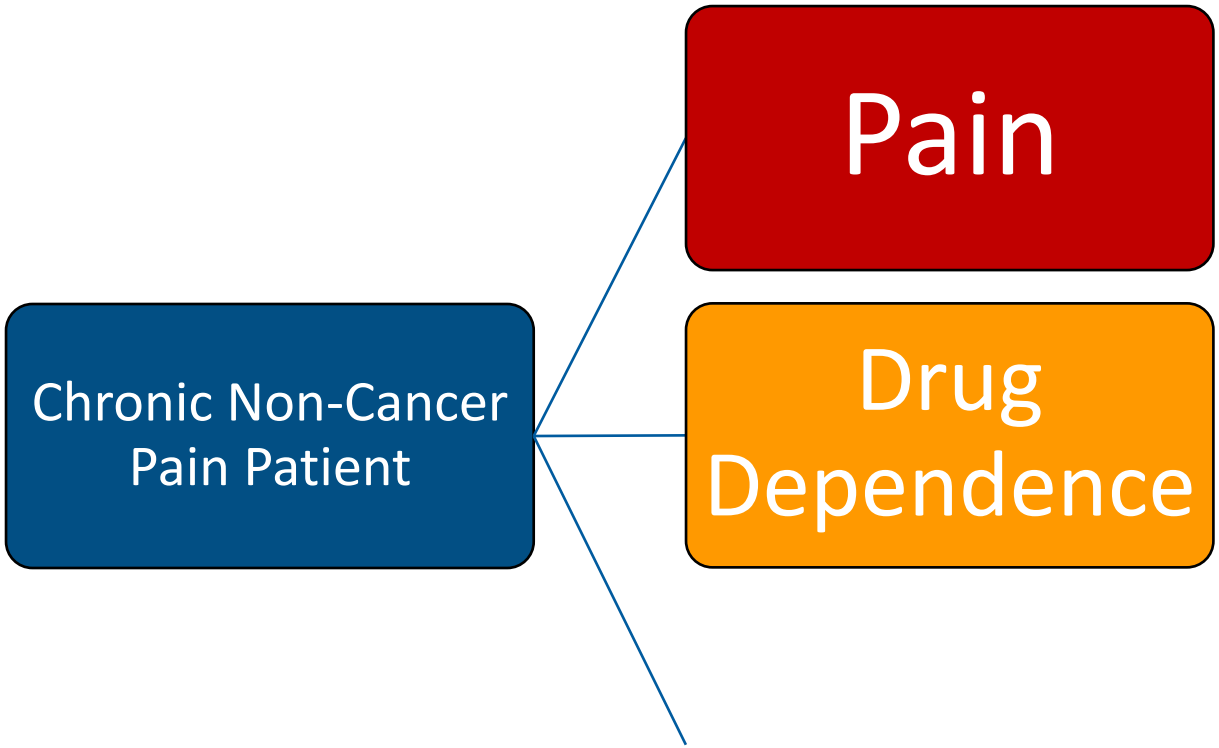


FIGURE 1. Schematic representation of the 3-tiered pain matrix. ACC = anterior cingulate cortex; AL-PFC = anteriolateral prefrontal cortex; INS = insula; ORB-F = orbitofrontal; PFC = prefrontal cortex; PGN-ACC = perigenual anterior cingulate cortex; pPAR = posterior parietal cortex; pTHAL = posterior thalamus.

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

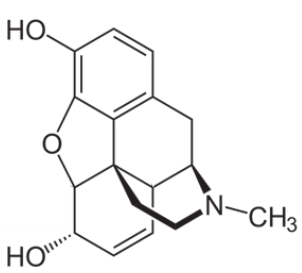
Synthetics (Narcotics):

- Meperidine
- Methadone
- Fentanyl
- Tramadol

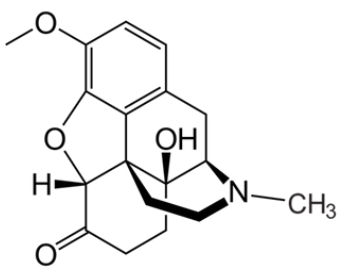
Calculating total daily opioid dosage in MMED

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

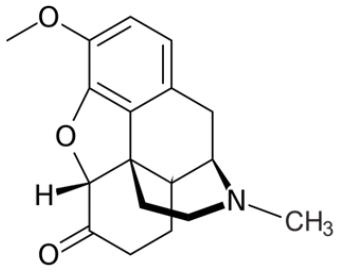
Morphine Milligram Equivalents (MME)
Morphine is the **standard** from which all other opioids are measured.



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)

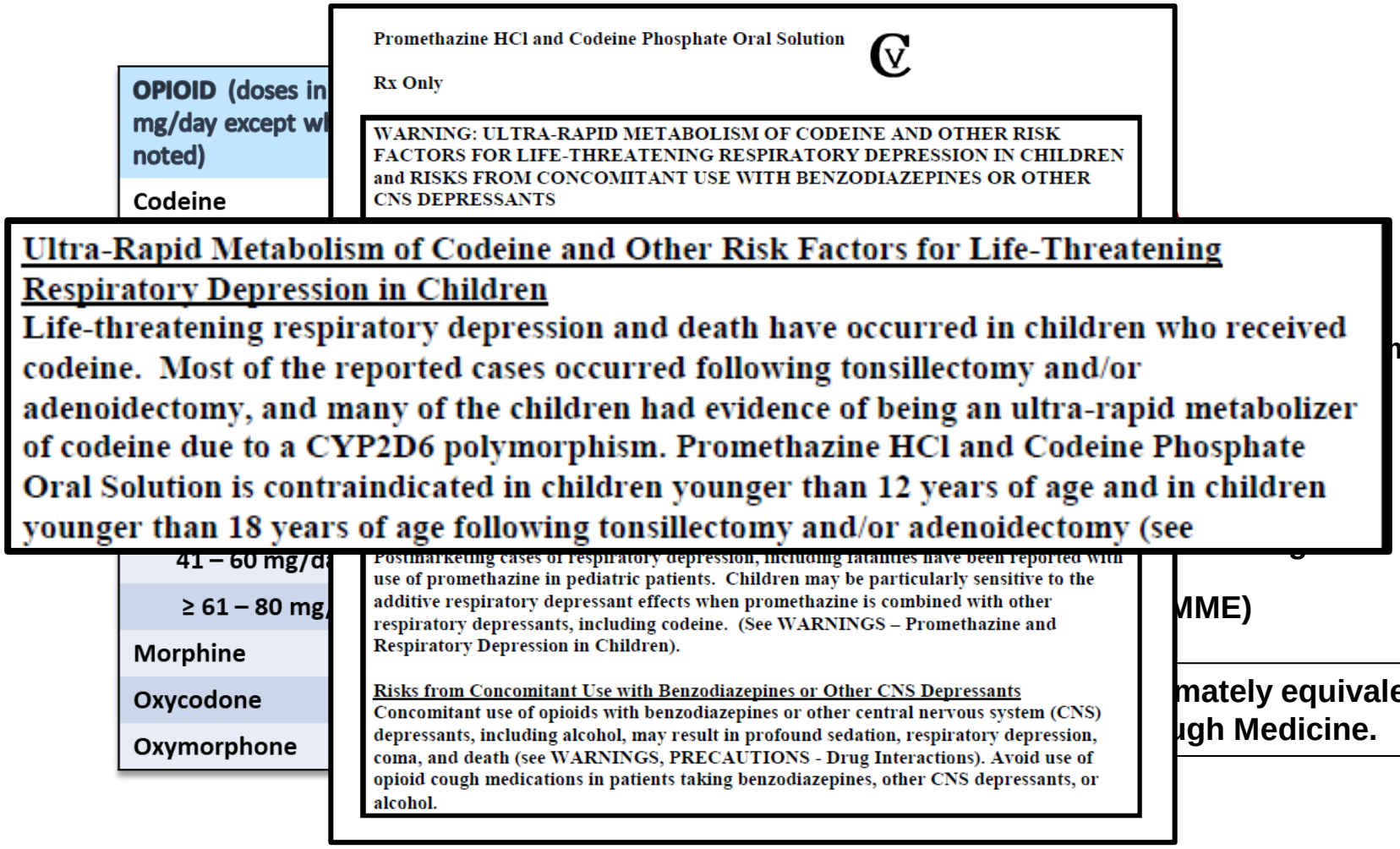
Oxycodone 5 mg = Morphine 7.5 mg (7.5 MME)

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)

Calculating total daily opioid dosage in MMED



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.

Identifying & Defining Opioid Use Disorders

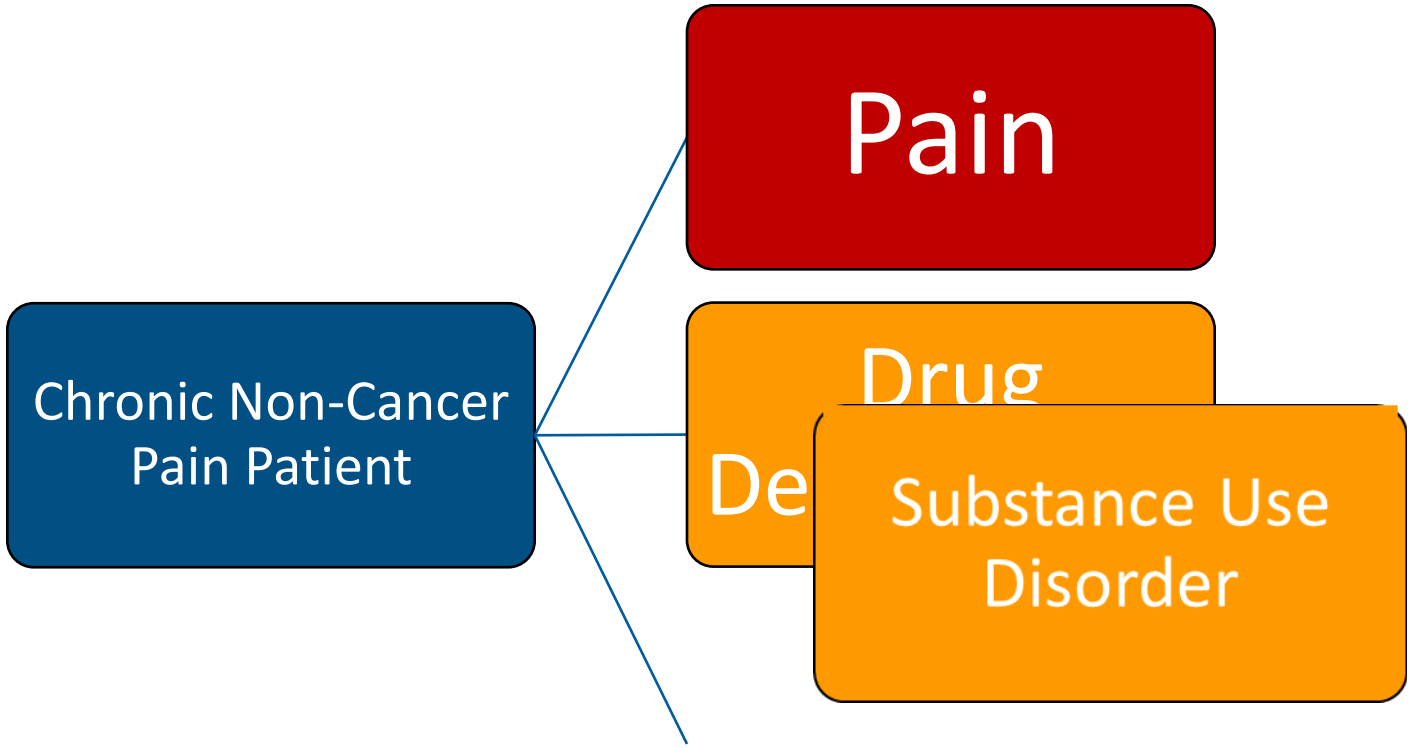
The DSM-5 states the following:

*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.
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Identifying & Defining Opioid Use Disorders

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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.

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

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11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

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

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6. Continuing to use, even when it **causes problems in relationships.**
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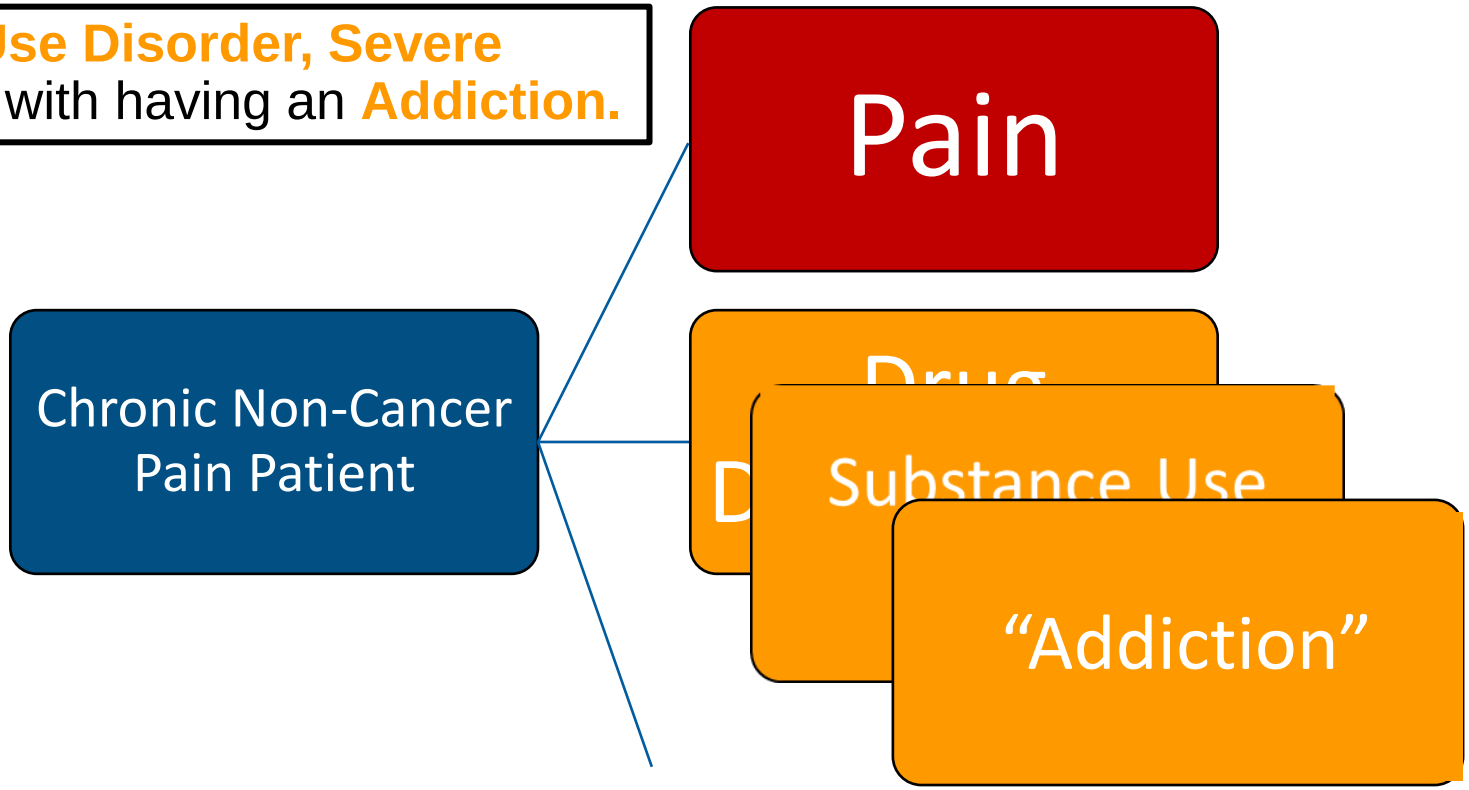
Severity of Substance Use Disorders:

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

Identifying & Defining Opioid Use Disorders

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

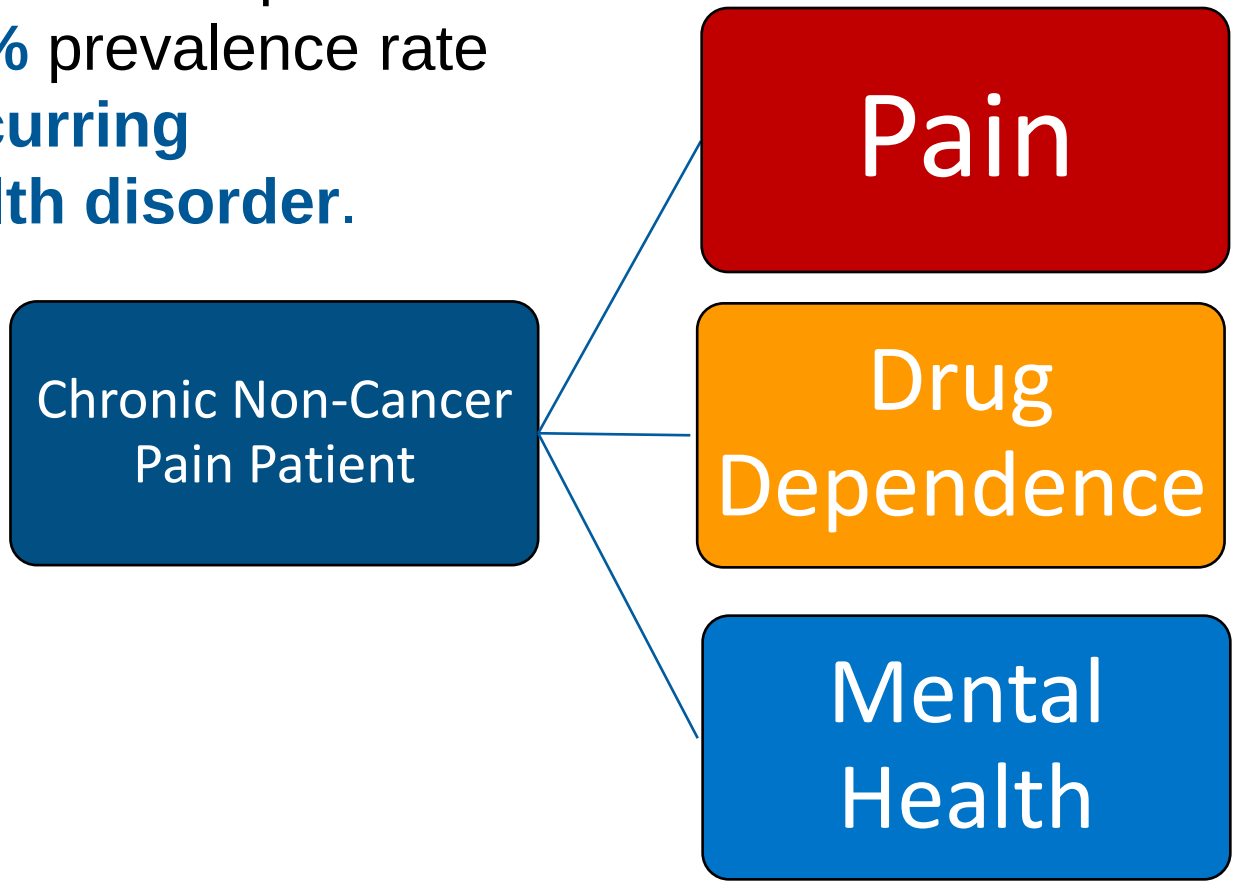


Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.

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.

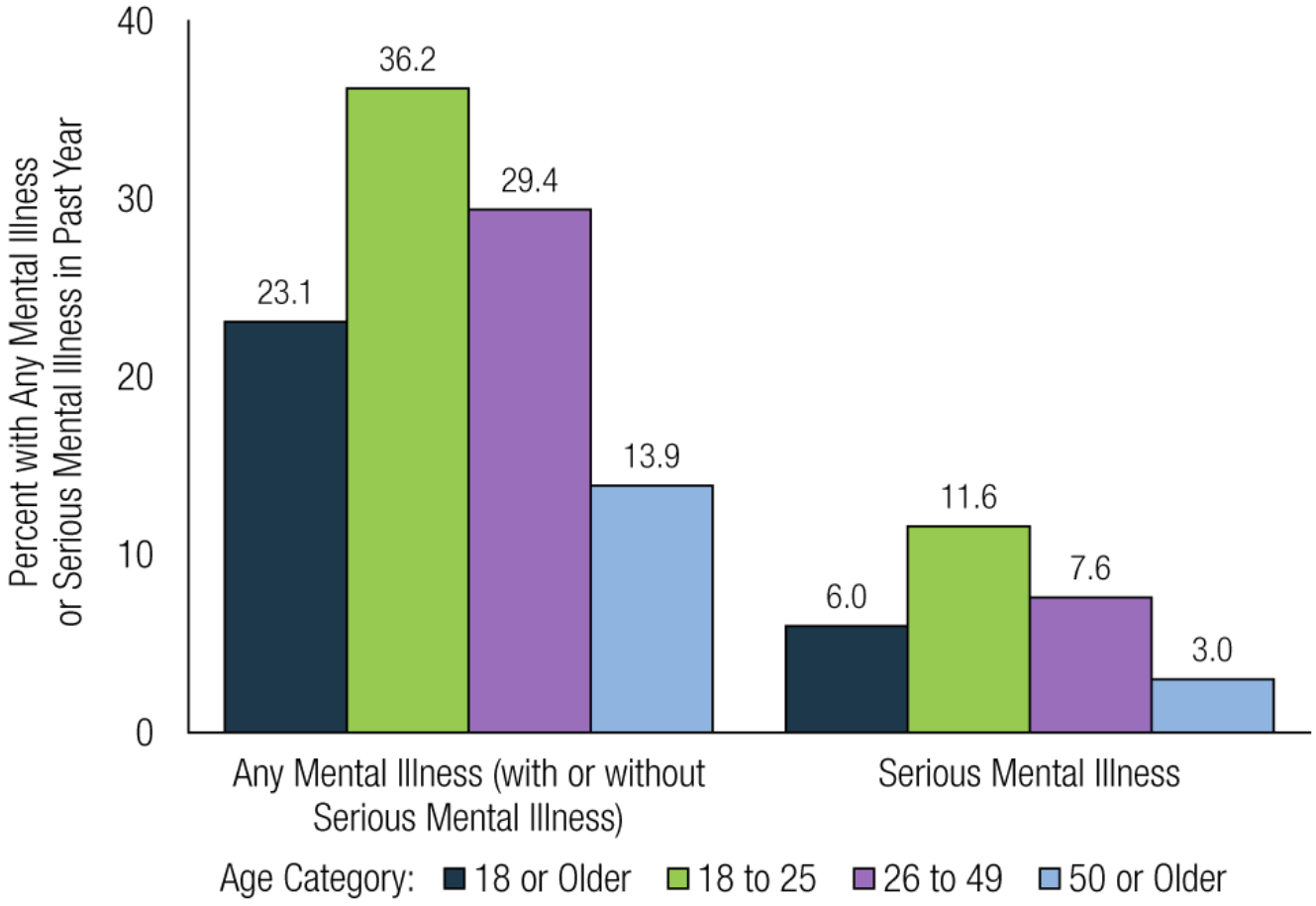
Chronic Pain and Opioid Dependence (CPOD)

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

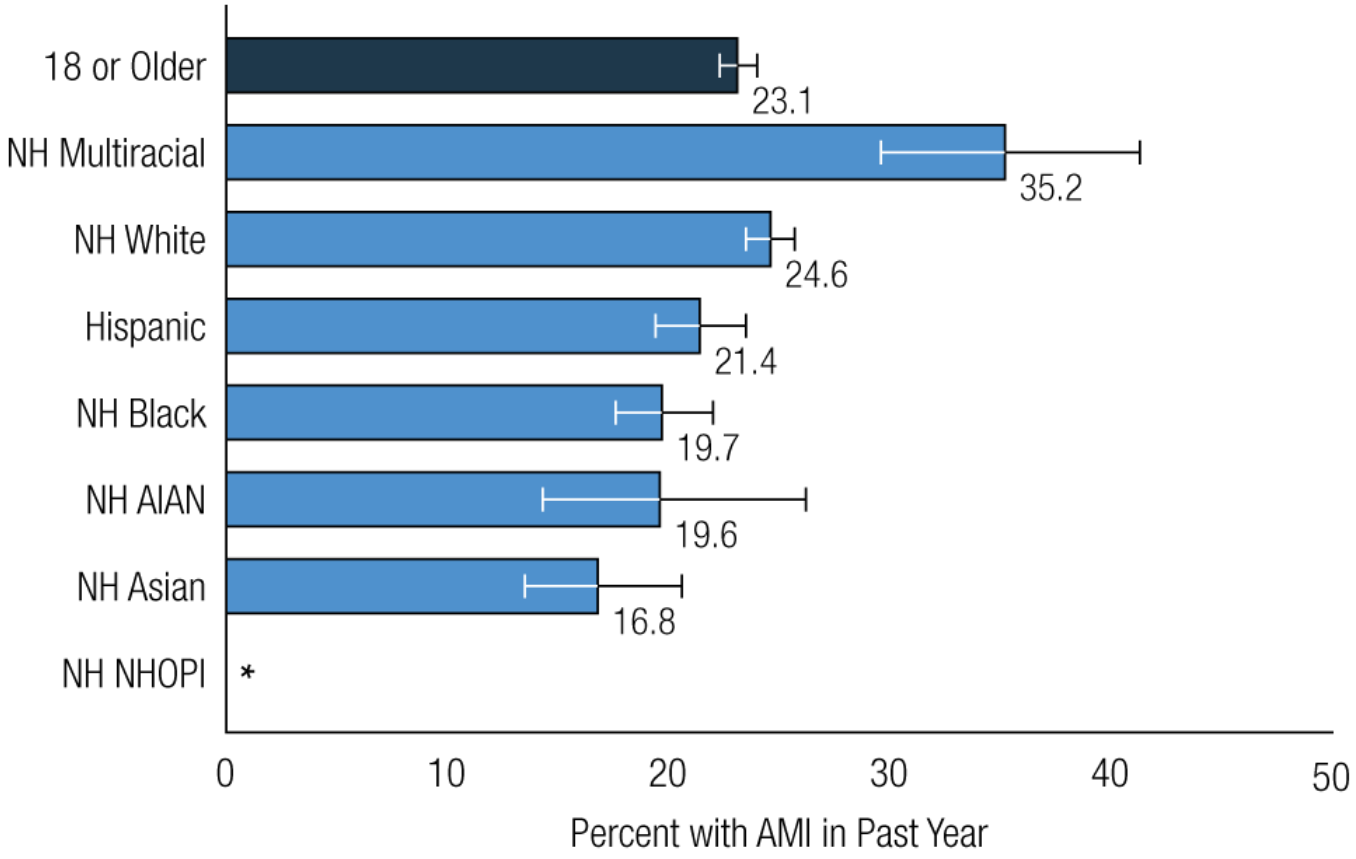
NNR.41



SAMHSA
Substance Abuse and Mental Health Services Administration

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.

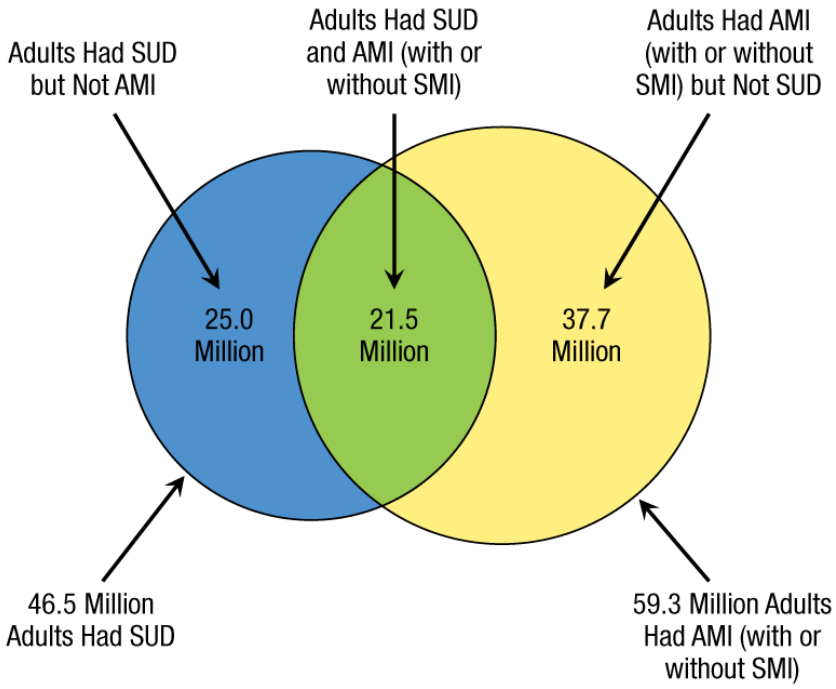
AIAN = American Indian or Alaska Native; Black = Black or African American; Hispanic = Hispanic or Latino; NH = Not Hispanic or Latino; NHOPI = Native Hawaiian or Other Pacific Islander.

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.

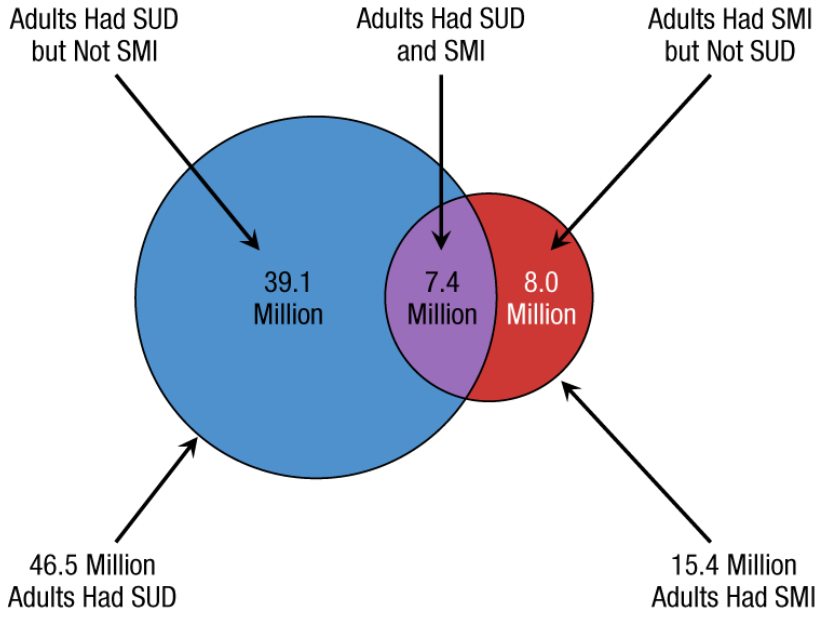
SAMHSA
Substance Abuse and Mental Health Services Administration

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

SAMHSA
Substance Abuse and Mental Health Services Administration

Chronic Pain and Opioid Dependence (CPOD)

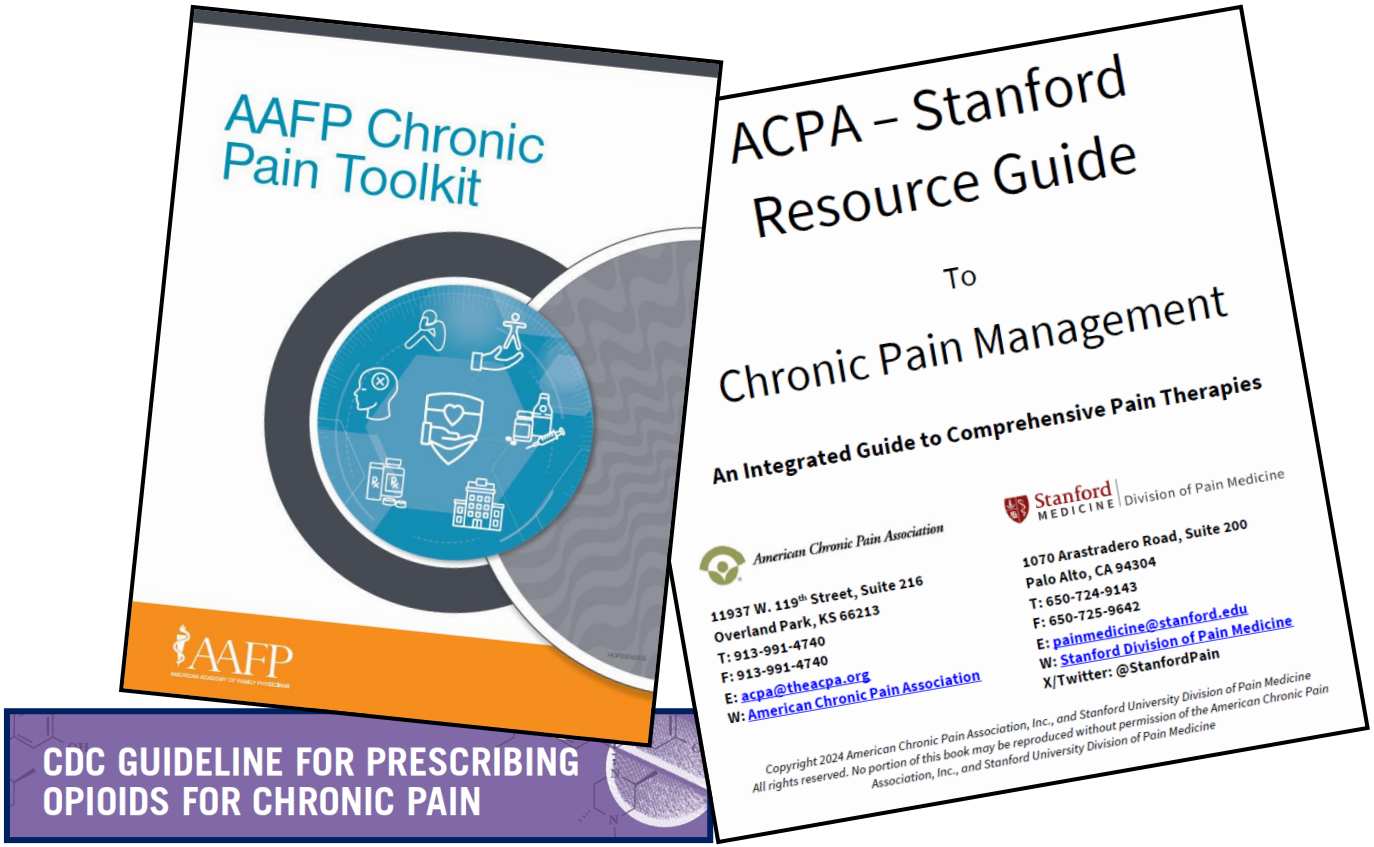
OBJECTIVES:

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



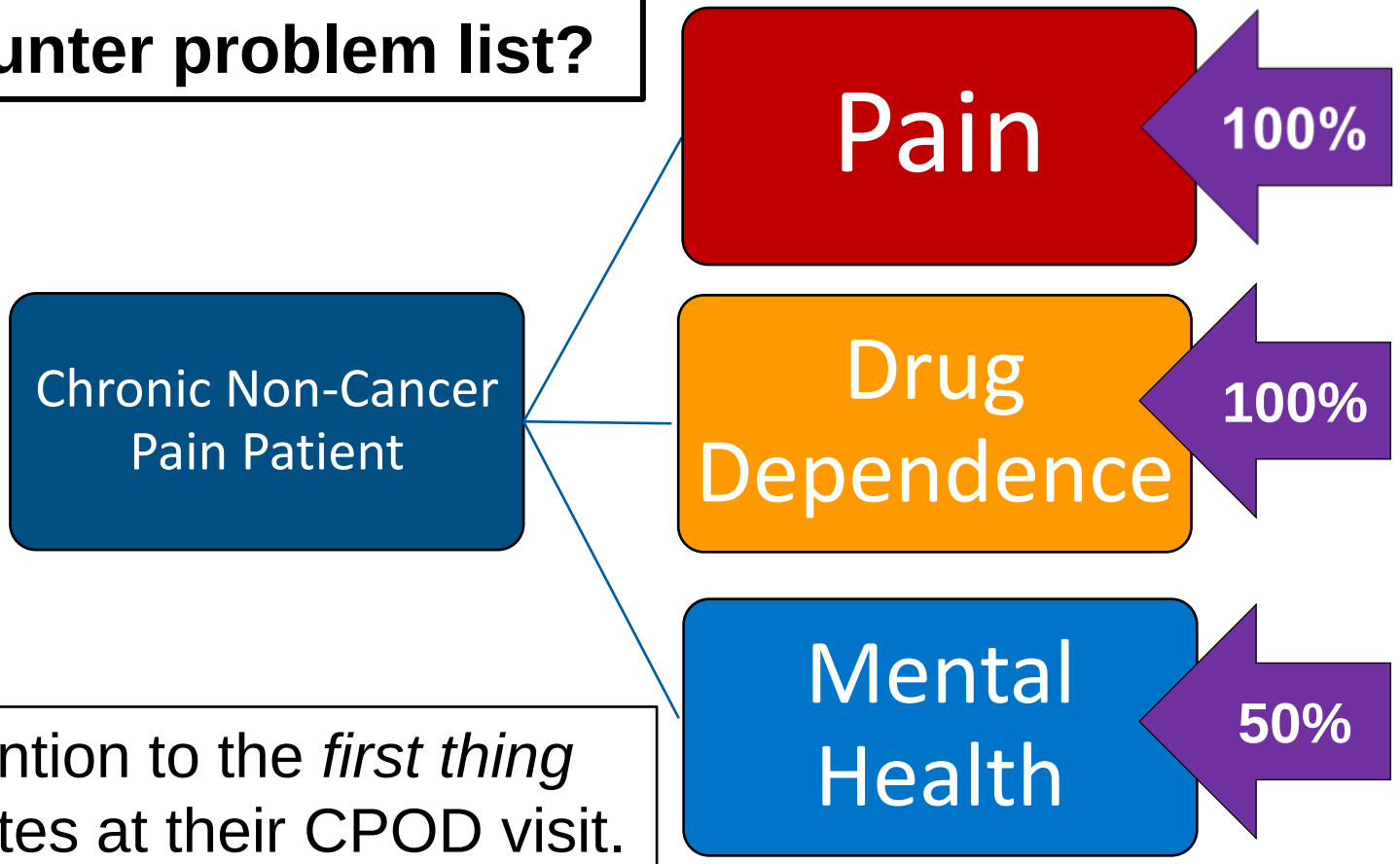
https://www.aafp.org/dam/AAFP/documents/patient_care/pain_management/cpm-toolkit.pdf

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?



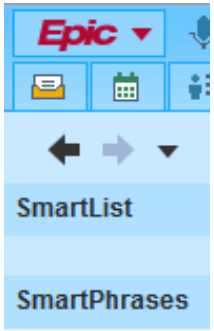
Pay close attention to the *first thing* the patient states at their CPOD visit.

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: ***

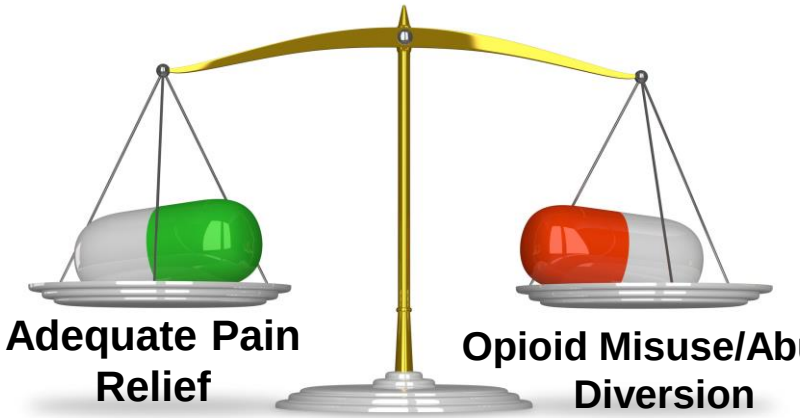


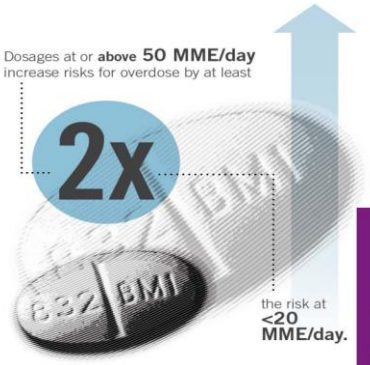
***EPIC* SmartPhrase – CPOD3PLAN [953852]**

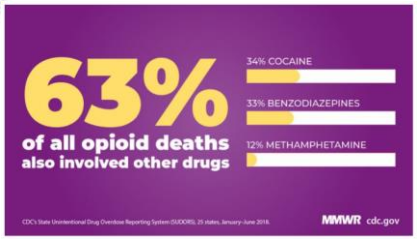
In every encounter, address ***risks and benefits*** of opioids and document how this influenced your decision in the ***plan of action***.

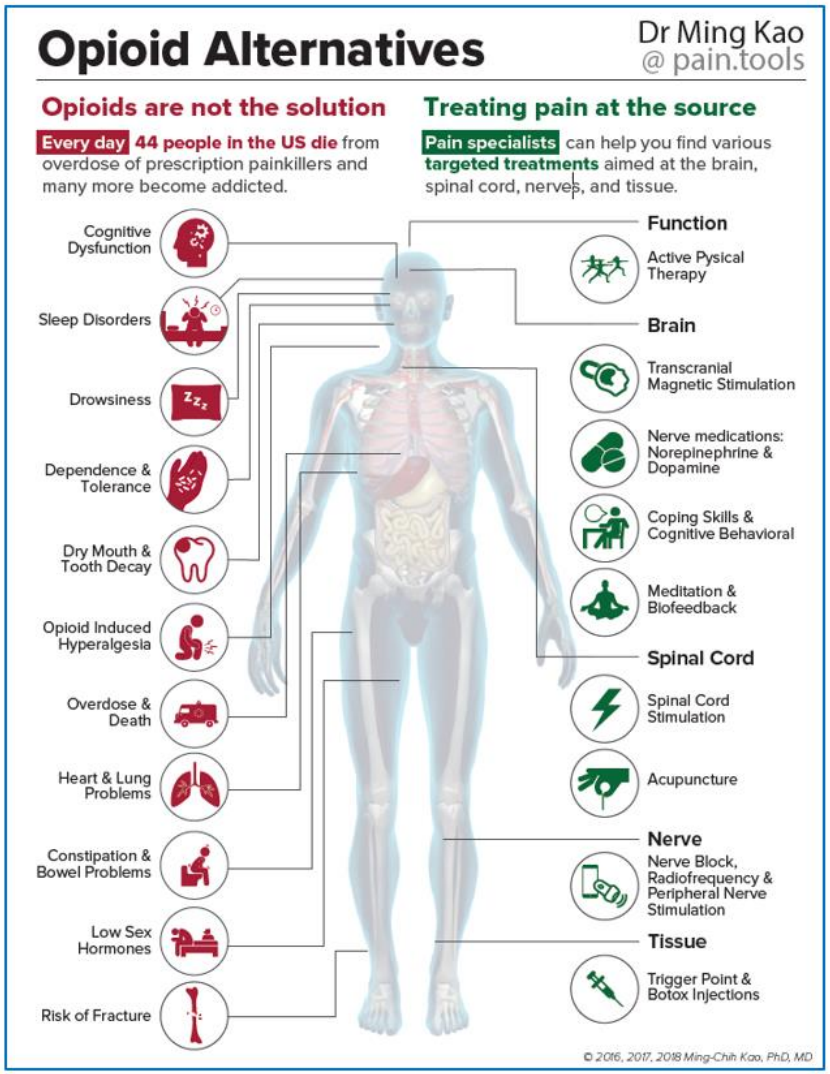
Document the ***timeline*** for your current plan and determine ***follow-up date***.

Chronic Opioid Use - Benefits vs Risks









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"

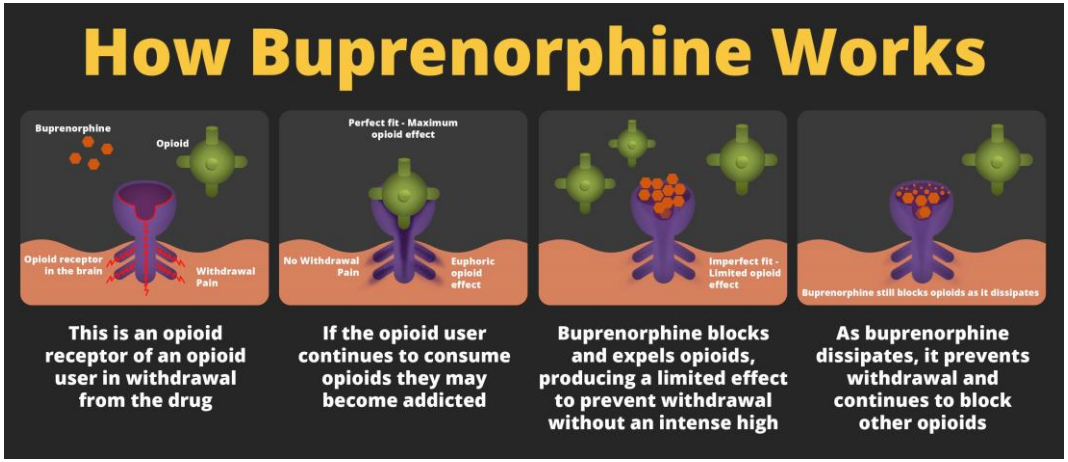
Continue Chronic Opioid Prescribing?

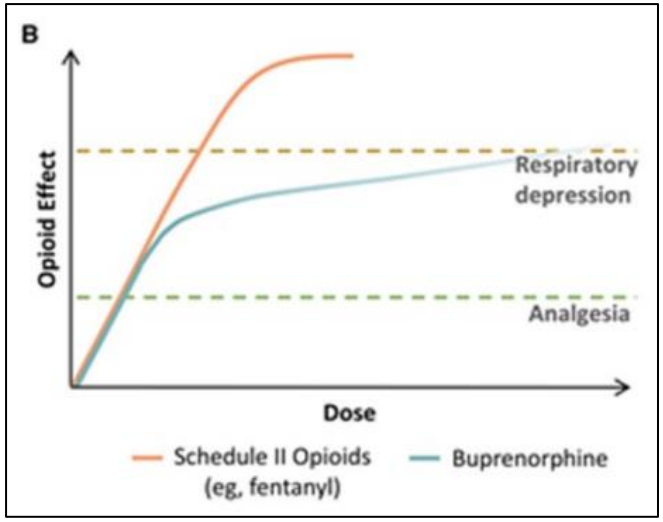
or switch to

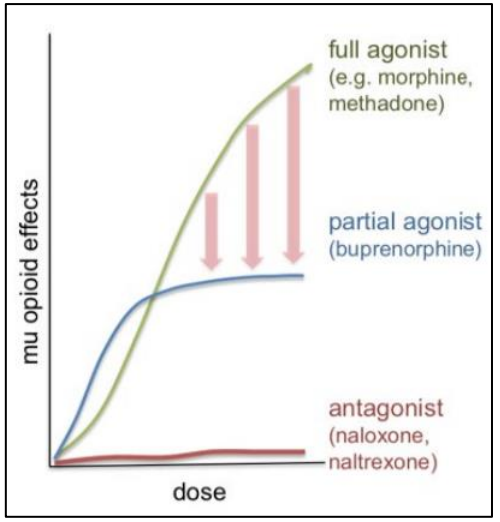
Medication for Opioid Use Disorder *(MOUD) ?

***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

Methadone
Full opioid agonist

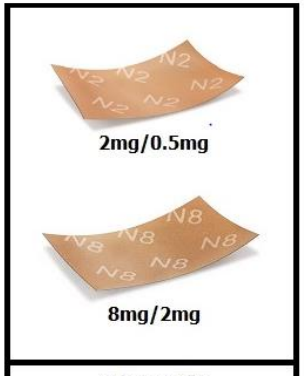
Naltrexone
Full opioid antagonist

- When high risk for unintended opioid overdose death
- With increasing Morphine Milligram Equivalent per Day (MMED)
  Consider for MMED ≥ 90 in healthy individuals
  Consider for MMED ≥ 50 in individuals with co-morbidities
- When long-term risk of opioid side effects exceeds the benefits
- of long-term opioid
- With increasing DSM-5 criteria OUD classification
  Opioid Use Disorder, Moderate and
  Opioid Use Disorder, Severe

Chronic Pain and Opioid Dependence (CPOD) – Treatment Strategy

Suboxone
Buprenorphine/Naloxone
(Sublingual)
Reckitt-Benckiser

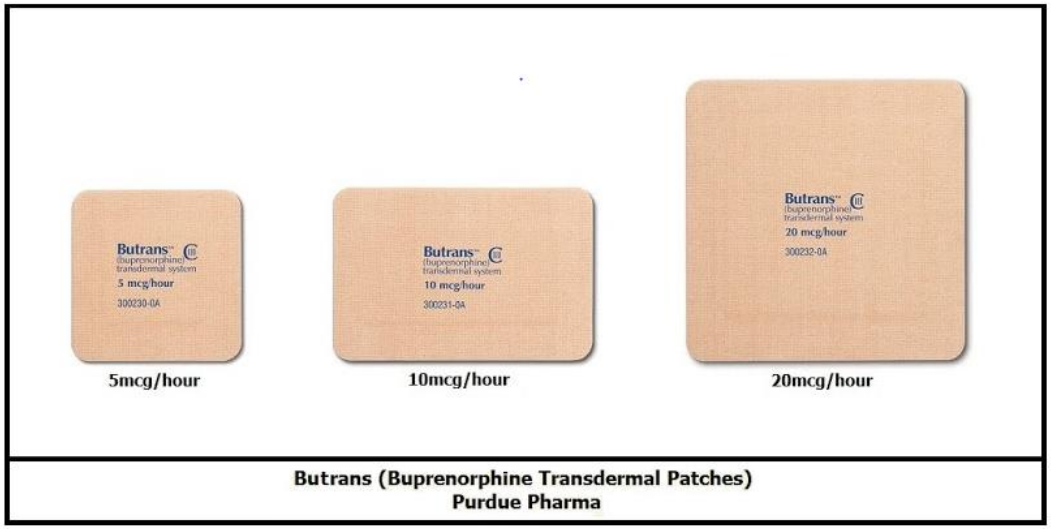
Subutex
Sublingual Buprenorphine
Reckitt-Benckiser



Suboxone Film
Buprenorphine/Naloxone
(Sublingual)
Reckitt-Benckiser

Buprenorphine/Naloxone
(Sublingual)
Amneal Pharmaceuticals

Sublingual Buprenorphine
Roxane Laboratories

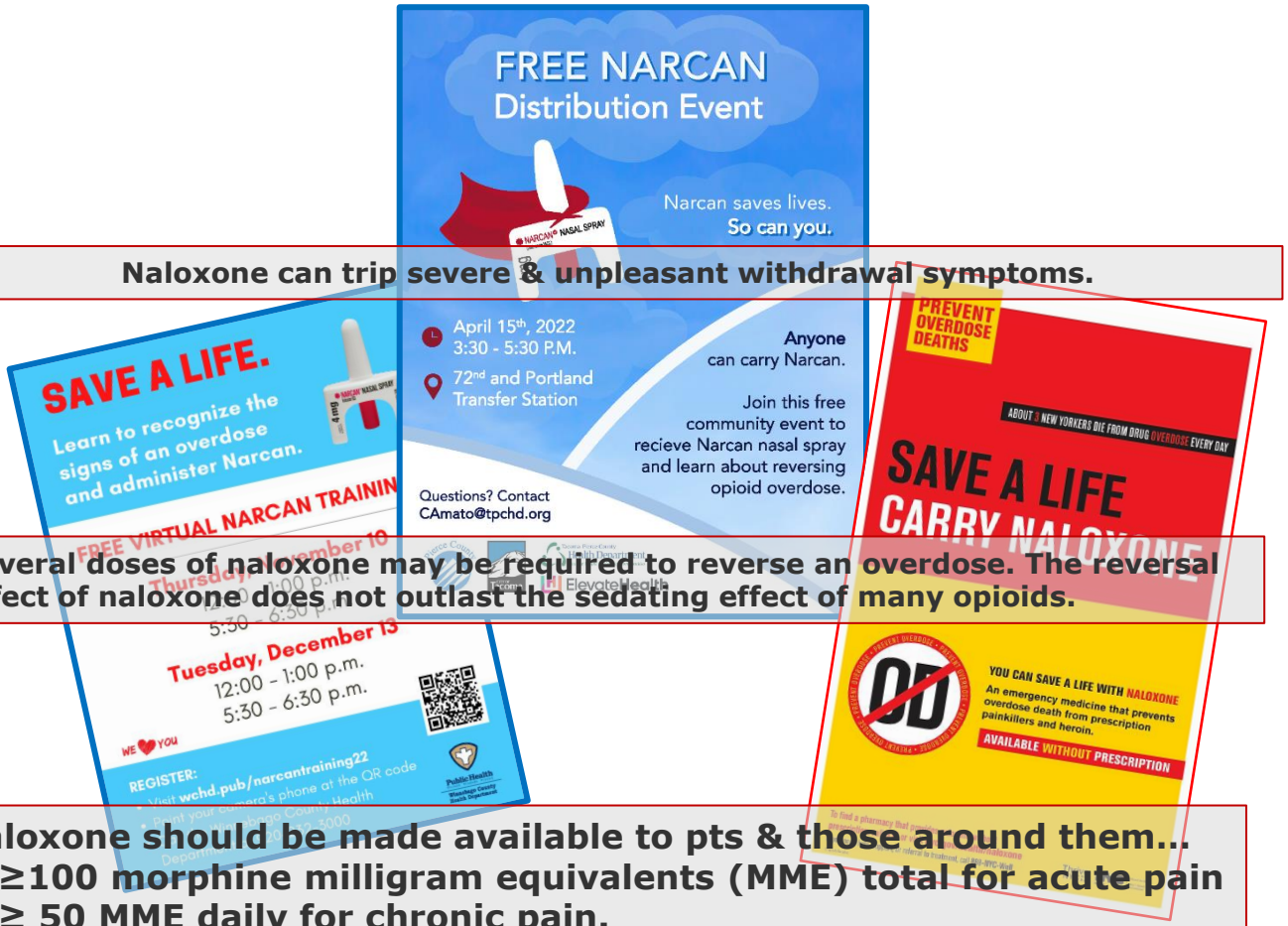


Butrans (Buprenorphine Transdermal Patches)
Purdue Pharma

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



Naloxone can trip severe & unpleasant withdrawal symptoms.

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.

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:

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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.

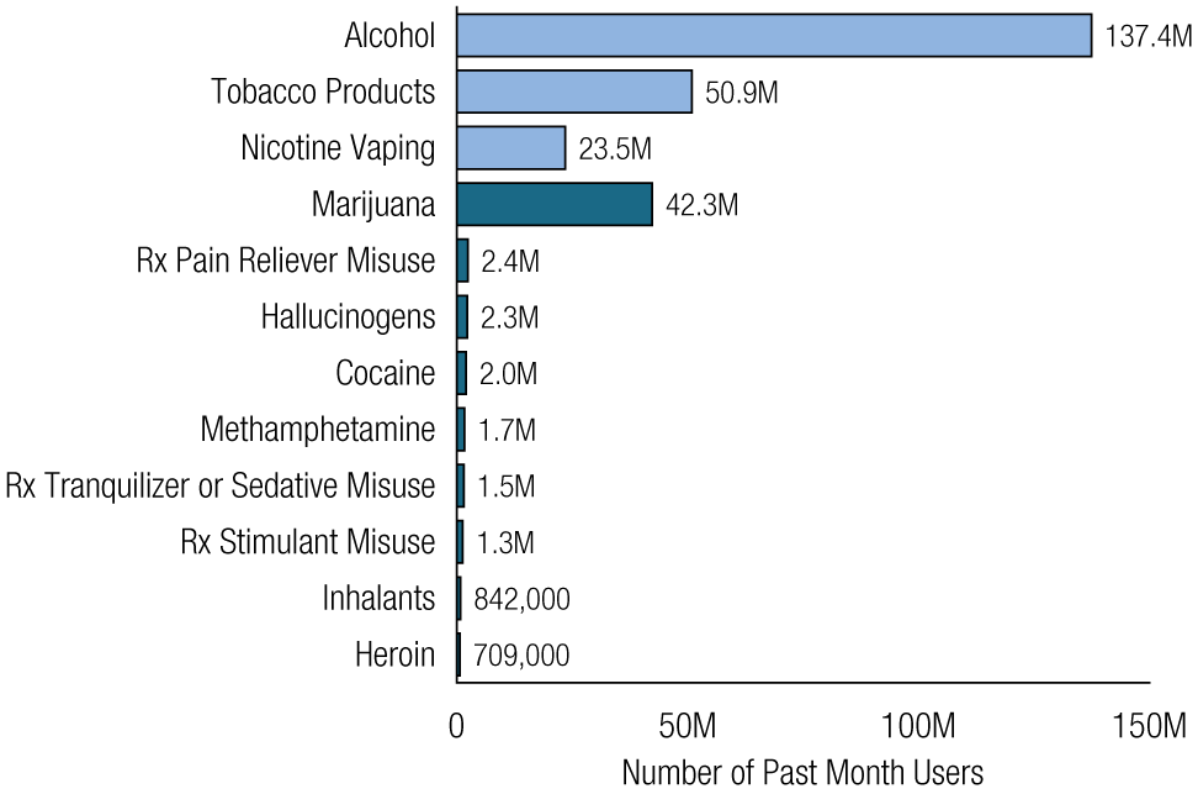
*Recommend **≤ 100 MME** in **total** prescription (Rx)*

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.

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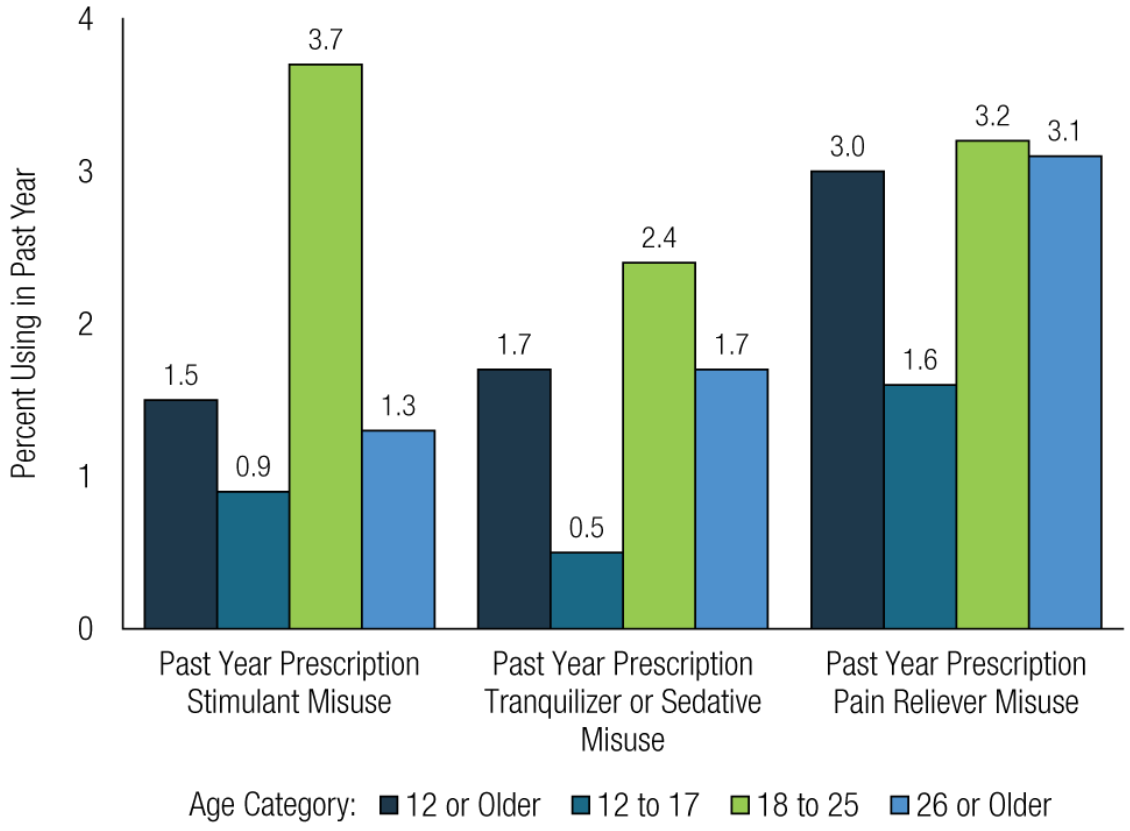
Past Year Prescription Stimulant Misuse, Past Year Prescription Tranquilizer or Sedative Misuse, or Past Year Prescription Pain Reliever Misuse: Among People Aged 12 or Older; 2022

NNR.20



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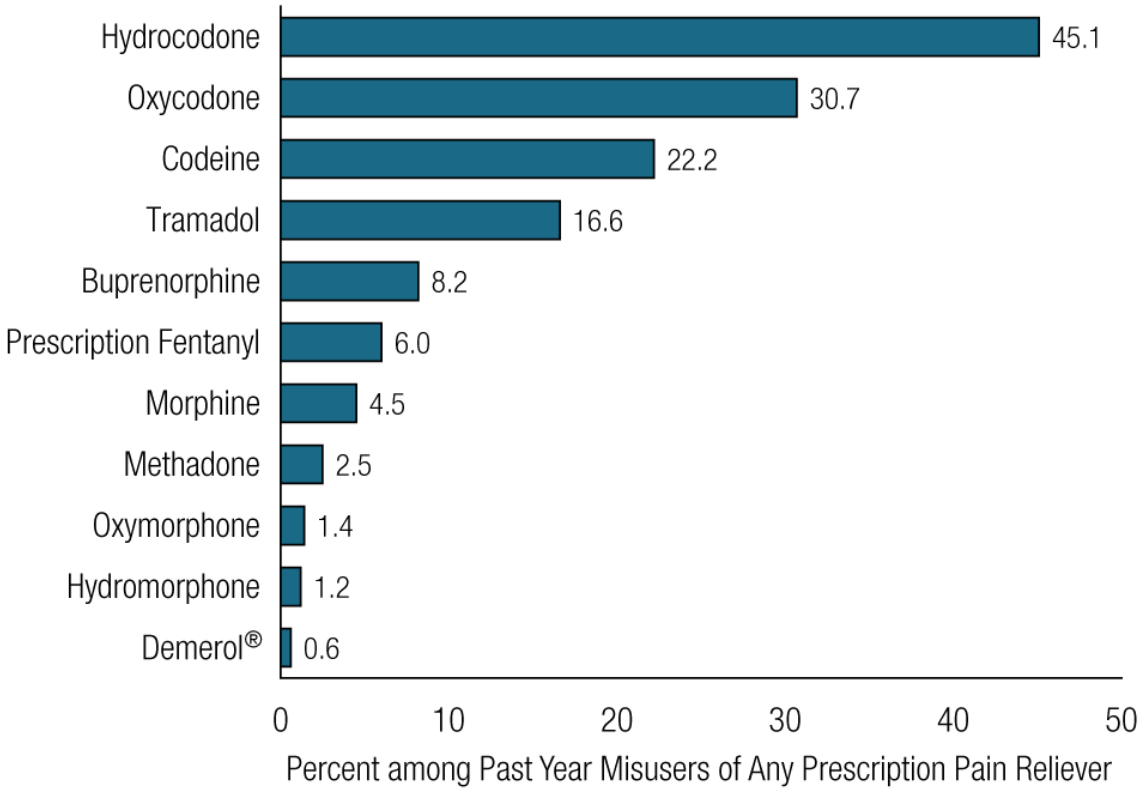
Past Year Prescription Pain Reliever Subtype Misuse: Among People Aged 12 or Older Who Misused Any Prescription Pain Reliever in the Past Year; 2022

NNR.21



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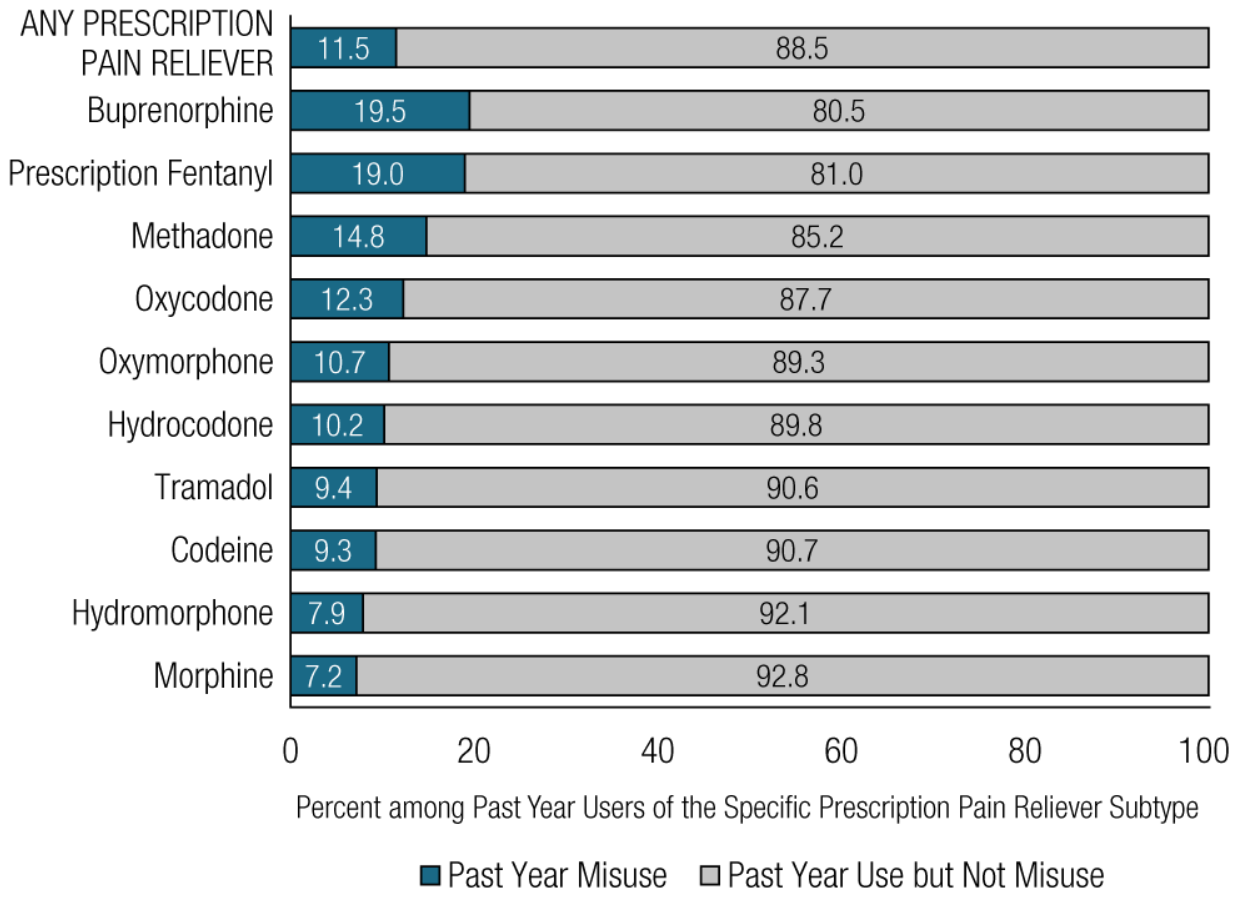
Past Year Prescription Pain Reliever Subtype Misuse: Among All Past Year Users of Prescription Pain Reliever Subtypes Aged 12 or Older; 2022

NNR.22



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

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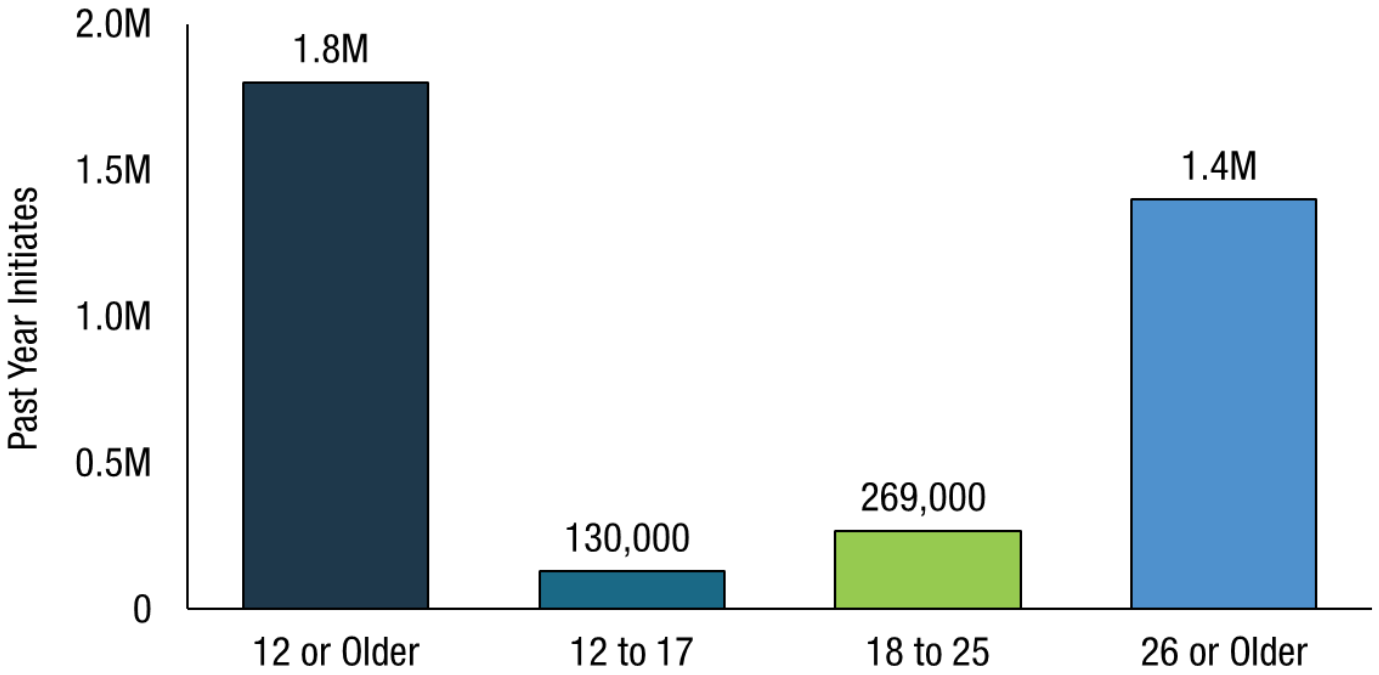
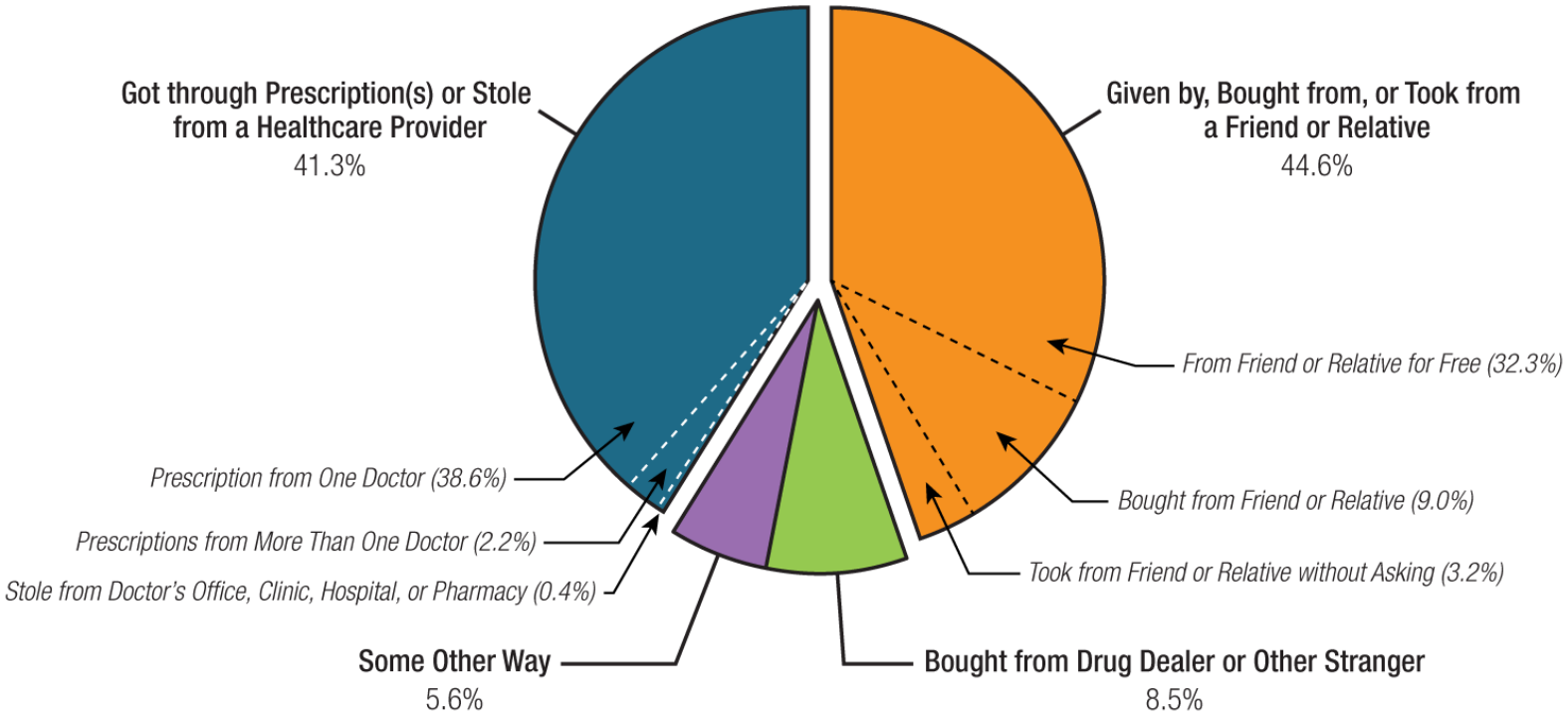
Past Year Prescription Pain Reliever Misuse Initiates: Among People Aged 12 or Older; 2021



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.

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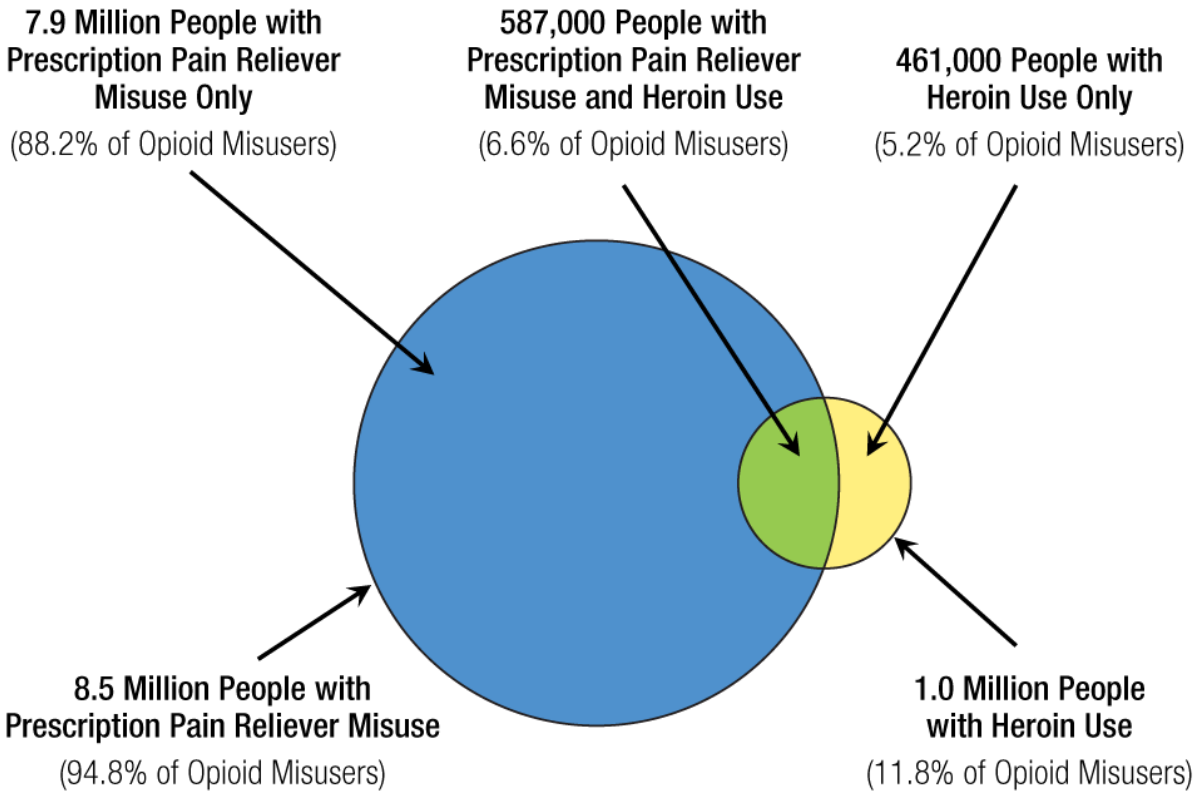
Type of Past Year Opioid Misuse: Among Past Year Opioid Misusers Aged 12 or Older; 2022

NNR.24



Note: These estimates do not include illegally made fentanyl.

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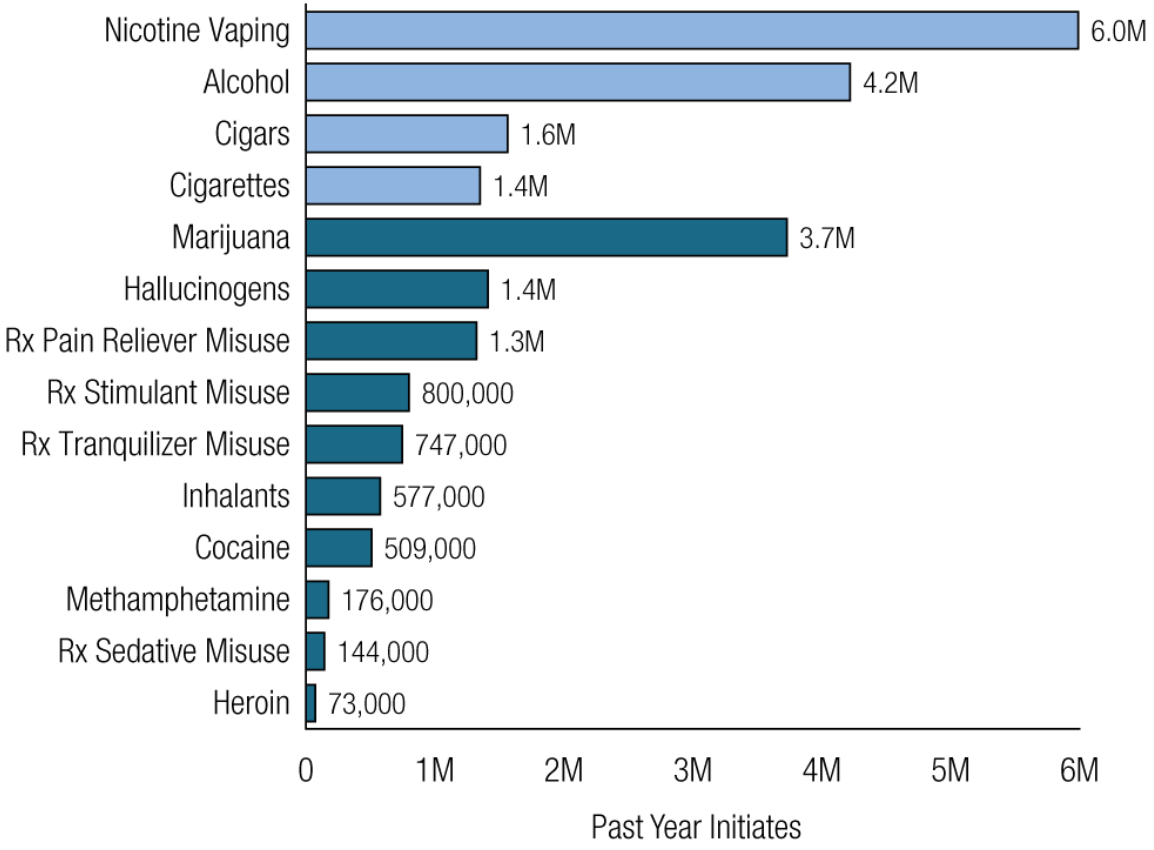
Past Year Initiates of Substances: Among People Aged 12 or Older; 2022

NNR.26



Rx = prescription.

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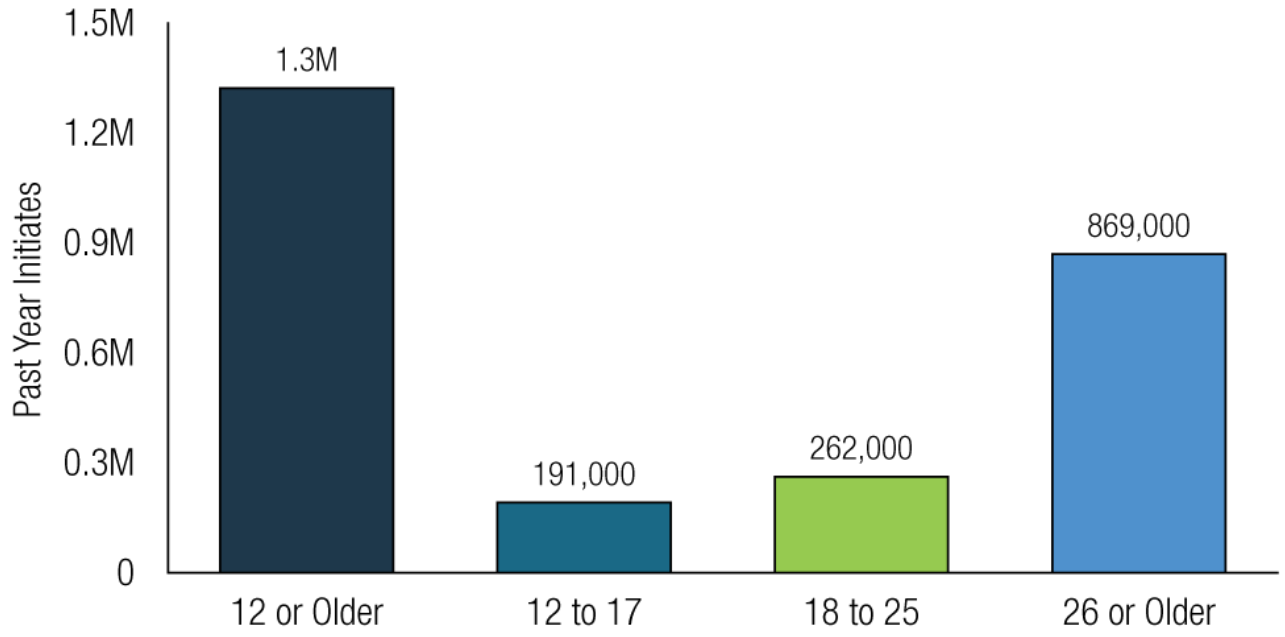
Past Year Prescription Pain Reliever Misuse Initiates: Among People Aged 12 or Older; 2022

NNR.29



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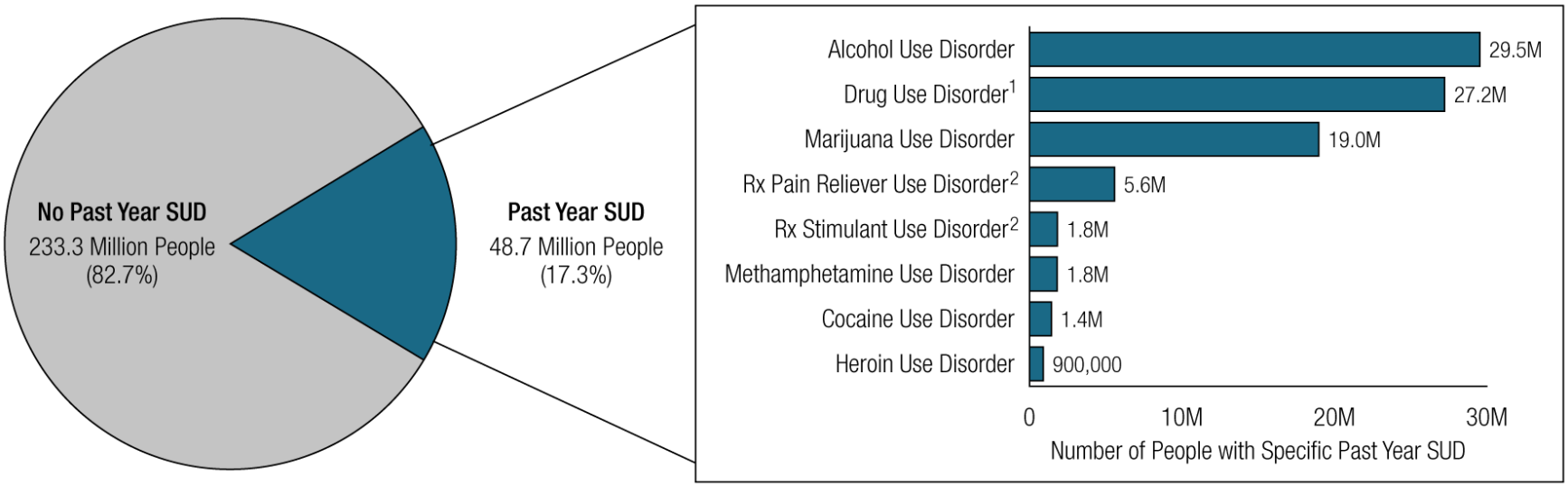
Past Year Substance Use Disorder (SUD): Among People Aged 12 or Older; 2022

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.

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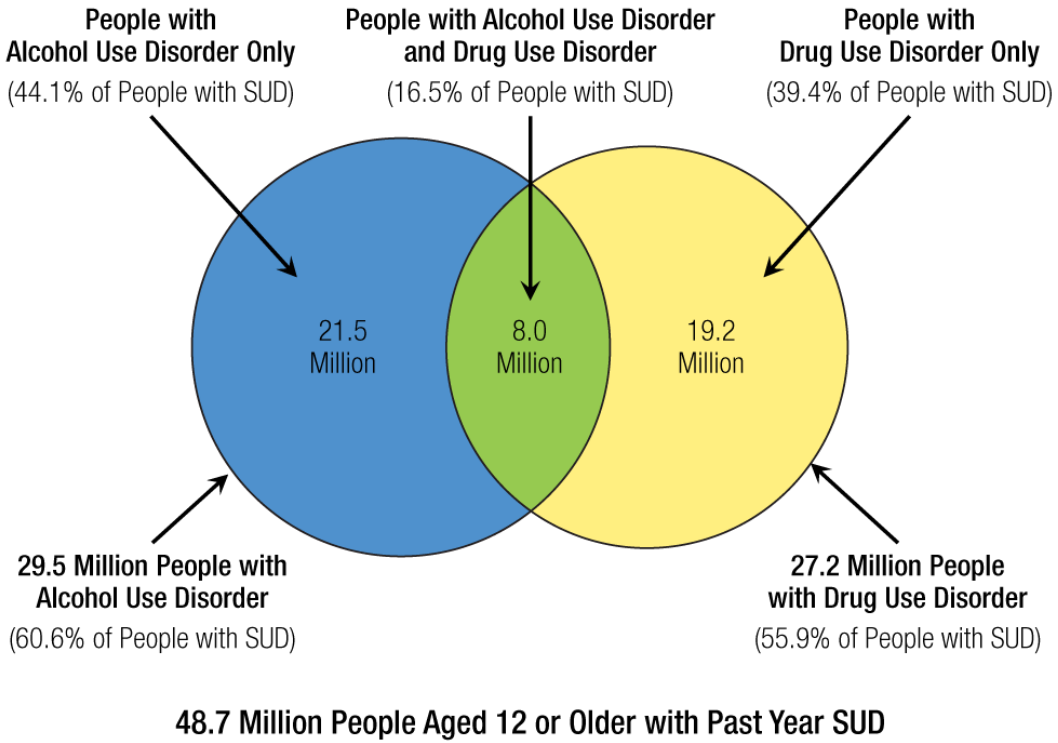
Alcohol Use Disorder or Drug Use Disorder in the Past Year: Among People Aged 12 or Older with a Past Year Substance Use Disorder (SUD); 2022

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).

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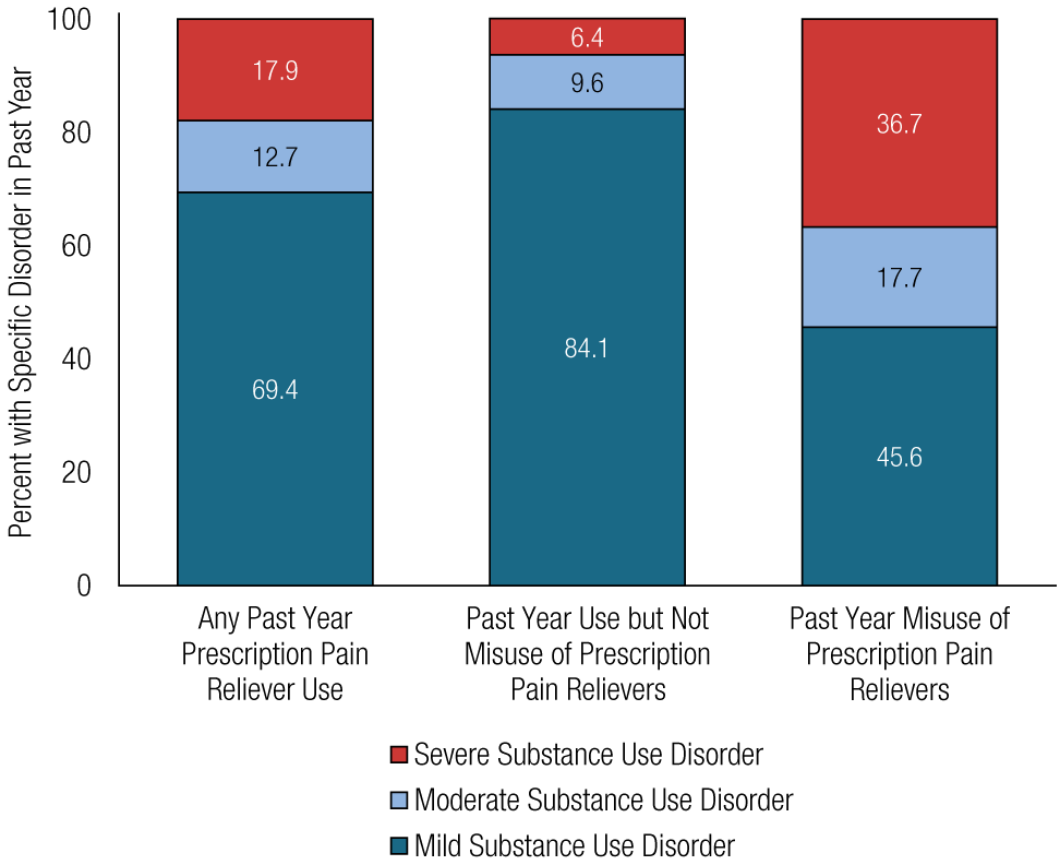
Prescription Pain Reliever Use Disorder Severity Level in the Past Year: Among People Aged 12 or Older with a Prescription Pain Reliever Use Disorder; 2022

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.

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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 bocks, 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: - Facilitate recovery - Reduce pain - Minimize side effects - Prevent chronic pain	Pain Control + Restore function: - 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.

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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…