Concurrent Use of Opioids and Benzodiazepines (COB)

Measure Description

This measure evaluates the percentage of patients at least 18 years old with concurrent use of prescription opioids and benzodiazepines for at least 30 cumulative days. This is an inverse measure therefore ***a lower rate*** indicates ***better performance***.

Calculation

[Numerator] = Measure Compliance

The number of patients who have received at least two prescriptions for benzodiazepines, with a concurrent overlap of opioid use for at least 30 cumulative days.

[Denominator] = Measure Population The number of patients with at least 2 prescription claims for opioids filled on 2 or more separate days with a cumulative days supply of 15 days or more.

Did You Know?

- COB has an increased risk of overdose and death, primarily due to respiratory depression.
- COB has the potential for increased dependence, addiction and reduced effectiveness, potentially leading to inadequate pain control or increased anxiety.
- Once the patient falls into the numerator, they cannot get
- out. Any opioid fill is considered for the calculation. There is no "reset" for switching opioids.

Common COB Drugs

Opioids

- Oxycodone (Oxycontin)
- Fentanyl (Actiq)
- Morphine (MS Contin)
- Hydromorphone (Dilaudid)
- Meperidine (Demerol)
- Tramadol (Ultram)

Hydrocodone/Acetaminophen (Norco)

Benzodiazepines

- Clonazepam (Klonopin)
- Diazepam (Valium)
- Lorazepam (Ativan, Loreev
- XR) Temazepam (Restoril)
- Alprazolam (Xanax)
- Midazolam (Versed)

Estazolam (ProSom)

Exclusions

- Hospice or palliative care
- Cancer diagnosis
- Sickle cell disease
- Injectable formulations of opioids or benzodiazepines
- Products with buprenorphine as a single agent or in combination products
- Fentanyl transdermal patch

Strategies for Rate Improvement

- Educate patients about the risk of COB (e.g. falls, respiratory depression).
- Assess medications for appropriate indication and duration at each visit and discontinue any non-essential medications.
- If concurrent therapy is medically necessary, limit medication use to the shortest duration (<30 days) at the lowest effective dose.
- Consider alternative medications or safer, non-pharmacologic therapies such as cognitive behavioral therapy or physical therapy.
- Coordinate care with all of the patient's treating providers.
- Follow CMS's 5 principles for co-prescribing Benzodiazepines (BZDs) and opioids:
  - Avoid initial combination by offering alternative approaches such as cognitive behavioral therapy or other medication classes.
  - If new prescriptions are needed, limit the dose and
  - duration. Taper long-standing medications gradually and, whenever possible, discontinue.
  - Continue long-term co-prescribing only when necessary and monitor closely.
  - Provide rescue medication (for example, naloxone) to high-risk patients and their caregivers as co-prescribing places the patient at a high risk of opioid overdose.
- When initiating opioid therapy, prescribe immediate-release opioids rather than extended-release or long-acting (ER/LA) opioids.
- The lowest effective dosage should be prescribed when opioids are initiated for opioid-naïve patients.
- Evaluate the benefits and risks with patients within 1–4 weeks of starting opioid therapy or of dosage escalation. Regularly reevaluate benefits and risks of continued opioid therapy.

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