NATIONAL QUALITY FORUM

Meeting Summary

Opioid Technical Expert Panel (TEP) Web Meeting 6

The National Quality Forum (NQF) convened a public web meeting for the Opioid and Opioid Use Disorder Technical Expert Panel (TEP) on October 10, 2019.

Welcome, Introductions, and Review of Web Meeting Objectives

Dr. Sam Stolpe, NQF Senior Director, welcomed participants to the web meeting. Co-chairs provided opening remarks and reviewed the following meeting objectives: to review and discuss measure gap prioritization and to review and discuss guidance for CMS federal programs.

Review and Discussion of Measure Gaps Prioritization

Dr. Michael Abrams, NQF Senior Director, reviewed the methodology used in the measure concept prioritization exercise. Derived from apparent gaps evident in the TEP-guided environmental scan which identified over 200 measures and 70 measures concepts, the TEP prioritized 33 measure concepts by systematic voting. From those 33, 16 rose to the top based on at least one of three summary scoring methods: average of all prioritization criteria,[a] weighted-average of those criteria which emphasized morbidity and mortality, or morbidity and mortality average in isolation. An overall-summary score based on all three methods led to the following top five list:

1. Long-term recovery from opioid use disorder (OUD) measures
2. Measures related to physical co-morbidities to OUD
3. Tapering strategy deployment measures for pain management with opioids
4. Consideration of special populations issues related to OUD treatment (pregnant women, criminal justice involved populations, homeless, adolescents, rural communities)
5. Consideration of psychiatric comorbidities during OUD treatment

Dr. Abrams asked the TEP if these rankings accurately reflected their input. One TEP member inquired as to where patient education fell in the overall ranking. NQF noted that patient education is reflected in the two measure concepts: "social risk factors: patient and family health literacy" and "social risk factors: stigma associated with provider attitudes." It was also noted that patient education is an implicit part of patient-centered pain management that is connected to item 3 above and to sound OUD treatment focused on comorbidities or otherwise (items 2 and 5 above).

Another TEP member recommended that the draft report include "patient desires" in the discussion of the patient-centeredness measure concept. This addition will better capture the

[a] Five prioritization criteria: morbidity and mortality impact, feasibility, performance gap, patient-centeredness, fairness

partnership and collaboration aspects of patient-centeredness which otherwise are not readily apparent.

Several TEP members recommended combining priority 2 (physical co-morbidity) with priority with priority 3 (psychiatric comorbidities), thereby opening the top five list to one additional measure concept. The TEP seemed to agree that this configuration makes sense given the general healthcare value of wholistic care. With those two priorities combined, a measure encouraging a patient-centered pain management plan would move into the top five measure concept list. The TEP agreed with this addition, and a member noted that the amended top five priorities would also be better balanced with three OUD and two pain management measure concepts.

Several TEP members questioned why racial and ethnic minorities were listed out under the special populations measure concept. Literature was cited showing that minority patients were less likely to receive treatment even after they have been diagnosed with OUD and that they are half as likely to receive medications after diagnosis of OUD. The TEP agreed that there is an inequity of access, and that the report should mention this when discussing special populations that include disparity groupings including racial minorities and those recently released from criminal detention. Moreover, this discourse noted that one of the reasons why this epidemic received attention is because of relatively high white morbidity and mortality. These morbidity numbers are summarized in the environmental scan that preceded and partially guided this meeting.

Review and Discussion of Guidance for Five CMS Federal Programs

As a guide for the TEP moving forward, and also as a potential component of the final report, Dr. Abrams reviewed the Shatterproof, Inc., substance use disorder measure set and a compilation of measures from five state dashboards. These measure sets were put forward additionally as a frame of reference for the TEP as they worked to complete the review of measure sets and measure set gaps in the five federal programs (see below). Dr. Abrams noted, without objection, that the Shatterproof and state dashboard examples were useful organization touchstones with themes that were almost completely overlapping with the environmental scan for this project.

Dr. Stolpe then reviewed and solicited additional feedback on the measure set recommendations guidance that the TEP provided HHS on the following federal quality and performance programs.

Medicare Shared Shavings Program
SSP Quality Measure Set

- Expand ACO-17, Preventive Care and Screening, Tobacco Use –Screening and Cessation Intervention
    - Should be a more comprehensive substance use disorder (SUD) screening measure
    - Tobacco, alcohol, opioids and other substances
    - Include documentation of pharmacotherapy for SUD being offered, initiated, or an appropriate referral made to specialty care

- Other potential quality gaps
    - Naloxone co-prescription
    - Non-opioid management strategies for high dose opioid patients
    - Long-term recovery from OUD
    - Physical and psychiatric co-morbidities to OUD
    - Specific populations for OUD treatment
- SSP Opioid Utilization Reports
    - Panel noted low quality gaps for existing measures; this suggests more meaningful measures may be needed
    - CMS should consider testing quality gaps for:
        - Concurrent Use of Opioids and Benzodiazepines (NQF 3389)
        - Initial Opioid Prescribing at High Dosage for opioid prescriptions initiated at greater than or equal to 50 morphine milligram equivalents
        - Initial Opioid Prescribing for Long Duration for opioid prescriptions lasting greater than seven days' supply
        - Initial Opioid Prescribing for Long-Acting or Extended-Release High Dosage

Feeback from the TEP garnered support for NQF measure #3389 *Concurrent Use of Opioids and Benzodiazepines, but explicitly cautioned against injudicious use of the* naloxone co-prescribing measure. Naloxone coprescribing should only be used for patients receiving high dose opioids and if the patient is a high risk of SUD. Use in other circumstances was considered by at least one member of the TEP to be wasteful and costly.

The TEP confirmed that the measures around opioid prescribing were recommended for utilization reports and not quality measure sets because the rates of such use is relatively low, and more important because tracking MME, per se, is not regarded as a patient-centered approach to determine when and if opioids are being properly prescribed.

Merit-Based Incentive Payment System

- Measure Recommendations
    - Co-prescription of naloxone within chronic opioid treatment
    - Nonopioid management strategies for high-dose opioid patients
    - Long-term recovery from OUD
    - Physical and psychiatric co-morbidities to OUD
    - Specific populations for OUD treatment
- Measure Guidance
    - The TEP noted the existence of the measure Osteoarthritis: Function and Pain Assessment and recommended a broader measure of function and pain assessment within MIPS.
    - The TEP especially emphasized need for measures of functional improvement over measures of pain scoring or pain reduction.
    - The TEP also noted the emphasized problematic nature of adding measures to MIPS that focus on decreases in pain score.
        - These types of measures introduce challenges to clinician prescribing behaviors, with the exception of measures used for palliative care.

- The TEP encourages CMS not to include such measures within MIPS.

The TEP had no additional comments.

Alternative Payment Models (APMs)

- TEP noted the challenge associated with MIPS-like measures given the variety of APM structures.
  - APMS can apply to a specific condition, a care episode, or a patient population.
- The TEP noted that measurement needs differ depending on APM structure and population.
- Measure Guidance – AAPMs
  - Assessment of quality gaps for receiving or maintaining AAPM status
  - Measures selected should be based on gaps and risk factors for the population using same guidance and recs from MIPS.
- Develop an opioid tapering metric for oncology APMs.

Several TEP members recommended that a behavioral health home could be a type of APM. One TEP member noted that Comprehensive Care for Joint Replacement is a relevant APM-eligible model which needs to have a comprehensive pain management component. During this portion of the discussion, one TEP made the point that measure development and deployment are resource intensive, so there will need to be selection strategies.

Hospital Inpatient Quality Reporting Program (IQR)

- Measure recommendations
  - Assessing whether patients were offered nonopioid options to manage pain
  - Patients who are identified with SUD that are offered or initiated on pharmacotherapy prior to discharge, or referred to an appropriate specialty service
  - Proportion of SUD patients who are linked to ongoing care in the community post-discharge
  - Proportion of patients treated for an overdose who are in treatment 30 days later
  - Proportion of patients who had an opioid overdose who were given a prescription for naloxone at discharge
  - Presence of a patient-centered tapering plan for patients discharged with an opioid prescription

Since the communication around pain measurement is being removed from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), the TEP recommended measures that assessed nonpharmacological options for pain control and management especially from the functional perspective. The liaison from AHRQ was asked if future versions of the HCAHPS would replace the pain measures being removed, this liaison (Elizabeth Kato) did not know, but offered to check for us.

Value-Based Purchasing Programs (VBP)

- The TEP noted that the measures used inside of the Hospital Value-Based Purchasing Program are drawn from IQR, meaning that they would naturally be a subset of the recommendations put forward in the previous section.
- However, the TEP particularly emphasized the need to have strong process measures included in value-based purchasing arrangements.
- Measures of opioid tapering at discharge and the prescribing of naloxone at discharge were emphasized.

A TEP member noted that in the report the TEP recommended a multimodal approach to pain and personal pain management plan. This includes many services that are helpful but also costly, and it is a challenging balance to make recommendations while being conscious of financial constraints.

Additional Remarks—Measure Development Focus

The TEP reviewed a previous point it made concerning measure scope: SUD beyond OUD is important to keep in mind when developing measures, because substance misuse or dependence rarely involves just a single drug.

The TEP agreed about looking beyond just OUD and having a more comprehensive focus on substance use disorders as a whole. Providers should look comprehensively at how they manage, identify, and treat SUD. At the same time, the TEP stated that there must be some differentiation between OUD and SUD.

Public Comment

Madison Jung, NQF Project Manager, opened the web meeting to allow for public comment. There were no public comments received.

Next Steps

Ms. Jung asked TEP members to send their feedback on the draft report by next Monday so that staff can update the report. The report will be posted for public comment on December 6, 2019 to January 6, 2020. The TEP will reconvene on January 21, 2020 to review the public comment.