Opioid Technical Expert Panel Web Meeting 1

Moderator: Kim Patterson
April 24, 2019
3:00 pm ET

Michael Abrams: …at NQF, and we are being recorded for posterity and for us to keep track of the proceedings. Want to welcome all of you and thank all of you for being part of the opioid use and opioid use disorder Technical Expert Panel. Thanks and congratulations goes to all of you. This was a very popular activity here at NQF and we received a well over a hundred nominations, and you are the select group that has made it to the activity here, and we're pleased to engage you.

We're going to be doing it all via Web. So, you know, we work hard to make sure that technology works and everything well, but do give us feedback on that if you have difficulties. But generally things I think you'll find will work pretty well. Encourage you both to use the telephone as well as the Internet portal to access it.

Today what we're going to be doing is giving you a full introduction to the activity. That includes an overview of NQF and what we typically do and our ethos and our procedures here, especially in the quality measurement space, but also quality improvement activities as well. And we'll overview this project specifically, and introduce to you the first major deliverable for us to

give to you, that is NQF staff to provide to you, with your input, an environmental scan of measures. And I'll be talking more about that a bit later.

And then we'll give you a chance to give us a bit of feedback regarding especially that environmental scan plan. And finally, we'll give you a little bit of input about a software here we use called SharePoint, to allow you connectivity to our documentation, including report drafts, et cetera, for you to keep pace on what we need from you regarding (the tasks). And there'll be an opportunity for public comment, this is a public meeting, as all of our meetings will be. And then finally, we'll head into next steps.

So, before I turn it over to Sam, let me just briefly introduce myself and my colleagues here. There I am. It's a pretty good picture of me in the center. And I have a master's in public health degree, which I'm very proud of. And you'll notice from my - the order in which I put my degrees there, I actually got that at Johns Hopkins before I even got my PhD in health services research and health policy at UMBC. And I have quite a bit of experience with Medicaid opioid related policies and broader behavioral health policies from a health services research standpoint.

Sam you're going to meet in a minute, I'll let him introduce himself. But we also have with us (Rumi Asoja) who is our senior managing director. She's been here quite some time, quite skilled with making sure that we stay on task with regard to substance contract like this with CMS and very skilled in the area of quality measurement as well. Similarly so, down in the bottom left, we have in the room (Poona Ball) who is our main project manager, senior project manager, on this - responsible for this project in particular.

And then in the middle, not with us today, out on leave for a short time, is (Kay Woods), a new project manager. And then, finally, you heard from Vaish Kosuri, and I will add that almost all of us - certainly all of us have public health background, which I think is excellent for this particular activity and very common here at NQF. But also, almost all of us have had some direct experience with opioid related public health issues. So I think we are well-staffed to serve you as an expert panel on this very important issue.

So with that, I'll turn it over to my colleague, Sam. Sam and I are co-leading this project, and ask that he briefly introduce himself as well before we get into the content for today.

Sam Stolpe: Very good. Thank you, Michael. Hello everybody. This is Sam Stolpe, I'm a pharmacist and epidemiologist by training, hails from the measure development world. And I'm delighted to be able to work with this really terrific team, and each one of you in advancing the deliverables and agenda of this particular project that we're engaging in. I know that many of you shared a sense of urgency and passion related to the opioid epidemic that we at staff at NQF. So I'm delighted that we share that in common and that we are going to benefit from your expertise as we try to make a significant crack in at least the way that the quality measurement world is - operationalize a response.

So for this next portion of our agenda, we're going to - you'll see on the screen that slide that represents the individuals that have been nominated for this committee and who are populating it. We're going to go through a - some disclosures of interest.

You received a Disclosure of Interest form from us before you were named to this committee. In that form you were asked a number of questions about your professional activities. And today we'll ask you to orally disclose any

information you provide that you believe is relevant to the subject matter before the committee. Now we ask that you don't necessarily summarize your resume or anything close to it. We're interested in your disclosure of information that's directly relevant to the work of the committee. We're especially interested in grants or research, consulting. But if it relates to the subject matter in front of the committee, please err on the side of disclosure.

So, just a couple of reminders relevant to this. First, you sit on this group as an individual. You do not represent the interests of your employer or anyone whom you may - who may have nominated you to the committee.

The other thing I want to mention is that you - we are not only interested in your disclosure of activities where you were paid. You may have participated as a volunteer, for example, on a committee where the work is relevant to the work of this particular committee. We're looking for you to disclosure those types of activities as well, but again, only if relevant to the subject matter before the committee.

Just because you disclosed doesn't mean that you have a conflict of interest. We view all disclosures in the interest of openness and transparency, so please, as we go through this, I'm going to call out your name, ask you to state the organization that you're affiliated with, and if you have anything to disclose. So let's go ahead and go around the table. We'll start with Anika Alvanzo.

Okay. Michael Ashburn?

Michael Ashburn: Hi, this is Michael Ashburn. I apologize for not being completely organized because I just - I wasn't expecting - I wasn't expecting this. But with regard to my consulting work, other things that might be a potential conflict of interest

or needs to be disclosed, one is that I do act as a medico-legal consultant for civil litigation as well as investigation of criminal behavior, mostly to the DEA and for the FBI. But I also do have - I've done medico-legal reviews for the Pennsylvania Board of Medicine, which is in the Department of State within the state government. And I have reviewed criminal cases for the states of Maryland as well as for Pennsylvania.

Sam Stolpe: Very good. Thank you, Michael.

Next, Antje Barreveld?

Antje Barreveld: Excellent pronunciation. This is Antje. I'm in the Boston area, in Newton Wellesley Hospital, which is part of the Partners Healthcare System. I'm a medical director for the pain management service and director of education outreach for our substance use service. And I don't have any financial disclosures. I also am part of the Centers of Excellence for Pain Education and one of the co-principal administrators for an NIH (pain and depression contract) under this.

Sam Stolpe: Thanks, Antje.

Patty Black.

Patty Black: Hi. I'm Patty Black. I am from Eugene, Oregon. I work for PeaceHealth. We have hospitals and clinics in Alaska, Washington and Oregon. I am also a board member for HealthInsight, now Comagine, that's in the northwest region and southwest region. I am here to represent the patient perspective and their voice. I coordinate patient family advisory councils as well as I do shadow coaching with clinicians.

Sam Stolpe: Very good. Thank you.

Jeannine Brant.

Jeannine Brant: Yes. Excuse me. Jeannine Brant from Billings Clinic, which is a fully integrated healthcare system in south central Montana. It's the largest employer in the area, (we) do a lot of national (themes) as well. My disclosures, I have been on (unintelligible) cannabis, but it's also been (unintelligible) transmucosal fentanyl products in the past. I've served on (unintelligible) panel for quality indicators and I have disclosed that in the past, so there is (unintelligible) over 10 years ago, but it was for quality measures for (Rand) for cancer care. And then I (unintelligible) served on the CBC panel presenting pain and (palliative) care for the new revised guidelines. And then I served on a lot of pain communities for the Hospice Palliative Care Association and also in Oncology Nursing Society.

Sam Stolpe: Thank you very much.

Caroline Carney?

Caroline Carney: Good afternoon. I am Caroline Carney. I work as the Chief Medical Officer for Magellan Health Rx Management and Magellan Health. And in that role I oversee all of our clinical programs related to treatment of conditions, including opioid use disorders, and on the behavioral health side, work to try to get into the (unintelligible) linked to behavioral health and MAT care for opioid use disorders.

I have two disclosures. I serve on the APA-NCQA-CMS organization, that group that is working on behavioral health outcomes related to the Medicare population and selecting measures to use for depression, first-break

schizophrenia, and opioid use. I also serve as our company's liaison to shutter-proof, which is moving forward in creating a group of opioid measures to look at treatment facilities for opioids.

Sam Stolpe: Thank you very much. Anthony Chiodo.

Anthony Chiodo: Hello. I'm a physical medicine and rehabilitation specialist. I'm associate chair of the University of Michigan Ann Arbor. I have no financial disclosures. And things related to this, I have been - I continue to be a member of the Pain Medicine Exam Committee for the American Board of Anesthesiology, the Chair of the American Board of Physical Medicine and Rehab where we set the criteria for credentials and professionals for physical medicine and rehabilitation physicians, and many of those credentials have to do with the appropriate use of opioid substances.

Sam Stolpe: Thanks very much. Jettie Eddleman please?

Jettie Eddleman: Yes. Thank you. Can you hear me?

Sam Stolpe: Yes, we can.

Jettie Eddleman: Thank you. Yes, Jettie Eddleman, I'm from Texas A&M University in College Station, Texas. We're a top-tier university. I'm under the Health Client Center, College of Medicine, in the Rural and Community Health Institute. We provide rural (unintelligible) for about 15 programs and several grant programs. And like almost in every rural program, and because of the size of the opioid epidemic, I have no financial disclosures, but we do really work essentially for quality, safety, and technology (unintelligible) for the rural communities. Thank you.

Sam Stolpe: Thanks very much. Maria Foy.

Maria Foy: Hi everybody. My name is Maria Foy, I'm a pharmacist at Abington Jefferson Health, part of the Thomas Jefferson system in Philadelphia. I'm outside of Philadelphia, in one of the suburbs in Abington. I have disclosures with Daiichi Sankyo. I am on Speakers' Bureau, and I did a FDA advisory, I was one of the experts that presented to the FDA for (ExcelRx) this past year.

I work in an inpatient setting. I'm part of the palliative care team. I'm available here in our institution for complicated pain patients. I've branched out from palliative care and I'm now involved in many of the stewardships here. I am involved in our enterprise (unintelligible) with Jefferson at main campus and on their treatment committee and education committee. I'm also involved in our stewardships here at Abington where we are decreasing opioid prescribing through a post-op stewardship program using - also developing a stewardship program for complicated and chronic pain patients and patients with a history of substance use disorder.

And I run a pain management committee here and I am starting a stewardship within the pharmacy department, hopefully within this next year where we can develop and monitor antibiotic - antibiotic, I'm sorry - analgesics and opioids appropriately here in our institution. Thank you.

Sam Stolpe: All right, thanks very much. Jonathan Gleason?

Jonathan Gleason: Jon Gleason from Carillion Clinic. I'm chief quality officer for the system, broad responsibilities for quality, safety, risk and other operational areas. I serve on several boards for Carillion, also on the board of the Blue Ridge Indemnity Company. But no direct conflicts there.

Had a consulting work with Allergan related to research and intellectual property. And that's an ongoing engagement and does not include any work around opioids.

Sam Stolpe: Thank you very much. Anita Gupta.

Anita Gupta: Hello everyone. My name is Dr. Anita Gupta. I'm currently senior vice president at Heron Therapeutics, Medical Strategy and Government Affairs, based out of San Diego. We're a small company in development of a non-opioid alternative.

My disclosures include that I'm currently at Princeton University in development of innovation at the Keller Center of Innovation. I'm currently also a former (SPA) advisor for the opioid and analgesic and anesthetic committee. I'm also currently a professor at Rowan University based out of New Jersey. And I'm also currently a visiting scholar at Georgetown University School of Medicine. And those are my disclosures, thank you.

Sam Stolpe: Thank you very much. Mark Hurst.

Man: I believe Mark had a leave conflict and he can't make today. He'll be here on the forthcoming meetings.

Sam Stolpe: Thanks a lot.

Katie Jordan.

Katie Jordan: Hi. I'm Katie Jordan. I'm an occupational therapist. I am the associate chair of Clinical Occupational Therapy for the University of Southern California Chan Division of Occupational Science and Occupational Therapy. I recently

served on our health systems steering committee for opioid prescription. And I'm also the compliance liaison for the occupational science and occupational therapy division.

I hold a couple of volunteer leadership positions. So, with our state association, Occupational Therapy Association of California, I serve as the chair of the Practice Ethics and Reimbursement Committee. And then with our national association, The American Occupational Therapy Association, I am the adviser to the American Medical Association Relative Value Update Committee, and I serve on two subcommittees there, the Healthcare Professional Advisory Committee or HCPAC, and the research subcommittee.

Sam Stolpe: Thank you very much. Navdeep Kang.

Navdeep Kang: Hi everyone, this is Nav Kang. I'm a psychologist by training and director of behavioral health operations for Mercy Health in Cincinnati, Ohio. We're a large health system. I don't have any financial disclosures and I don't think I have any disclosures overall, but, you know, in the area of transparency as Sam mentioned at the beginning.

I served on Ohio Governor Mike Dewine Recovery Ohio Council, which - where it's a group that advises the administration on effectively behavioral health redesign in a number of ways to (unintelligible) agencies and develop better practices for prevention, treatment for behavioral health across the board, behavioral health (unintelligible) addiction, etcetera. I'm also a fellow at the Obama Foundation. I don't think that has any (unintelligible).

Sam Stolpe: Thanks, Nav. Brandon Marshall.

Brandon Marshall: Hi everyone, this is Brandon Marshall. I'm an associate professor in epidemiology at the Brown School of Public Health in Providence, Rhode Island. I'm also an expert advisor to our Governor's Overdose Task Force and I oversee the state overdose surveillance and metric program to measure our progress (unintelligible).

I don't have any disclosures except that I serve on the FDA Drug Safety and Risk Management Committee which evaluates good drug applications for opioid products and treatment that (unintelligible) for opioid use disorder.

Sam Stolpe: Thank you. Sarah Melton.

Sarah Melton: Hi. This is Sarah Melton. I'm professor of pharmacy practice at the Gatton College of Pharmacy at East Tennessee State University. I was nominated to this committee by the American Pharmacists' Association. I'm a volunteer for the College of Psychiatric and Neurologic Pharmacists and serve as the chair of our substance use disorder committee. And also have served in Tennessee and Virginia over the past few years onto governor commissions related to substance use disorders.

Sam Stolpe: Thanks very much. Gary Mendell.

Gary Mendell: Yes, hi everyone. Honored to be with you all today. My background, unlike most of you, was my career was not healthcare, it was in the hotel business. But I have some real-life experience in the sense that my son (Brian) struggled with addiction for about seven years, eight different treatment programs, and ultimately we lost him related to addiction in 2011.

But what came out of that was my really being struck by the fact of how much research existed in this field that wasn't being implemented. And that for

every disease in this country, there was one (well-funded) national organization related to the respective disease -- you know, a well-funded non-profit, I'm sorry -- and that did not exist for addiction. So I left my career in business. We formed a national non-profit Shatterproof five years ago. Primarily we started with state advocacy, and then two years ago I saw (unintelligible) a quality measurement system related to addiction treatment. And a lot of my thoughts were pulled from National Institute of Medicine report that was published in 2006 which had a lot of recommendations related to quality measures.

And in the last year and a half I've been - it's been a large portion of my time understanding this field related to quality measurement. And we scoped out a project related to building a quality measurement system in this country for treatment programs. And Caroline, thank you for mentioning it, Caroline Carney, who's involved. We, recently, we funded with about $5 million from some foundations to build this, pilot it, five states. And we also just recently went through a process with the National Quality Forum to take the measures that we had drafted and pressure-test that with 15 experts' approval process, as well as about a dozen other expert interviews and public comments to revise our set of quality measures to pilot this system.

So that's the experience I bring to it. And we're now building it. We've hired Research Triangle Institute as our quality measure data contractor, if you will. We have the five states selected. We have - the quality measures will be informed by claims data, both commercial and Medicaid, as well as information from providers, as well as AHRQ consumer information.

Michael Abrams: Thank you, Gary. Gary, we're going to move on, this is Michael speaking. We're going to move on. Thank you. Those details are important but we want

to keep to the DOI discussion, but excellent, thank you. Thank you for all that.

Sam Stolpe: All right. Thanks very much, Gary. Darlene Petersen?

Darlene Petersen: Yes, thank you. So I am (unintelligible) family medicine and addiction medicine. I think my only disclosures would be I have (past) consulting as a treatment as a kit with what was then Kaiser, now (Indover). And then I am part of the Opioid Response Network, and I think that falls under a grant on those. And then, volunteer, I am on a hospital, associate in pain committee. And then I am also part of the American Academy, Family Physicians' Opiate Response Committee.

I think that is it as far as any relative activities related to this.

Sam Stolpe: Thanks, Darlene. Laura Porter.

Laura Porter: Hi, this is Laura Porter, and I am a Stage 4 colon cancer survivor and a patient advocate. I am representing the patient perspective on this panel, along with my personal experience with opioids. I am - I have been on the - one of the FDA panels, advisory committee, for opioids in the past. And that should be it. Thank you.

Sam Stolpe: Thanks very much. Now we have you listed as James Rhodes, but I know that your name is Clay.

James Rhodes: That's right. Clay Rhodes. I work at Humana. I'm our enterprise opioid strategy leader. I do not have any financial disclosures. Other disclosures, I did lead teams that worked with pharmacy quality alliance and measure

testing of their opioid measures, as well as I didn't participate in the NQF Incubator, the session on appropriate pain management.

Sam Stolpe: Thanks very much, Clay. Darshak Sanghavi.

Darshak Sanghavi: Hi everybody. It's Darshak Sanghavi, I'm the chief medical officer at Optum Labs, which is a research and convening part of Optum. And we're located within UnitedHealth Group. My disclosures, I have none, other than the fact that I've worked for Optum and UnitedHealth Group which also owns United Healthcare.

I am a member of our executive task force that's in charge of our opioid related strategies here. Also developed a dashboard that's used both at our enterprise as well as by (number of space) to track and quantify a number of features related to the opioid crisis.

The other disclosures for - I was, formerly before being here the Director of Prevention and Population Health at CMS at the innovation center.

Sam Stolpe: Thanks very much. Now, Jeff, we've left you off the list, and our apologies. We would welcome your disclosures.

Jeff Schiff: Thanks. At least I got in the right part of the alphabet.

I'm Jeff Schiff, I'm the medical director at the Minnesota Department of Human Services. I have no financial disclosures. I am a pediatric emergency medicine doc. I have worked with the Medicaid core set development in a bunch of different areas that continue to work on Medicaid for quality measurements in Minnesota. I work on a project as the statewide quality improvement project that runs through Medicaid on opioid prescribing, and

help coordinate the state's opiate response, including prevention, treatment and emergency response. Thanks.

Sam Stolpe: Thanks very much. Evan Schwarz?

Evan Schwarz: Hi. So I'm an emergency physician as well as a medical toxicologist with (unintelligible) and addiction medicine at Washington University in Saint Louis. And I'm involved with opioid stewardship and treatment of opioid use disorder here.

As far as other things to mention, I sat on a one-time task force (unintelligible) team as well as statewide opioid task force. I'm also a physician consultant for our state targeted response program and have just done some general medico-legal consultant work in the past.

Sam Stolpe: Thanks very much. Norris Turner.

Norris Turner: Yes. Hi everyone. Norris Turner. I'm currently in the role of Vice President of Strategic Alliances and Measure Implementation at Pharmacy Quality Alliance. We're a non-profit measure developer.

We do have four opioid measures that are related to the state's appropriate prescribing of opioids. Also have the measures in development related to initial opioid prescribing. So that's an important disclosure, I believe.

Background-wise, I'm a pharmacist and a research scientist where I've spent the majority of my time doing clinical development in the pharmaceutical industry. So there were five of those years I was employed at Purdue Pharma where I did clinical trial work, mostly on buprenorphine patch product Butrans.

Another disclosure, my most recent time of my career in the industry was at Johnson & Johnson, which I think many of you know has been a company that has been a part of lawsuit. I was not involved in any opioid related work with Johnson & Johnson and I do (unintelligible). I think that completes my disclosures.

Sam Stolpe: Thanks, Norris. Sarah Wakeman?

Sarah Wakeman: Great. This is Sarah Wakeman. I'm medical director at the Mass General Hospital Substance Use Disorder Initiative and our inpatient addiction consult team. I'm also program director of our addiction medicine scholarship program. And I serve as chief medical officer for RIZE Massachusetts, which is a non-profit that is essentially creating a fund-to-fund innovative research across the commonwealth to address the ongoing overdose crisis.

I've served on other committees. I was on Governor Baker's opioid working group in Massachusetts. I'm on the American Society of Addiction Medicine Ethics Committee. And I also chair the policy committee of the Massachusetts Society of Addiction Medicine. And I'm doing some research with Darshak at Optum Lab currently. I think that's it.

Sam Stolpe: Thank you very much. Sarah Wattenberg.

Sarah Wattenberg: Hi. This is Sarah Wattenberg, I'm Director of Quality and Addiction Services at the National Association of Behavioral Health Care. We're a membership organization representing mental health with substance use providers at all levels of care. We have facilities and programs in almost every state and represent both for-profit and not-for-profit providers. I spent 17 years in the

government at HHS and the White House Office of National Drug Control Policy. And when I was there, I worked on quality and addiction issues.

I was on the NQF Shatterproof technical panel that recently concluded. And I currently liaise with the executive branch on a wide range of quality and addiction issues. I do not have any financial disclosures.

Sam Stolpe: Thank you very much. Arthur Robin Williams. Maybe on mute. See him logged in.

Woman: He might not be able to speak on the line.

Sam Stolpe: All right. We'll loop back around for disclosures with Arthur. Bonnie Zickgraf.

Bonnie Zickgraf: Yes, hi. Good afternoon. Bonnie Zickgraf. I am a registered nurse by profession. Currently - for the past over 11 years, worked for URAC, which is an accrediting organization out of Washington, D.C. I recognize a lot of the organizations already on the line. There are over a thousand managed care organizations and pharmacies throughout the U.S. that URAC is currently accrediting.

I actually though live in the Orlando area and I do have greater than 10 years behavioral health and clinical dependency, both inpatient and outpatient, experience, as well as addiction and crisis center nursing in the trenches with the patients and their families as well. I have no financial disclosures. However, I do want to disclose that I have been approached by several county sheriff's department who would like to interview on the radio, strictly voluntarily, about this particular committee and the purpose that it serves.

They're very, very interested. I can tell you law enforcement is behind this project a thousand percent.

And I also want to say thank you to NQF for the inclusion onto this esteemed panel. Thank you.

Sam Stolpe: All right. Well, thank you very much everybody.

Man: (Unintelligible)

Man: Sorry, who was speaking there? It was very difficult to hear you, very garbled. Can you speak again?

Arthur Robin Williams: Arthur Robin.

Woman: Yes. We're still hearing some background, but I think that's Arthur. Do you mind just dialing in once again? Might ease the problem. Also just a note that this is not - this Webinar does not allow you to speak using your computer. You do have to be dialed in separately from being dialed in to the Webinar. So the Webinar will call you but you can't speak to your computer. So if you need to speak up, please do that.

Sam Stolpe: All right, thanks very much (unintelligible). We had Anika join as well. Do you want to give your disclosures please?

Well, if not, then I think we can move forward.

Thank you all. I'd like to remind you that, if you believe that you might have a conflict of interest at any time during the course of this meeting or future ones, please let us know. You can either do so in real time during the course

of this meeting by reaching out via the chat, and - to the NQF staff. And if you believe at any time during the course of our ongoing dialogue that a fellow committee member may have a conflict of interest or is behaving in a biased manner, you may point this out during the meeting or approach one of our co-chairs, or go directly to NQF staff. We certainly don't want you to sit in silence if you believe that there are any irregularities due to conflict of interest or bias. So, please speak up.

Now, are there any questions from the committee at this point, or anything that you'd like to discuss based on the disclosures that were made today?

All right. Well, hearing none, I'll just welcome you to provide us any feedback related to biases that you may perceive during the course of the deliberations, and keep that in mind. And we can go to the next slide please.

I'll hand it over to my colleague (Poona Ball) to take us to the next portion of our meeting.

(Poona Ball): Okay. Thank you, Sam. And again, welcome to everyone who's joined us. Just a quick reminder how to use the technology in front of you. We do ask that you keep yourself muted as we're speaking. And obviously, you can speak up when necessary. But for our sake, we're going to go ahead and ask you to mute yourself right now.

Also, if you need to, as we're going through, if you have a question, feel free to raise your hand. That feature is on the Webinar. And then, also if you want to chat, if you, you know, we're talking and you don't want to disturb the flow but you want to get a comment in before you forget about it, you can also send us a chat directly.

So there are many options to reach out to us, and of course, you know, as we'll go through, we'll have multiple opportunities for you to speak up. But the hand raising method makes it easier for us to make sure that everyone gets a chance to speak up and one - or one or more voices aren't overtaking the conversation. Okay.

With that, I'll jump in to NQF. So I know that many of you are - haven't worked with us in the past and we're really looking forward to hear these fresh voices. To familiarize yourself with us, we are National Quality Forum, or NQF for short. We have a very unique role in this healthcare realm.

We were established in 1999. We are a non-profit, non-partisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement and quality improvement.

Essentially our goal is to make healthcare in the U.S. better, safer and more affordable. I'm sure all of you have heard something very similar to before. In order to do that, we've taken on a few tasks. So our mission involves being a neutral convenor, really being the standard-setting organization in healthcare. We do that with the help of our board of directors, various (standing) committees, Technical Expert Panels, so on. And we do it through multiple mechanisms. But mainly our goal is to build consensus, endorse national (unintelligible) and educate and do outreach.

We have multiple activities in these areas. So, one, this is probably what people are more familiar with, which is performance measure endorsement, consensus development process as it's officially known as, or CDP, we do have 600-plus NQF-endorsed measures across multiple clinical and (cross-cutting) areas. There are currently 15 standing committees for that. So that

focuses more about once measure is fully developed and ready to be used, getting it - multi-stakeholder group together to give us feedback on its own merit, is it ready to be used.

Next is the Measure Applications Partnership or the MAP. This provides recommendations to HHS on selecting measures for 18 federal programs. When we go deeper into this presentation, you'll notice that we - part of our role is to also provide feedback on certain federal programs. But we'll get more into that in a little bit. But this group is separate where, you know, measures have come forward and will be given recommendations.

Next is the National Quality Partnership. This group (conveys) stakeholders around critical health and healthcare topics. They spear action on patient safety, early elective deliverables, and other issues. And I know that some people had mentioned that they'd worked on an opioid project with that group as well.

We also do measurement science work, which is the category that this project would fall under. It's basically when we convene private and public sector leaders to reach consensus on complex issues in healthcare performance measurements, and some project we've had in the past or attribution, alignment, (SCS), and so on.

So, really the goal of these are to take a topic such as opioid use and (unintelligible) to see what we can do to get the next step, either providing some sort of guidance or to - and/or creating measure concepts.

So with that, I'll actually give it to Sam to actually go into what we'll be doing with this work.

Sam Stolpe: Thanks, (Poona). So, for the next few minutes, my task is to orient you to a bit of a background surrounding the formation of the Technical Expert Panel, as well as the task at hand which we're going to look to accomplish between now and February of 2020. So we'll begin with the regulatory background.

As many of you are aware, the formation of this Technical Expert Panel fell under the auspices of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment Act, which was passed by this last congress and in late 2018. Now, NQF was specifically called out in the wake of this important act being passed to convene this Technical Expert Panel, and we're going to be recommending opioid and opioid use disorder quality measures for possible use inside value-based payment and reporting models under Medicare.

Now, our task is not strictly confined to that, but that is one of the key deliverables that will emerge from this project. And I'll define that a little bit further as we go along.

So, looking at the role of the Technical Expert Panel itself, we're going to guide and provide input on a couple of items. The first of which is the environmental scan and final recommendation report. So, and through this environmental scan, we're going to be looking to identify measures and measure concepts that relate to opioids and opioid use disorder. And they have some very specific items that were included in that, and those are improving care, prevention, diagnosis, treatment, and…

Operator: The conference has been muted.

Sam Stolpe: …and the associated health outcomes.

Next up, one of the deliverables we're going to be looking for is recommendations for revision of existing quality measures. Also the need for development of new measures. So, exploring measure concepts and prioritizing them. And then lastly, when I mentioned Medicare, this is what I mean, we will specifically be looking to identify quality measures put forth as a recommendation of this Technical Expert Panel for inclusion inside of five public-facing quality and performance systems administered by CMS, namely the merit-based incentive payment system, (APM) that also fall under macro structure, the Medicare shared savings program, the hospital inpatient quality reporting program, and the hospital value-based purchasing programs. So we have both a very broad set of tasks before us related to the environmental scan, and a very narrowed focus in the recommendations that we'll be putting forward to CMS.

Now, your role as a member of this committee is to serve as an expert working closely with the NQF staff to achieve those goals. And so we'll be asking you to review meeting materials, to participate in all of the meetings that we have scheduled and to come to consensus with the fellows that you have around the table to - specific to the task that we have before us.

Now we also have two co-chairs, and we can invite them at some point to introduce themselves, but those co-chairs have a set of roles as well. They'll be facilitating the panel meetings and participate as panel members themselves. They keep the panel on track to meet the goals and objectives that we've put together, without hindering discussion and input from the committee itself. And they'll also be assisting NQF in anticipating questions and identifying additional information that may be useful for the panel, so.

So we as project staff have our own roles as well, and I'd just like to outline that briefly for you. So we of course facilitate the meetings and conference

calls. We are ensuring communication amongst all project participants. We facilitate necessary communications between different NQF projects and external stakeholders, so, not specific to this project, but as you know, there's a lot of things that are going on in the opioid space and we don't want to be recreating the wheel, so to speak, but rather complementing the existing things that are out there.

We're here to respond to NQF member and public query related to the project. We maintain the documents and project activities, as well as edits and drafts, reports, and project materials. We'll also be responsible for the publication of multi-environmental scans and the final report which will emerge as another key deliverable of this project.

Now as you're likely aware, NQF is a very transparent organization, we strive to have as much transparency as possible in all that we do. We include the public as these meetings are all open to the public. And we do invite them to participate at the close of every meeting. We invite public comment as well. But over the course of the project, as we move forward, we'll be inviting the public to review the draft reports and project feedback as well as to participate in these meetings as we go forward.

Now, just a couple of items and backgrounds. I know that all of you around this table are very familiar with this crisis, but we felt that this wide, this graph in particular, told a lot of the story of what happened over the course of the last 20 years. Starting from the left, you'll see three points, one of which follows a linear progression, the others, which have this (unintelligible) (logged) rhythmic explosion right around 2013. So that linear progression comes from prescription painkillers which have gone from a fairly modest number in 1999 to a very alarming number here in, you know, 2019. And the particularly concerning things, the crisis level increase in the use and overuse

obviously of synthetic opioids, as well as the rise in heroin use, and the public health crisis that that's precipitated.

This next slide I'm going to walk through what this pie chart is actually depicting. It's very interesting. And so if we look at the overall impact of opioid use disorders, that would be the area in orange. And the tiny sliver that we're looking at is the overdose deaths, the individuals that actually died from this. And this is actually proportional.

The population that this affects is quite huge in comparison to those who are dying. And as we know, the number of people who are dying from this is extremely alarming. So the things to keep in mind, the vectors that we can use to try to curtail this crisis, so, overall, prevention, treatment, interdiction tend to be the levers that we have at our disposal as a healthcare system to try to reduce harm for the population at large.

And then inside of the proportion of the population that actually is facing potential death associated with this, as we have some agents that reverse - that the effects of opioids in real time, Narcan, which as you know just had approval for, a generic equivalent, as well as safe injection sites. But under the domains of prevention, we also have education and counseling, treatment, there's (prodromal) detox and recovery treatments that are available. There's a bunch of things that we can do in the interdiction domain, and these are all things that we're going to want to talk about related to ways that we can measure the extent to which these interventions are being deployed.

So we want to think about what works, we want to think about both the angles that we need to approach in this, not just opioid use but also substance use disorder and its overall - overarching impact it's having on the U.S. society.

Next slide. And the reason that each one of you was selected for this committee is because of your expertise inside of the opioid domain and it's also because of your actual familiarity with quality measurements and its importance. So we know you get it. But this is just to remind you of just how important it is that we do this and what the actual need is. So, improving opiate related costs and health outcomes, as you know, is a shared responsibility that we have across the entire healthcare system, both for medical care and for social services.

And we need measurements specifically for accountability, for incentivizing good care, for knowing where to direct the resources that we have at our disposal, as well as for establishing best practices.

Now with that, I'm going to go ahead and hand it over to my colleague Michael to take us through some of the work that we've already done that we're going to be finishing up. And then we'll have for you to react to help us inform as we move forward to the next deliverable.

Michael Abrams: Yes. Thank you, Sam. So let's just - I think I want to make sure that everybody knows who's onboard here. So, would you go back, Vaish, to Slide Number 6 for us, and let's just take a look at the slate that we've put together.

You all are the driving force for this project. And, you know, the nomination process was set up to identify people who would be qualified. As I said, we got, you know, well over a hundred nominations in that respect. And then staff across the board here at NQF reviewed everybody's application and selected this group that you see up on the slide, minus Jeff Schiff. Apologies again for that, Dr. Schiff, for us leaving you off the slide. But if you haven't done so already, please, I'd encourage you to have a look at least at the brief bios that are posted not at our Web site, and Vaish is going to talk about that

at the end of our presentation, how you access that. So you get familiar with the committee composition that we've brought together.

And just as a brief overview of how we came to that, we were interested in finding balance between individuals who did pain management, had pain management expertise, as well as those who were experienced with substance use disorder. And then we looked in several other domains as well, for example, the fine people of rural expertise, and other Medicaid, Medicare expertise and so forth, so that we would get a balanced view for this (topic). So, please have a look at that.

And I want to just point out, we selected two chairs, and they have graciously agreed to co-chair this activity for us. And that is Brandon Marshall at Brown University. So, thank you very much, Dr. Marshall, for agreeing to do that. And then also Dr. Schiff, Jeff Schiff. And there's our excuse for leaving you off the slide in the first place, we were excited to have you as the chair and we made that error omission.

So I just wanted to let you all know, you know, about composition, again encourage you to review everybody's bio and to think about that as we proceed in these Web formats with our discourse. So, now, Vaish, if you can go back to the environmental scan. There we go.

So what I am going to do in the next couple of slides is tell you how we're addressing the first major aspect of this project, which is mostly for us as NQF staff to deliver to you and to the public a cogent document that reviews measurements related to opioid and opioid disorders. And it should be obvious, the reason that we're using that very clunky, somewhat redundant name is because we're interested both in analgesic measures that refer to

analgesic applications of opioids, but then also measures that refer to opioid use disorders, and arguably, more broadly, substance use disorders as well.

So, on the next two slides, go to the next slide. There are three questions that we are keeping in very close mind as we review the literature on your behalf, and I want to quickly go through those, and I will put up some reminders of that at the end when we have discussion. But the idea here is that these would be guiding principles for us to generate a good environmental scan analytic compendium of measures and measurement concepts. So I'm going to go through each of the three. The first two questions are on this slide, and I'll paraphrase a bit.

Question number one is that we're looking for metrics, existing or emerging metrics or measurements that address this question, the question being how do you effect the opioid overdose epidemic that is impacting the United States specifically? So, question number one is about what are the measures that are out there or that are emerging. That's bullet number one on this slide.

Bullet number two is more conceptual, looking for theories-backed, science-based ideas that would inform the development of measures that either exist or that could be in one's mind's eye based on aspects of the problem. The time series that Sam showed you, for example, clearly demonstrates the power of epidemiology to reveal different select CDC now calls, as I'm sure you all are aware, waves of the epidemic. The third wave that we're in right now, very much fueled by synthetic opioids (unintelligible). That's very obvious from the data that I'm using just as an example of a concept that may well be something of import, either with regard to reviewing measures that exist as we do that, or thinking about measures that need to be created in order to address the various aspects of this problem.

Next slide please. And then the third question that we're asking related to the environmental scan is one very much looking into the future. Where should we go? What advances are necessary? Again, all three questions looking at the opioid overdose epidemic in particular and in the United States. So this third one is a reminder to us that we are interested in considering gaps, errors of omission that currently exists in whatever measurement concepts and measurement - specific measurement tools that we identify for you during the scan.

So the next slide please. So, just to let you know where we are. So, staff, this is somewhat of a fast-tracked study. We're going to go over the timeline for you. But it's to give you some sense. And it's a 12-month study, it's an 18-month study, arguably, that we are shoe-horning into 12 months, we think we can do that. It's sort of all hands on deck. But in order to do that, staff has already begun working on drafting and identifying literature.

And the search strategy that we used is briefly summarized here and it's really the first and the third bullets on the slide that are most germane, that is that we surveyed the peer-reviewed and the (gray) literature, PubMed being where we're getting most of our peer-reviewed literature. And then the (gray) literature coming from a variety of sources including various HHS sites, the National Academy of Medicine, various measure developer sites and so forth, where we're looking for reports, in fact our own (gray) literature at NQF for accessing as well.

And we're using search terms, very straightforward, as follows. Looking for things that refer to metrics or measures that you see on that first bullet. And then the last bullet, looking for pain management or substance use disorder related measures. And what goes along of course with substance use disorders is that we are finding a number and of course emphasizing ones that

refer specifically to opioids, but we aren't excluding measures that might be germane to say methamphetamine use or even alcohol abuse if they are substance use disorder treatment and measurement concepts that might be of interest. Okay?

That's just how we're doing that. The other thing that's noted on this slide is that we make somewhat of an arbitrary decision to truncate our search back just to January of 2013 in order to limit the number of sources that we were finding. We can always go back further if we feel that's useful. But you will note that that is linked to the wave number three of - per the CDC, that is the (sentinels) increase that we're seeing with regard to this epidemic. So there was a little bit of logic, it wasn't purely arbitrary.

Next slide please. Okay. So, another aspect of environmental scan is to ask individuals outside of the committee for their input in a very targeted way. We've already selected some key informants as well, but we're going to be asking you for your input on that. Ultimately we expect to get at least nine individuals on the phone with us for at least an hour to give us their inputs regarding the environmental scan that we're doing, and the activity more generally.

And these would be - the composition of these individuals would be complementary to you all on the committee and with some overlap, but the idea is to get some additional targeted and concentrated inputs from key stakeholders. And we've already developed an interview guide that looks a lot like the questions that I just showed you with the proviso that we especially are asking the informants to tell us about sources of information and ideas that they think we may have missed. And we will, you know, brief them somewhat similarly to how we're briefing you in terms of where we're

looking, to try to really seek novel areas of inquiry outside of the sources that we've already come up with.

So, next slide please. Okay. So…

Operator: The conference has been unmuted.

Michael Abrams: Excellent. So at this point, what we want to do is we want to pause and we want to hear from you all. There are - I introduced three questions at least in this environmental scan strategy. The first is measures and sources of emerging measures. The second is measure concepts and ideas from the literature or elsewhere. And the third is future directions. Okay? As three guiding constructs to the environmental scan.

And then I've ask you about - or queued you regarding the interest in us reaching out to key informants in this space as well. So with those constructs in mind, I want to open it up for a discussion and ask that you all chime in or you can use the hand raised function in order to be recognized, and to give us some input where you think - ideas you think maybe we haven't considered at this point in terms of generating the environmental scan.

Yes, very good. And I'm reminded by my colleagues, also, if you have overall questions about the process that we're undergoing as well, now is the appropriate time to address those.

Woman 1: Bonnie Zickgraf.

Bonnie Zickgraf: Yes, thank you, I appreciate that. I do have a hyperlink that I would like to share back through NQF for distribution to this panel. It's actually a 2011 YouTube video, it's about 14 minutes long. It is a TED Talk. However, this

individual actually speaks to the gaps that are found, and I believe that still exists today with regard to the problem that we have at hand. So I'd like to distribute that to the panel. I think it is very well worth taking a look at it from the gap perspective, and then to marry that of course to what measures we've got in place to address these gaps. And if they don't exist, then obviously we know what the story is before. So I'm happy to do that if the panel is in agreement. Thank you.

Sam Stolpe: Thanks very much. This is Sam. Why don't you submit to the NQF staff and we're happy to disseminate that to the committee at large?

Woman 1: Jeff Schiff, next question?

Jeff Schiff: Thanks everybody. This is Jeff Schiff. I wanted to ask just a scope question, because some of us live in the world of quality measurement for healthcare and I think you're asking for measures that are perhaps, or measure concepts, that are perhaps beyond that linked healthcare and social service. So I want to just confirm that.

And the second part of my question is really about this idea of metrics. Are we looking at suggestions for sort of public health epidemiology tracking metrics around overdose deaths or co-occurring, you know, use of fentanyl with amphetamines, etcetera? Curious as - I'm just trying to get my head around some of that scope.

Sam Stolpe: Jeff, this is Sam. That's a very - that's a very good question. You're right, we're - we have a very broad task in front of us, and it's characterizing the most salient features of the opioid landscape that would be responsive to measurement. And that involves a very broad view that may fall a little bit outside of what you may traditionally think of and also the narrowed - falls

outside of the narrowed set of deliverables that we have related to the recommendations that we'll be making to CMS specific to those five quality and performance programs that I outlined at the beginning of the presentation.

So, for example, EMS services, dentistry, there's a bunch of other professions that may come to mind such as physical therapy and the like that may not have the sort of quality measure levers that you would see inside of a health system per se. But then again they may, you know. And we want to think very broadly about what the - oh, it's in the confines of this environmental scan about what the most impactful measures would be, as well as what was currently existing.

So when we put together this environmental scan, we'll have just a list of every measure that we can get our hands on related to opioids and opioid use disorder, and then we'll be complementing that with the prioritization of gaps. We'll be thinking very carefully about what's missing and what potentially measure developers could do to address this by constructing new measures that we think the opioid crisis would benefit from having in place.

Michael Abrams: Yes. And Jeff, this is Michael speaking. So I would add to that that, you know, sort of the endpoint outcome that's strongly implied by our charge is that we reduce the number of people who overdose and die who use opioids, right? So that's sort of the overall outcome. And as Sam said, appropriately, for the moment we are as staff trying to pull together all measures, quality measures, healthcare quality measures, that would include public health approaches as well as more sort of traditional medical approaches. Pulling those together, that might have an impact on this particular problem.

Having said that, as many of you are aware, NQF standard in terms of approving measurements very much focuses on an evidentiary presentation

that involves asking the question, can the healthcare system impact on the outcome or on the process that is being measured? And that would be certainly a consideration that we would use in the prioritizations that also Sam mentioned as well.

So that may well take us somewhat away from or it may not take us away from more public health, population-based approaches, but we will see and we will engage you all heavily to help us make that sort of determination and make that kind of filtering with regard to measurement.

Sam Stolpe: And Jeff, this is Sam. Maybe a concrete example would be useful. So, one measure that came across that we took a little bit of a look at is (unintelligible) use of benzodiazepines in patients with opioid prescriptions. So that's a very interesting measure, at a health plan level. That isn't just looking strictly at like opioid related deaths, but some of the things that we know, once they're hand in hand, are kind of a dangerous combination.

Now, an example of a measure concept that we came across as we were reviewing the literature, we are still continuing to review it but it's something that came to mind, that there isn't a measure that exists that does this but there very well could be, was the rate of administration of Naloxone in an inpatient setting. And you would think that that is just indicative of a good thing, right, that we're actually saving patients who may have overdosed. But it also could be indicative of bad things, that you're dosing your patients, that you're over-administering. So maybe there needs to be - maybe that's an indicator that we could potentially leverage to improve the quality of inpatient care.

Darshak Sanghavi: Yes. And this is Darshak from Optum Labs, and I was wondering if I could also make a comment broadly, and tell me if this is out of scope for our committee discussion. But one of the things that I'm struck by in looking at

the landscape of measures is that the opioid crisis has been going on for many years and, you know, as we all understand, is one of the leading killers of previously healthy individuals. And yet to this date, CMS has essentially zero endorsed measures that are meaningful related to the crisis.

And our team here is sort of proposing a gap analysis and a roadmap to additional measures. And for those (unintelligible) process, that's a three to four-year journey. And then going through the entire rigmarole of CMS adoption is going to take several more years. So I think I'm struck by the fact that, for a public health crisis, the broader way in which CMS contracting tries to address acute health problems is totally inadequate for addressing this issue in a meaningful way fundamentally.

So, one thing I was wondering, if the committee, is this in-scope or out of scope, is, is there a role for rapid prototyping and deployment of measures a scale broadly at the state or payor or other levels in some format or through systems that are not necessarily through NQF endorsement or through CMS, in ways that can be impactful broadly?

I can tell you that our enterprise United Health group, we have done that in really meaningful ways. And I can also describe the experience this year of trying to get our CDC compliance measure through the MAP onto the CMS SSP program was incredibly frustrating. I can also say, at the NQF MAP, like, half the people hadn't even read the packet when they voted on it. So it does seem as though that, although we talk about taking this crisis very seriously, the strategy that we're pursuing you through measurement is there are fundamental problems in how it is structured and it needs really to be fundamentally re-thought.

Sam Stolpe: Darshak, thank you…

((Crosstalk))

Darshak Sanghavi: …very much for your comments. This is Sam. Was that CMS speaking? Did you want to…

Caroline Carney: No, this is Caroline Carney, I wanted to build on that if I could and bring in one other comment.

I think another natural extension of the committee's work is to also consider payment methodologies around this area. So it's great to be able to measure something, but how do we reimburse correctly for quality care, especially in the chronic pain treatment space? So I'm seeking to see if that is part of this.

My second comment is in the state in which I am currently residing, we have seen a great growth in the use of prescription opioids by veterinarians ending up in the hands of individuals, not to the animals for whom they were intended. So I also would like to extend the scope of the providers that we consider to include the group of veterinarians.

Sam Stolpe: Thanks very much for that. So I'm going to begin with a response to the two of you related to the scope. And if our CMS colleagues are on the line and would like to add to what I'm about to say, we would invite you to do so as well.

So, CMS's approach to this is multi-factorial, but our charge is very well-defined. And certainly, while we'd love to be able to do a lot more than what we have taken on and maybe there'll be additional opportunities to extend the work of this group, our task is in fact fairly well-defined. But if our CMS colleagues would like to add anything about the (current things) in the

pipeline or anything else that may enlighten the committee related to this topic, I would invite you to make (it at this point).

Michael Abrams: So this is Michael speaking here, at NQF. So, just also in response to Darshak, I mean in my view, you know, my initial response to your suggestion about the speed at which measures are emerging is one that I think everybody is sympathetic with and, you know, arguably, particularly germane for this issue which has emerged rather dramatically in recent years, but, you know, as you said, has (unintelligible) go well back a number of years and it could have been noticed earlier.

It's certainly the case that this activity and the intent of CMS, and this activity, you know, generally speaking, activities like this, are to try to accelerate and open a pipeline for development and to create an environment where it's more likely that quality, good-quality measures would emerge. And I might add that, you know, if you look at like the, you know, IOM's quality chasm report going back to the early '90s that, you know, led to this kind of, you know, quality measurement development, when they talk about quality measurement, they talk about efficiency, right? And this is kind of a system efficiency issue that you're talking about. So we're certainly sympathetic to it. It seems like it would be fair game as a concept.

But we, as staff, have a burden to sort of demonstrate that with evidence from the literature and from the real world suggesting that things are actually going too slow. And then we ask that you all as a committee help us then tell that story, if that's the argument that we're going to make, that for some reason this is special case where it should be more quick, you know, things back to like HIV drug development and approval back in the '80s, you know, why that needed special approval rates with regard to (asking a) drug development. So

we have a burden to demonstrate that, but it certainly would be fair game, in my view, with regard to concept.

With regard to Caroline's comment about a veterinarian, that is a very interesting suggestion, and currently there is no veterinarian, you know, on our panel. But I've made a note of that and perhaps it could be something that we think about specifically with regard to, you know, our key informant interviews or at least with regard to the literature we pull. It's certainly the case that these analgesics are effective in all mammals, not just homo sapiens. So it's certainly a reasonable suggestion to make. So, thank you for that.

(Lamita Jones): And I would just add, this is (Lamita Jones) from NQF, I think part of the scope of the task is to really identify best practices and recommendations. As many of you have mentioned, this is a broad area of space, and we really want to get to kind of the helm of it. Really part of this is creating and organizing frameworks that really identifies the direction by which we should prioritize measures in this space.

So again, we're kind of bringing in front of you the environmental scan of what we've looked at thus far. But I think part of the role of this group is to really identify, okay, what rises to the top? And where do we want to focus the next realm of opioid and opioid use?

So, thank you for your comments. I think this will really help to propel this work, and appreciate, you know, your comments and feedbacks on the direction of this project.

Norris Turner: This is Norris Turner. Could I just make an additional comment? Is there time?

Jeannine Brant: Yes, is there time for comments?

Man: Go ahead, go ahead.

Jeannine Brant: This is Jeannine Brant. Just a couple of thoughts. You know, I just start thinking about pain care quality measures and some of those likely or most of them existed prior to 2013 (unintelligible) American Pain Society (unintelligible) the pain care quality surveys (as our) research team (unintelligible) pain care quality indicators for 326 U.S. hospitals, 40,000 patients. So it might have something that informs the current discussion.

The other thing that somebody brought up was the use of opioids with benzodiazepines, and I know psychiatry, we recently put a study looking at concordance with the prescribing guidelines, and I know we do have a psychiatrist on our team, so I (unintelligible) the body of literature or group working on that looking at some guidelines, so that might inform our discussion as well.

And then finally, I wanted to talk about an emerging concept that might be of interest. Recently reviewed a paper and then they've been looking in this area about decision-making capacity for patients with opioid use disorders, and primarily (unintelligible) of addiction, in the sense that, you know, should there be some quality (unintelligible) guidelines and standards for, you know, determining competency and which really could guide the treatment plans and their ability to engage in treatment decisions and treatment success.

Woman: Thank you for that comment.

Man: Hi, this is…

Woman: I think Michael had his hand up for a while.

Michael Ashburn: Hi. Michael - this is Michael Ashburn. When kind of guiding back into the weeds a little bit about sources of information for performance measures, I also wanted to suggest if there's a way many institutions including our own have created dashboards to track - to create performance measures, and it might be worthwhile exploring as best one can what performance measures are currently in use by institutions that are trying to track this.

For instance, we have several performance measures on chronic opioid use as well as acute opioid use and are actively using them and try to change behavior, with the expectation that these measures will improve patient outcomes.

Sam Stolpe: Excellent suggestion. Thank you.

I believe Norris Turner has his hand raised.

Norris Turner: Yes. No, thanks, Sam. Yes, no, I was just, you know, contemplating, I mean for us (at PQA), you know, one of the things that we're challenged with our opioid measures being predominantly related to safe and appropriate prescribing of opioids, you know, recognizing the massive nature of this crisis, the dynamic nature of this crisis, knowing that if you pushed too hard in any one part of the crisis or the issue, even though it's well-intended and serve a good, it could exacerbate problems elsewhere.

And so, you know, one of the things, you know, we've recognized, I know I've given a lot of thought to, is, how do you look at the broader context of this crisis, that no matter what you're trying to do, you're doing that part you need to do, like in our case, you know, we have our defined scope, but we're not

just operating on this focused scope, we're doing it in the context of a greater crisis. So, things like, you know, the problems with inversion from veterinarians or the intersection with public health or criminal justice, the social service connection, we're not doing our work, you know, outside of this broader context. I don't have the answer as to how we should think about those other things, but it seems like the value of what we'll do would be elevated immensely if we make sure it's really clear the - in the broader context of this crisis the role, the work we do will play and where it intersects with other issues that we're not addressing, but we call out areas that need to be addressed, you know, that are beyond the scope of what we do.

And so for me, I feel like, with all this great diverse talent and thinking and experience on this committee, how can we, you know, how can we accomplish that?

Michael Abrams: Yes. Yes, this is Michael speaking at NQF. That's a good comment and it's a, you know, scope related comment and it goes back to what I think Sam was trying to convey when he talked about prioritization. At some point, so we can give you some idea, I mean, just a simple search that we described to you yielded something like 700-plus peer-reviewed and (gray) literature publications. So that's obviously, you know, thousands of pages, and we've winnowed it down to something just over 200 items that we're going through carefully.

And then to give you some other numbers, put them close together for us, measures that refer to opioids, from CMS as well as from our NQF portals and databases, and it was something on the order of 2000 measures that refer to opioids in some way. Sam and I are about to review that. We'll probably get it reduced down to, you know, something on the order of a few hundred. But prioritization will be part of the work of this group that will be part of the

environmental scan, we'll try to boil it down some, but then will be part of the deliberation that you all will carry out after that. And then presumably, Norris, it would help us address directly, you know, the things you're talking about, what are the places where we should be focusing this kind of healthcare quality measurement enterprise on this particular problem. Where are the measures that arguably provide the biggest return on investment, to use an economic term, would be one way for us to engage in that endeavor. So…

Norris Turner: Yes. No, appreciate that. You know, the one thing I would just quickly say is that, you know, probably the video that was recommended earlier, it sounds like that could probably (unintelligible) describe, talks about all the dimensions of the crisis. There's, I think it's on American Journal of Public Health, just some - at the outset, I think it would be helpful to identify some key references or things that give us insight into the broader crisis and all the dimensions and inputs in it. So that when we're thinking about gaps and everything, it's with this broader crisis in mind, so we don't wait till the end to think about that, but we're thinking about it at the beginning. And I have a good paper that I think, you know, touches on that aspect of it.

Michael Abrams: Please, would you send that to our opioid inbox then and we will take a look at that? That's excellent. Those sorts of contextual pieces are certainly important. There's a story here that we must tell in addition to zeroing in on useful measurement tools for the field to either develop or to deploy.

Norris Turner: Okay. Will do. Thanks.

Sam Stolpe: Vaish, who has their hands raised?

Vaish Kosuri: So, Dr. Anita Gupta had her hand raised. Do you still have a question, doctor?

Anita Gupta: Yes. Yes, sure. I just - thank you very much, first of all. And I wanted to build upon some of the comments that were already said about the safety of opioid and the benzodiazepine point. I think it's really important to emphasize the issue about concurrent prescribing, not only with benzodiazepines but other medications that can really increase the issues related to opioid related adverse events, both in inpatient setting and the outpatient setting.

I think that this is really an issue for opioid (unintelligible) and I think that is something that we need to really address, you know, as we look at quality and performance for all healthcare providers, both from a patient perspective and also from a provider education perspective, and how we can build upon best practices here. You know, again, from an educational perspective and also from, you know, the downstream effect for patients, you know, (unintelligible) that they can become functional and how we can address really a performance-based model here. And I think that's a really important point, that, you know, I understand that CMS is proposing, and I think that we need to look at very closely.

Sam Stolpe: Yes, thank you very much. That's a terrific comment. And I'm glad that we're thinking along these lines early. It seems like everybody on the committee is understanding what our charge is. So as staff finalizes the environmental scan, we'll of course share those results with you and we'll be inviting you to complement what we've already found. There's been some comments in the chat box relevant to measures that you may be using at your own institutions or that you've seen in dashboards, as was mentioned earlier. We invite all of those.

So, first, let's - we'll get out to you the list of measures that we've found, and then have you read after that. And you'll look for glaring omissions or maybe

even say, like, "Hey, this doesn't actually pertain like you think it does." So we may even (strike) measures from that. But we're looking to be as comprehensive as possible. We're also putting together this repository of concepts that NQF staff and this committee will review and prioritize for measure concepts at the end.

Woman 1: Thanks, Sam.

(Sarah): This is Sarah. Oh, I'm sorry, I can't raise my hand because I'm not online. Could you just - I'll have a comment, if you could just let me know when is a good time.

Woman 1: We'll do, we'll do. Thank you, Sarah. I think we have Dr. Gleason who has hand raised. If you would like to make a comment.

Jonathan Gleason: Yes, thank you. Yes, thank you. So for us, I can tell you, the clinic board, the Carillion Clinic board, and our executive team are focused on many things with this. We are part of the opioid crisis here in southwest Virginia.

But one of the aspects that we think is really important that we'd not want to lose sight of in this group is the opportunity to ensure that we have procedure-specific opioid-prescribing measures for all high-volume (unintelligible) perform procedures U.S., with the ultimate goal of having fewer patients next year with opioid use disorder than we had this past year, because we know many of those patients or those people are initially impacted through well-meaning but ill-informed (unintelligible) opioid prescribing.

So, to me that's a critical piece that we have to get right, is have a very robust, acceptable, doable measures for procedure-specific opioid prescribing.

Woman 1: Thank you, Dr. Gleason. I think we have Jettie Eddleman next who wanted to make a comment.

Jettie Eddleman: Yes, thank you. So, yes, I 100% agree about the different comments for prescribing and that I just want to say that there are the complexities that need to be looked at around prioritizing and making adaptations that would be specific to the rural, you know, (unintelligible) those providers and populations (unintelligible) that some of the very best practices that may have been most effective in urban setting need (unintelligible) and so that we can have better measurement. And I think that's something that we can add.

And then, I certainly can say that (unintelligible) provide an excellent resource for veterinarian medicine and that we also have a center for optimizing rural health (unintelligible) an excellent resource. So, thank you so much.

Woman 1: Thank you, Jettie. I think we have Dr. Schiff. And I also want to send a reminder that, if you're not speaking, please mute your line so we don't (unintelligible) any disturbances. Thank you so much. So, Dr. Schiff?

Jeff Schiff: Thanks. Hey, I just wanted to bring up two things real quickly. One is something that I think (unintelligible) a lot in the states in the Medicaid programs, is about what's the level of accountability for a measure? So, for example, as I'm (unintelligible) one of the things we're dealing with right now in our state, and I'm sure a lot of states, is how many jails offer buprenorphine either continuation or initiation, or any kind of medication-assisted treatment. So there's sort of that level of infrastructure measure I don't want to lose track of for the concept because I think some of those can really make a difference if we start thinking about who's accountable or what level, for those kind of things.

The other thing I just wanted, and I really supported Norris's comments about making sure we have a broad frame of the crisis as we think about those concepts, the other concept that I wanted to bring up to everybody, because it's similar to what Dr. Gleason said in southwest Virginia, we've really worked hard on identifying new chronic users as a concern, with the idea being that, if opioid prescribing is done at the acute event, better, we'll have less folks who progress to new chronic use.

Because we have, of the folks who start opioids in our population, we have about 5% who are still using opiates at 45 days. And we think that's a problem. So that's just a concept that I think is worth exploring and I'll make sure you guys get some material on those as well.

Sam Stolpe: Thanks very much.

Woman 1: Sarah, I think you're next.

Sam Stolpe: So, just a reminder, we have two Sarahs, so - yes.

Sarah Wakeman: Was that Sarah Wakeman?

Sarah Wattenberg: This is Sarah…

Sarah Wakeman: Oh.

Woman: Which Sarah?

Woman 1: I think when the name was inputted, it's just Sarah, Sarah. So, either one of you…

Sarah Wattenberg:Okay.

Woman 1: …can go ahead.

Sarah Watternberg: So, Wakeman, you can go first and then I'll follow you.

Sarah Wakeman: Okay. Sounds great. I just want to comment first, thanks for the comment just now about buprenorphine in the correctional system. I think that's an important one to mention.

And I was just going to mention that we've heard a lot from people who were commenting on sort of prescribing guidelines and metrics related to prescribing. And at the beginning, someone commented that, if we think about our charge, is really trying to reduce deaths, overdose deaths due to opioids. And that slide showing that really of prescribing - rate of decrease in prescribing - deaths due to prescription opioid has gone down. We're in the third wave of the crisis due to - that's related to illicitly manufactured fentanyl, and so I think we have to make sure that we're focusing on metrics related to treatment of opioid use disorder as really a crucial component, in particular, access to medications for opioid use disorder given the mortality benefit of those.

So, happy to share some thoughts we've had at our institution and work around that. But just want to make sure that is being talked about as much as if not more than the comments around prescribing.

Woman 1: Great, thank you so much. I think Sarah Wattenberg?

Sarah Wattenberg:Yes, hi. So we touched on it a little bit, but I really would like to see in terms of a concept get a little bit more of an intentional focus on polysubstance use.

I know it is hard because it kind of goes into other drugs and potentially other measures and sort of broad in scope. But it's rare that a person uses only one substance and we have high rates of alcohol and other substances found when people die. It's hard to recovery from one addiction without, you know, sort of addressing all of them. Alcohol is ever-present. Stimulant abuse is on the rise. In five years it's going to be something else. As Sarah Wakeman said, you know, we're getting a handle on some of the prescription opiods.

So I just think we also now have this, you know, escalating suicide rate and some new intel coming in around the overlap between mental health, suicide and opioid use. And I just think we would be missing an opportunity if we don't really kind of scope this out a little bit better.

Woman 1: Thank you so much, Sarah, for your comment. We have Anika Alvando who has a hand raised as well. Anika? If you could maybe shoot your question in the chat, if you're having some trouble with the audio, we'll get to you. We have Navdeep Kang with his hand raised.

Navdeep Kang: Yes, thank you. This is Nav Kang. Sarah Wattenberg, I understand what you're talking about when it comes to the broader scope. I think it would just be challenging given the time involved to actually get to everything else. Your point is well taken. I mean, the occurrence of polysubstance use and the lack of, you know, for lack of a better term, you know, clean opioid use disorder only is, you know, is certainly a challenge.

But I wanted to echo what Sarah Wakeman was saying around the need to focus on treatment. Our health system does a lot when it comes prescribing practices and trending the opioid burden, as we call it, down, whether it's for folks who are chronically prescribed opioids or, you know, the use of opioid sparing techniques and opioid-naïve patients, etcetera. But we can't forget

that there's millions of people who had opioid use disorder and part of the - I think the term was clunky before, title of our TEP is around opioid use disorder.

And so there is the quality discussion in formal addiction treatment settings and, you know, what are some of the measures or metrics in those spaces, but then also in hospital-based settings as well and the initiation of treatment. If you are an emergency room and you have the patient who presents with any type of opioid use disorder, any type of diagnosis falling underneath that category, then are you using the clinical withdrawal scale? And if the score is above a certain level, are you using buprenorphine products, and (does that dose match his scoring)? I mean, there's a whole linear set of thinking that is out there nationally. However, the adoption rates are less than stellar. And could this be an opportunity to impact the places where patients are most and those who are at greatest risk of mortality? In addition to doing the important prevention-based work, so we don't have more people entering into the (unintelligible).

Michael Abrams: Yes. This is Michael at NQF. That's a really good comment. And if you recall, the slide that we showed that showed various pathways that we might effect, you know, talked about sort of the continuum from primary prevention to, you know, tertiary prevention, or, you know, direct treatment across all (ASAM) levels, to use one system of care, and - or incentive outpatient treatment, if not inpatient treatment and so forth. So that's a good, indeed, a good potential concept for us to consider and one that certainly would influence the engineering of a measure that might be specific to a certain venue or level of care.

Navdeep Kang: Sure. Thank you.

Woman 1: Thank you. We have Anika's message in the chat. She just wanted to second Sarah Wakeman's comment regarding treatment of opioid disorder, and hopes that it will be considered when looking at the initiation of treatment in (BET), inpatient and ambulatory settings. Thank you, Anika.

Now we have Bonnie Zickgraf.

Bonnie Zickgraf: Yes. Thank you very much. This is along the lines of the concept that we're discussing and perhaps research that NQF is already pursuing -- on behalf of the panel, I appreciate that -- with regard to of course the percentage of deaths, I know that's all over your Web site, 47,000 deaths in 2017, combined with the illicit use as well as prescribed use.

So I think when we look at measures, we almost have to look at different activities and interventions based on where the most impact can occur. But also, I haven't heard - well, I heard a little bit about informed decisions, but also informed decisions including all the way through discontinuation of these drugs, and then also some kind of discussion with regard to treatment and (unintelligible) care.

So I think we need to at least put that in the concept bucket, if you will, especially the alternative care during discontinuation. So, those are the only comments I want to make. Thank you.

Woman 1: Thank you, Bonnie. I think we had a comment in the chat from Antje Barreveld. Do you want to speak to your comment, Antje? That would be great.

Antje Barreveld: Sure. I just wanted to highlight that there's many barriers to really measuring substance use disorder care and opioid disorder treatment because essentially

we have a barrier with Suboxone waiver requirements, we have barriers around education, lack of funding for team-based care. So I think I'm really struggling in knowing what the measurements are. I think it's much easier to talk about quality measurements for chronic opioid management for substance use disorder, there's so many barriers.

So I just want to put that out there, that if we continue to have a waiver requirement for Suboxone prescribing, I don't really see how we can best measure how we are treating patients with lifesaving medication.

Michael Abrams: So, Antje, this is Michael here at NQF. You mentioned the Suboxone waiver, I think I - I think I get that. That has to do with physicians having a limit to the number of people they can treat. Is that what you're referring to?

Antje Barreveld: Also being required to complete training. So, for instance, a physician needs to do eight hours of the course, for some people costs money, there aren't free courses, so it is a significant amount of education. I think the education is worthwhile, but we know that getting your Suboxone waiver does not mean that you actually use the medication to treat opioid use disorder. You're not necessarily even screening your patients for opioid use disorder.

So, just getting a waiver is not necessarily a quality measure of how many (way) the prescribers the institution has for instance, but it just highlights the barrier that exists in getting this lifesaving medication out there because there just aren't enough prescribers and there's very little reimbursement for team-based care.

Michael Abrams: Okay. And that was the other thing you mentioned, for team-based care, you're saying that reimbursement wasn't necessarily available, that was the

other example of a barrier that you used, did I get that right? Team, T-E-A-M, right?

Antje Barreveld: Correct. Having peer support, recovery support, you know, psychiatric care, psychological support. So I - obviously taking care of patients with substance use disorder is very time-consuming and very resource- heavy, so, it's very easy to sort of just prescribe a medication, but that's not necessarily going to be only solution to helping manage someone's opioid use disorder.

So I would say that, in summary, I think it's - our greatest challenge as a group is to really look at what those measurements of quality opioid use disorder care are in light of so many barriers to actually accessing and providing care.

Sam Stolpe: Thanks very much, Antje. Antje, am I - are we saying your name right? Let me just make sure that we're doing that.

Antje Barreveld: Yes, you are. It's Dutch. Antje. And some people say Antje.

Sam Stolpe: Okay. Thank you so much. And our apologies. Thanks for that.

So we're going to need to curtail the conversation very soon. So let's - we'll recognize one or two more people, and then we're going to wrap up discussions.

Woman 1: I think Norris Turner.

Norris Turner: Yes. No, I was just going to say, as a theme I kind of picked up on a number of the comments is, you know, the whole thing of things that are going to be outside of our scope but they're going to play heavy in terms of the impact of the work we do ultimately in terms of the ability for the measures that we

ultimately settle on, actually having the impact we intend them to. And I think, you know, maybe there's the opportunity, as a part of the body of our work, to call out those areas very deliberately like what Darshak talked about with respect to the challenge with the speed of getting things out there in (unintelligible) as needed there when policy barriers or data infrastructure barriers. And I think for, at least, for us to call those out where they run interference in the ability for the measures we recommend to actually have the impact, you know, we want them to, so.

Sam Stolpe: Thanks for that comment, Norris. I think you're spot-on, that we - part of our consideration for the measure concepts that we'd like to make, I think we've also discovered in the course of this conversation, there's things that are going to be really hard for us to capture that might be extremely desirable. So we will want to identify those (areas) as well. I think that'll naturally emerge in the course of discussion.

Norris Turner: Great.

Sam Stolpe: …had her hand raised? Katie, go ahead with your comment.

Katie Jordan: Hi. So, in addition to the American Medical Association relative value update committee (unintelligible) I also sit on part of the CPT editorial board, and I just wanted to follow up with a comment about reimbursement for team-based care. Just like translation between research and practice, I think there's definitely a lag in the CPT editorial process and the relative value update committee process in providing mechanisms for providers to describe and code their services and get reimbursed for the work that they're doing. And I think that does create a huge barrier when we're trying to keep up with evidence-based practice, and especially in situations like this where there's such urgency around addressing this crisis.

So I just want to acknowledge that that is a barrier. And since CMS is involved in this TEP and on this call, maybe that's something where they could also be a part of the solution.

Sam Stolpe: Very good, thank you.

Michael Abrams: Sure. So this is Michael here. So maybe we - there has been some discussion about patient reported outcome, as we refer to them here in NQF, that is, you know, direct information from the patient perspective. So that leads me to perhaps, as closing comments for today, if perhaps one of our - somebody might like to comment, in particular a patient representative might like to comment about the discourse thus far and to fill in some ideas related again to measures we should be thinking about, measure concepts, or future directions and gaps and how you think we're doing with regard to our environmental scan.

So, maybe, perhaps Gary Mendell would like to comment, or Laura Porter, or anybody else who might feel compelled to offer some information from the patient perspective, to close us out today.

Gary Mendell: This is Gary Mendell, I'll jump in for a second.

Michael Abrams: Thank you, Gary.

Gary Mendell: Yes. We've received a lot of comments, you know, over 300 comments on our measures, and many of those were patient groups. And we're going to be testing the AHRQ (CAHPS) measures, see how well they work. And once we get that in, you know, we'll learn a lot over the next couple of months and I'll

be able to inform the group as we test them and we could test the feasibility of them.

One of the issues we're going to have with testing patient measures is, do we get enough of a sample where they're valid and reliable? And that's just something we don't know yet.

But another thing we're looking at related to patient measures is there's been some work out of the UPenn related to correlating patient experience in a Yelp like method, compared to how well they rate, how well they correlate with the validated measures by AHRQ. And that's something that we're going to look at also as our pilot develops.

Michael Abrams: Thank you for that. That's great.

Sam Stolpe: Okay, with that, we'll go ahead and wrap up our committee discussion for this particular session. We have one more item of business, which Vaish will be leading. I'll hand it over to my colleague Vaish to walk us through our SharePoint overview.

Vaish Kosuri: Hi everyone, this is Vaish, project analyst on the team. I just wanted to go over a little bit about the SharePoint Web site. This is for TEP members only and documents for the public will be posted on our public Web page. So, throughout, you know, the life of this project, the NQF team will be sharing documents with the committee through the HR point site. All committee members should have received a document about two days ago regarding their credentials for access. If you have any questions regarding this Web site or having trouble, please email us at opioid@qualityforum.org. We will also have a slot at the end of this PowerPoint which has our contact information.

We encourage you to try the Web site when you get a chance. You'll notice that today's meeting materials have been posted. There's a calendar available, which is updated to reflect all our Web meetings and the time for that project. Additional reference materials such as the scan as well as reports will be posted as we (unintelligible) deadlines.

So you can see, as you can see, there's the screenshot of our homepage for the TEP. Right now this is an early version of our TEP page, but currently we have our Web materials posted. On the left, on the left-hand side of the screenshot you can see the committee calendar, which will provide the dates of our Web meetings. And so this is sort of what it looks like. If you guys have any questions, once again, opioid@qualityforum.org.

And finally, one thing about SharePoint is that it's sort of like (unintelligible) documents, so if you see any plus signs, that means that there's a document available. So please note to click on the plus sign, and you'll be able to view some of the documents we've posted. And in that way you can access the materials needed. And now, I think we'll be opening for public comments.

Woman 1: So if you want to make a public comment, please either raise your hand or you can put something in our chat box and we'll call upon you in that fashion. In the meantime, do we want to go to the next steps (unintelligible) lined up?

Vaish Kosuri: As you can see on the PowerPoint right now, our next Web meeting is May 13, 2019. This timeline shows you our, you know, broad range of dates, including Web meetings, our environmental scan, as well as comment periods during which the public can provide comments on some of the reports that we are providing. And so this is a reference for you guys to look at, if you have any questions regarding the date.

Woman 1: Okay. And we're not seeing any comments or raised hands. Was there anyone that's not on the Web platform that would like to make a public comment? Okay. Okay.

Sam Stolpe: All right. So, just - this is Sam Stolpe speaking - on behalf of the NQF staff, I just wanted to say a word of thanks to each of you for your time and expertise, for the lively discussion that we've had today, for cutting some time out of your day specifically to review this with us. We are really excited to be working with each of you, and you're more appreciated than you probably realize. Michael, did you have any parting words?

Michael Abrams: No, no. Just to thank. This is somewhat of an intense timeline, we're aware. So please let us know if you have trouble communicating with us or accessing materials on the Web site, or if there are any issues about attending these meetings. But it's very important for you to be engaged with these meetings and to respond to the materials that we're dutifully preparing for you.

So, thank you very much. As Sam said, we're really excited. This is a really important, high-profile activity. So we're very pleased that all of you are shepherding us through this important activity.

Sam Stolpe: All right, very good. Thanks, Michael. We'll be following up via email, of course, and looking forward to continuing the discussion in early May. So, thanks everybody. We'll talk again soon.

Woman: Thank you.

Woman: Thank you.

Man: Thank you.

Man: Thank you.

Woman: Thank you.

Woman: Thank you.

END