



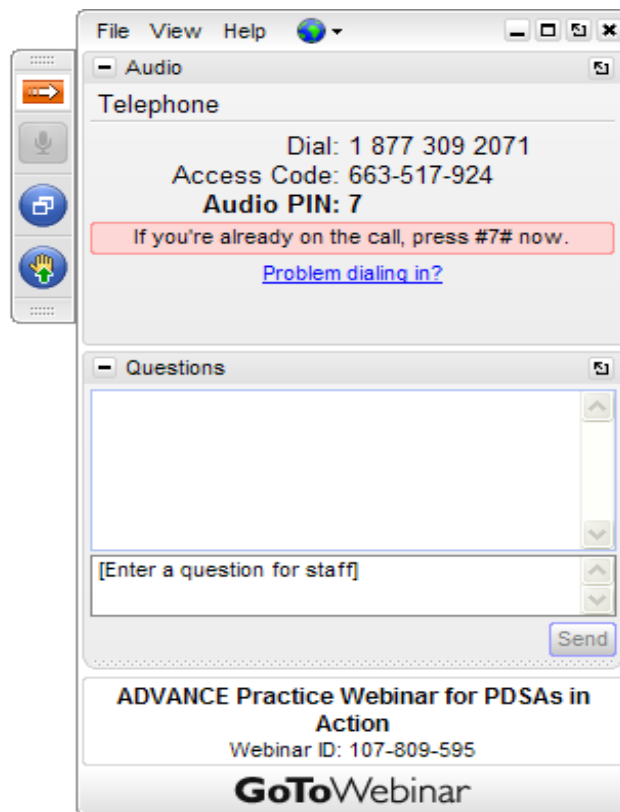
# **Strategies in Managing Opioid and Benzodiazepine Co-Prescribing**

Scott Endsley, MD  
Associate Medical Director, Quality  
Partnership HealthPlan of California

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# Audio Instructions

To avoid echoes and feedback, we request that you **use the telephone** *instead* of your computer microphone for listening/talking during the webinar.



Please insert your individual audio pin

# Conflict of Interest

- All presenters have signed a conflict of interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.

# Managing Pain Safely Update

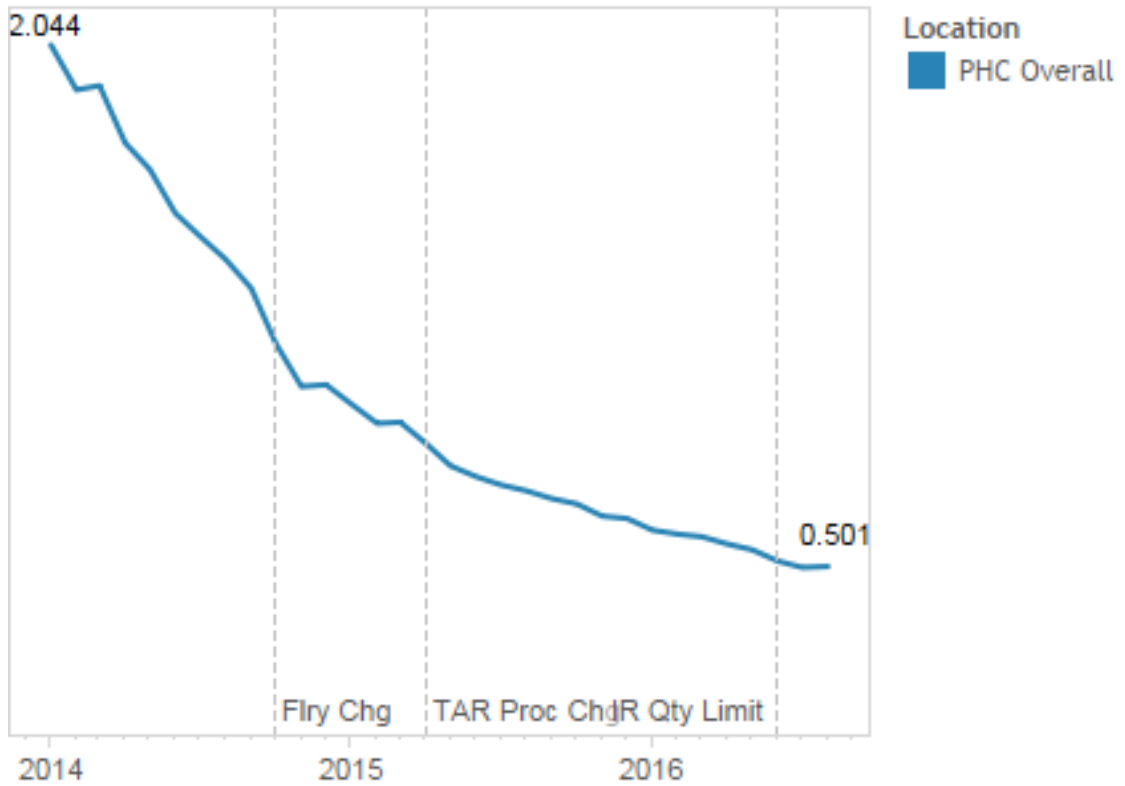
- Provider education and forums
- Website with guidelines/ resources/ tools  
<http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx>
- Prior pharmacy authorization changes
  - *high dose*
  - *dose escalation*
  - *new starts of immediate release*

# Managing Safely Update

- Support for alternative therapies
- Support of community coalitions
- Quality improvement program incentives
- Collaboration with California Health Care Foundation (ex. coalitions, integrated care grants)

# Managing Pain Safely Results: High Dose

Opioid Users P100MPM All: PHC Overall, Dose: Unsafe Dose (>120MED)



**75% Decrease  
January 2014-  
September 2016**



# The New Initiative: Reducing Co-Prescribing

- **Benzodiazepines**

- Most frequently used psychotropic
- Introduced 1955 with chlordiazepoxide
- Positive modulators of GABA system

- **Benzodiazepine Uses**

- Anxiety and panic disorders
- Seizure disorders
- Insomnia
- Alcohol withdrawal

- **Benzodiazepine Formulations**

- Short acting – half life 1-12 hrs
- Intermediate acting – half life 12-40 hrs
- Long acting – half life 40-250 hrs



## EQUIVALENT DOSES

Alprazolam	0.5 mg
Chlordiazepoxide	25 mg
Clonazepam	0.5 mg
Diazepam	10 mg
Lorazepam	1 mg
Temazepam	20 mg

# The New Initiative: Reducing Co-Prescribing

- **Benzodiazepine Risks**

- Sedation
- Decreased cognition and memory loss
- Dyscoordination with fall risk
- Respiratory depression

**ALL  
benzodiazapines  
are on the BEERS  
LIST**

- **Combined Opioid & Benzodiazepine Risks**

- Benzodiazepines amplify opioid effects on mu receptors
- Inhibit metabolism of opioids
- 40% of opioid users also use a benzodiazepine (more likely to use higher doses for longer than opioid-only users)
- 70% in MAT programs on benzodiazepines – remove protective effect of buprenorphine on respiratory depression
- 60% of opioid overdoses had a benzodiazepine in their urine
- Risk is 3.8x greater for overdose if on a benzodiazepine
- Risks higher in older patients



Learn about the risks of  
prescription opioids  
[www.cdc.gov/drugoverdose](http://www.cdc.gov/drugoverdose)



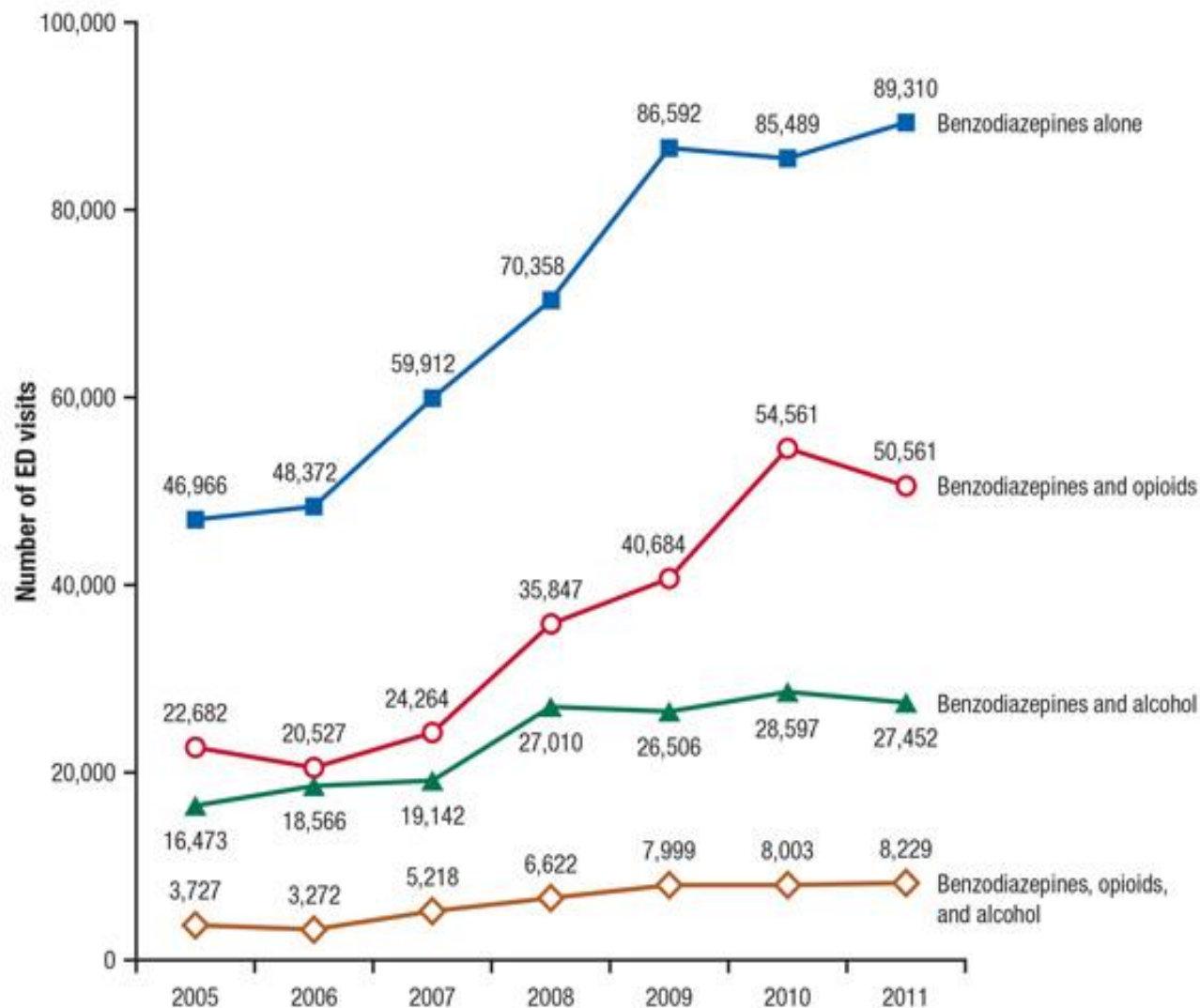


# The Scourge of Alprazolam (XANAX<sup>™</sup>)

- Most prescribed psychotropic drug in America
- 50 million prescriptions (2013)
- Rx rates increasing by 9% per year
- Peak in the 20-30 age range
- Tolerance develops rapidly
- 125% increase in ED visits (2004-2008)
- 124,902 ED visits for alprazolam alone (2010)
- Other risks
  - Suicide
  - Pregnancy risk



# Number of ED Visits: Opioids and Benzodiazepines

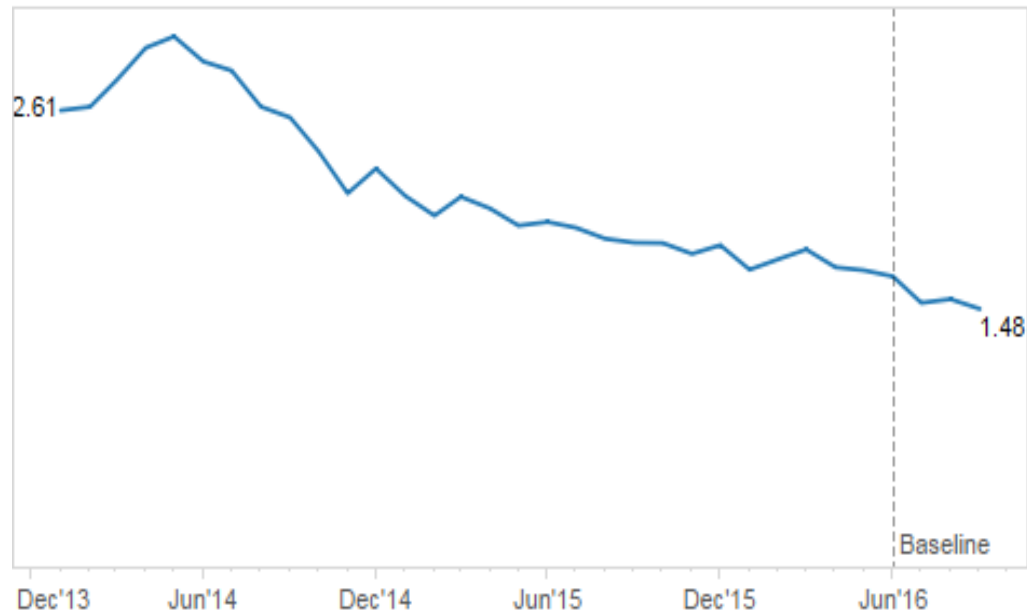


\* No other drugs were involved.

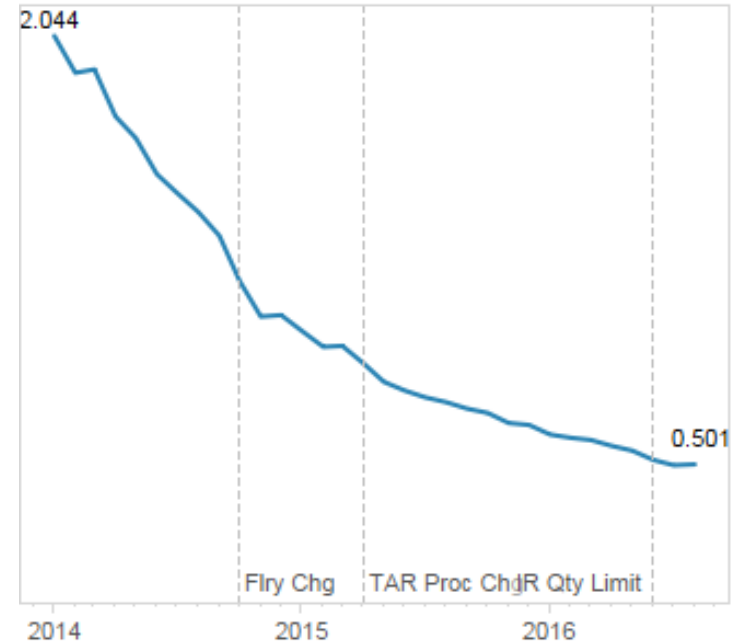
Source: 2005 to 2011 SAMHSA Drug Abuse Warning Network (DAWN).

# PHC Plan-Wide Data: January 2014- August 2016

**Members Co-prescribed per 100MPM** Location: PHC Overall; PCP: All



**Opioid Users P100MPM** All: PHC Overall, Dose: Unsafe Dose (>120MED)



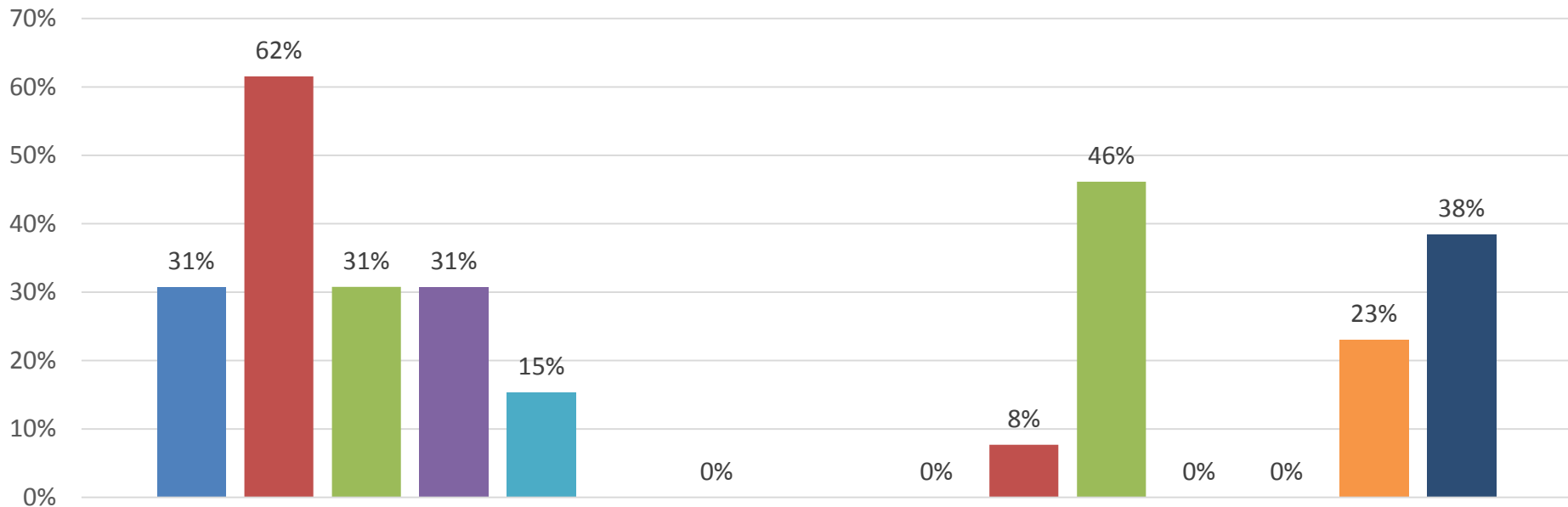
## Opioids/Benzodiazepines or Muscle Relaxants Co-prescribing Rate:

Number of users with at least 3 months of continuous eligibility who concurrently filled prescriptions for opioids and benzodiazepines or muscle relaxants with 65% or higher overlapping days supply during the measurement period per member per month per 1000.

Numerator Exclusions: members with active cancer, defined as those who had 3 or more claims with a cancer diagnosis in separate days in the 6 months prior to the measurement period.

The trend of Users P100MPM for Latest Fill Month. Color shows details about Location Selector. The data is filtered on User type, Latest Fill (Month / Year) and Month. The User type filter keeps Unsafe Dose (>120MED) and Safe Dose (<=120MED). The Latest Fill (Month / Year) filter ranges from January 2013 to August 2016. The Month filter ranges from Jan 2014 to Aug 2016. The view is filtered on Location Se-

# PHC Data: Hospitalization Pilot: Co-meds (%) with Opioid Admits



In Admit Record

In Profile

■ ETOH

■ meth /stim

■ benzo

■ heroin

■ No other

■ Opioid only in profile

■ No Opioid in Profile

\* Note- small sample size

# Opioids and Benzodiazepines: Safe Use

- Check CURES before starting a patient on either benzodiazepine or opioids
- Don't start if you have alternative choices
- Evaluate for PTSD or other behavioral disorder, and develop behavioral care plan
- One prescriber, one pharmacy

# Opioids and Benzodiazepines: Safe Use

- Use formulation best suited to indication (short acting for sleep induction, longer acting for bridge in anxiety)
- If anxiety, use short term (< 6 weeks) as a bridge to more effective anti-depressant therapy (SNRIs, SSRIs, bupropion)
- Use in conjunction with other modalities such as cognitive behavioral therapy, stress reduction
- Do NOT stop abruptly but establish a taper schedule

# Nasal Naloxone

*Just added to the MediCal Formulary!*  
Now available without a prior authorization form

Nasal Naloxone

Naloxone HCL 4 mg spray, non-aerosol (EA)

Mfg codes: 69547

Narcan



*Consider prescribing naloxone for patients using both opioids and benzodiazepines*

# Opioids and Benzodiazepines: Strategies in Tapering

## WHO TO TAPER

- Patients who are high risk of overdose
- Concomitant respiratory compromise
- Motivated patients
- Considering addiction treatment/ medication assisted therapy

## WHICH ONE TO TAPER FIRST?

- CDC recommends tapering opioids first
- If memory difficulties or low dose benzodiazepine, start with benzodiazepine



# Opioids and Benzodiazepines: Strategies in Tapering

## TAPER STRATEGIES

- Switch from short to long acting (ex. Lorazepam)
- Go slow (3-6 months)
- Reduce daily dose by 5-10% per week
- Early follow up – 1 week after taper start
- Slow taper after ½ of original dose achieved
- One prescriber, one pharmacy
- Expect anxiety, insomnia, resistance – use psychotherapy
- If rebound/withdrawal symptoms, use buspirone, clonidine, hydroxyzine, propranolol

# PHC's Strategy to Address Co-Prescribing

- Education (Provider and Member)
- Data Sharing- View your PHC patients on both opioids and benzodiazepines
- 1-1 Conversations with PHC Medical Directors
- CDC Guideline Promotion
- Community Coalition Support
- MAT Support

# MPS Toolkits

- PCP Toolkit
  - Key resources for providers
- Pharmacy Toolkit
  - Information regarding safe dispensing and naloxone
- Naloxone Toolkit
  - Information to support providers in setting up a site-level naloxone program
- Tapering Toolkit
  - Key tips on how to effectively taper a patient from opioids

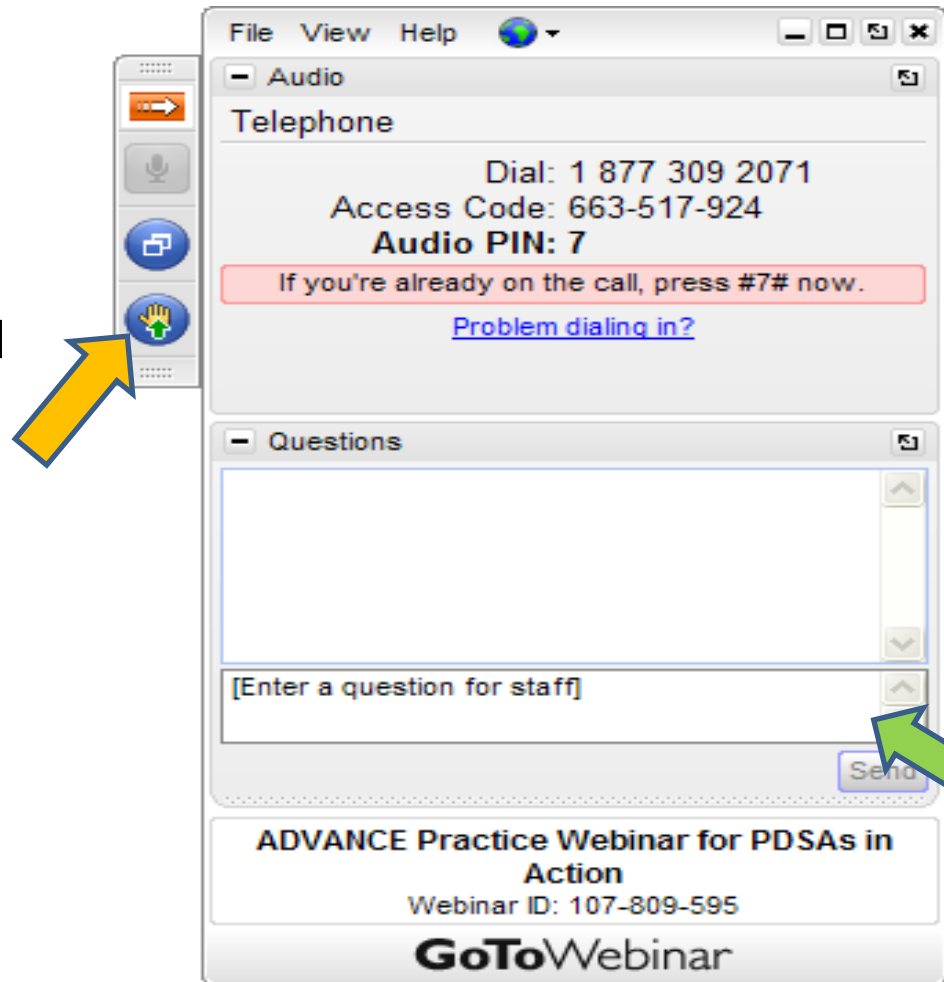
All toolkits can be found on the MPS webpage:

[www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx](http://www.partnershiphp.org/Providers/HealthServices/Pages/Managing-Pain-Safely.aspx)

# Questions?

If you have a question or would like to share your comments, please

- Type your question in the “question” box, or
- Click the “raise your hand” icon





## Contact Information

Danielle Carter  
MPS Project Manager  
[dcarter@partnershiphp.org](mailto:dcarter@partnershiphp.org)