# Risk of Continued Opioid Use (COU)

## APPLICABLE LINES OF BUSINESS

- Commercial
- Medicare

## MEASURE DESCRIPTION

Percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued use.[i]

Two rates are reported:

- The percentage of members with at least 15 days of prescription opioids in a 30-day period.
- The percentage of members with at least 31 days of prescription opioids in a 62-day period.

A new episode of opioid use is a period of 180 days prior to an opioid prescription dispensing date when the member had no pharmacy claims for either new or refill prescriptions for an opioid medication. A lower percentage rate indicates better performance.

## APPLICABLE MEDICATIONS

| Opioid Medications Containing: | | |
|---|---|---|
| • Benzhydrocodone<br>• Buprenorphine (transdermal patch and buccal film)<br>• Butorphanol<br>• Codeine<br>• Dihydrocodeine<br>• Levorphanol | • Meperidine<br>• Methadone<br>• Morphine<br>• Fentanyl<br>• Hydrocodone<br>• Hydromorphone | • Opium<br>• Oxycodone<br>• Oxymorphone<br>• Pentazocine<br>• Tapentadol<br>• Tramadol |

This measure does not include:

- Injectables
- Opioid cough and cold products
- Single-agent and combination buprenorphine products used as part of medication assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products)
- Ionsys® (fentanyl transdermal system)
- Methadone for the treatment of opioid use disorder

## EXCLUSIONS

Patients are excluded if they:

- Received hospice care during the measurement year
- Died during the measurement year
- Had at least one of the following at any time during the 12 months prior to the initial prescription dispensing date through 61 days after that date:
    - Cancer
    - Sickle cell disease
    - Palliative care (HPCS palliative care codes are not exclusions for COU. For additional information, see the Hospice and Palliative Care Exclusions Guide.)

## TIPS FOR SUCCESS

Patients with subacute pain that initially received opioid therapy for acute pain and have been treated for more than 30 days should take care to ensure that opioid prescribing does not unintentionally become long-term opioid therapy. Initiation of long-term opioid therapy should occur only as an intentional decision where benefits are likely to outweigh the risks, following an informed discussion between clinician and patient and as a part of a comprehensive pain management approach.

**Reduce or avoid opioid prescribing:**

- Leverage electronic medical record (EMR) to identify prescribing that meets COU criteria. Share lists with providers in the practice for review.
- Maximize the use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the patient and specific condition.
- Use the lowest dosage of opioids for the shortest length of time possible.
- Avoid prescribing additional opioids to patients "just in case" pain continues longer than expected.
- Reference the CDC Guideline for Prescribing Opioids for Chronic Pain.[ii]
- Track the total number of days in the calendar year that the patient is prescribed opioids.
- Establish and measure goals for pain and function.
- Use caution when prescribing to patients with renal or hepatic insufficiency or who are aged 65 or older.
- Avoid prescribing opioids to patients with moderate to severe sleep-disordered breathing.
- Review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving other opioids from other prescribers or dangerous combinations that put them at high risk for overdose (e.g., benzodiazepines) and to check status of patient medication usage habits.

**Review risks with patient:**

- Consider employing UDS screens to assess other illicit substance use or other opiates.
- Discuss benefits, risks, and availability of non-opioid therapies with patient.
- Emphasize the importance of consistency and adherence to the prescribed medication regimen.
- Educate the patient and caregivers about side effects of medications, including the risk of addiction and what to do if side effects appear.
- Reinforce the treatment plan and evaluate the medication regimen considering presence/absence of side effects, potential costs, and clear written instructions for medication schedule.
- Instruct your patient on crisis intervention options, including specific contact information and

facilities.

**Mitigate common risks:**

- Establish exercise or bowel regimens to avoid constipation.
- Perform fall risk assessment.
- Monitor patient for cognitive impairment.
- Use caution when prescribing concurrent opioid medications with other central nervous system depressants such as muscle relaxants, non-benzodiazepine sedative hypnotics, or anticonvulsant medications such as gabapentin and pregabalin.

**Ensure follow-up with patient:**

- Establish follow-up appointments shortly after prescribing opioids and when adjustments are made to reassess the pain management plan.
- Talk frankly about the importance of follow-up to help the member engage in treatment.
- When scheduling an appointment, address any potential barriers such as transportation, location, and time of day.
- Provide reminder calls to confirm appointment.
- Reach out proactively within 24 hours if the member does not keep scheduled appointment to schedule another.
- Engage caregivers in the treatment plan. Advise them about the importance of treatment and attending appointments.
- Appointments should be with a physician and potential psychosocial treatment should be with a licensed behavioral therapist.
- Providers should maintain appointment availability for members with opioid prescriptions.
- Coordinate care between providers. Encourage communication between the behavioral health providers and primary care physician (PCP).

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i National Committee for Quality Assurance. HEDIS® Measurement Year 2022 Volume 2 Technical Specifications for Health Plans

ii Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States. Surveillance Special Report. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2018.