Opioid Technical Expert Panel Web Meeting 2

Moderator: Kim Patterson
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12:00 pm ET

Poonam Bal: Hi, everyone. This is Poonam Bal from NQF. Thank you for joining the second webinar for the opioid technical expert panel. We thank you for your time. If we can just go to agenda slide please. So today our goal, we will talk about our environmental scan and the findings we've had so far. We'll go through the purpose, methodology and some of the emerging results from that search, and we'll obviously give an opportunity for our public members to comment and then we'll talk about next steps going on from here. With that, I'll ask Vaish to do roll call.

Vaishnavi Kosuri: Hi, everyone. This is Vaish from NQF. I'll get started on roll call, so Jeff Schiff?

Jeff Schiff: Here.

Vaishnavi Kosuri: Brandon Marshall?

Jeff Schiff: He's coming shortly, he just said so …

Vaishnavi Kosuri: Okay, great. Anika Alvanzo?

Anika Alvanzo: Here.

Vaishnavi Kosuri: Michael Ashburn? Antje Barreveld?

Antje Barreveld: Here.

Vaishnavi Kosuri: Patty Black?

Patty Black: Here.

Vaishnavi Kosuri: Jeannine Brant?

Jeannine Brant: I'm here.

Vaishnavi Kosuri: Caroline Carney?

Caroline Carney: Here.

Vaishnavi Kosuri: Anthony Chiodo?

Anthony Chiodo: Here.

Vaishnavi Kosuri: Jettie Eddleman?

Jettie Eddleman: Here.

Vaishnavi Kosuri: Maria Foy?

Maria Foy: Here.

Vaishnavi Kosuri: Jonathan Gleason? Anita Gupta?

Man: By the way, before (unintelligible), I just don't know where my view button is.

Vaishnavi Kosuri: No worries if you can just keep the mute or if you can keep the sound down, that will be great. Mark Hurst? Katie Jordan?

Katie Jordan: Here.

Vaishnavi Kosuri: Navdeep Kang?

Navdeep Kang: Yes, I'm here. Thank you.

Vaishnavi Kosuri: Sarah Melton?

Sarah Melton: Here.

Vaishnavi Kosuri: Gary Mendell?

Gary Mendell: I'm here.

Vaishnavi Kosuri: Darlene Petersen?

Darlene Petersen: Here.

Vaishnavi Kosuri: Laura Porter?

Laura Porter: Here.

Vaishnavi Kosuri: James Rhodes?

James Rhodes: Here.

Vaishnavi Kosuri: Darshak Sanghavi? Evan Schwarz?

Evan Schwarz: Here.

Vaishnavi Kosuri: Norris Turner?

Norris Turner: Right here.

Vaishnavi Kosuri: Sarah Wakeman?

Sarah Wakeman: Here.

Vaishnavi Kosuri: Sarah Wattenberg?

Sarah Wattenberg:Here.

Vaishnavi Kosuri: Arthur Robin Williams? And Bonnie Zickgraf?

Bonnie Zickgraf: Good afternoon, I'm here. Thank you.

Vaishnavi Kosuri: Great, thank you.

Brandon Marshall: And this is Brandon Marshall, I'm here as well.

Vaishnavi Kosuri: Great. Is there anyone else who joined the call while we were doing roll call? Great, thank you. I'll give it back to Poonam.

Poonam Bal: Thank you everyone for joining today. So we also want to just acknowledge very quickly our federal liaisons. We didn't touch upon this as much during our first webinar so we just - our federal liaisons, they will have two major roles.

One will be to communicate the work of the technical expert panel back to their agencies, but also to be a resource to our technical expert panel as needed to answer any questions about what agencies might be doing. We want to thank them for their time and their interest in our work, and we're looking forward to working on this together.

Next slide please, all right, just so just a reminder of kind of the major aims of this work, first, our goal is to get the environmental scan done. This includes our literature review, measure search, key informant interviews and state laws. We will be providing that detail to you today about what we've done so far and what we found.

Also once that's done and we have the basis, we will be using that environmental scan to identify current and potential measures and measure concepts. And once we have those finalized we'll make recommendations on inclusion and identified quality measures - I'm sorry, inclusion of those into several federal quality programs. So that's really the main goal.

We're going to jump into the environmental scan, but before we do that, just a reminder, just best use of this webinar services, please keep yourself on mute if you are not speaking. It just helps with keeping background noise off. If you have your cell phone near the computer, sometimes - or your phone, it does cause sound in the background so if you can try to keep your cell phone away from the computer that would be helpful as well.

And in order to speak up, we do ask that you try to raise - use the hand-raising feature as a technical expert panel. If you would like to make a comment on something that we've done or ask questions, raising hand is the best way to make sure that we're getting to everyone and everyone is given the chance to speak up.

If you just want to agree with people or have a general comment, but don't feel like it needs to verbally said or you're just not able to make a verbal comment, you can also send a chat to staff so we can make sure we acknowledge that as well. And I think that's core event, were there any questions before we go on to the actual meeting here?

Okay, not hearing anything, I'm going to go ahead and ask if our co-chairs want to make any remarks before we get started, Jeff and Brandon?

Jeff Schiff: This is Jeff. I just want to welcome everyone and say thanks for the - for joining. I think Brandon and I have a little discussion this morning and really are thrilled with the quality and the expertise that's on this group, and we're anxious to go ahead and continue to work. I think when we get to our first discussions, I will stop and just add - just have a quick discussion about how we engage on the phone most effectively. But again welcome.

Poonam Bal: Thank you. Brandon, do you want to add anything?

Brandon Marshall: No, just thank you, thank you, Jeff, for summarizing our conversation. I'm looking forward to participating in this activity.

Poonam Bal: Great, thank you. So with that, I'll give it to Michael to go over the environmental scan.

Michael Abrams: Thanks, Poonam. So welcome everybody. This is Michael Abrams here at NQF and what I'm going to try to do over the next few slides is to set up discussion about the organization of the environmental scan that we're doing for you all and the results that we're seeing so far and sort of the overarching themes. And then I'm going to hand it to my colleague, Sam Stolpe, to give you some specifics about some of the findings that we see.

But the idea of these next few slides will be to principally address the three questions that you now see up on your screen, the first one being looking for measures that currently exist that address the treatment of pain or the treatment of the opioid use disorders.

The second major question that we're trying to address with the scan are measure concepts, there we go, measure concepts that is nascent measures that exit or ideas - important ideas that exist surrounding the development of such measures that's referred to on the first bullet.

And then, finally, to look for information such that exist in the literature, and from stakeholders, and key informants that suggest where there are holes with regard to the first two bullets, especially the first one, holes in terms of measurements or gaps that need to be filled to address the particular problem that we have convened to consider.

Next slide please, so just to remind you, we did show you this on our last meeting, but just to remind you sort of the general and straightforward types of searches that we've done either on the literature or with the databases that I'm going to tell you about in a moment to look for metrics, measures, indicators, surveys, quality and performance indicators, those kinds of words were searched in the peer review literature and then the gray literature.

And then in that literature as well as in measure sets, we looked for terms like pain, substance use disorder, opioid, exploded to include things like opioids and its derivatives, addiction and addictive, and that sort of terminology as well was searched for. So hopefully this is fairly straightforward search that we've done in order to be fairly comprehensive in isolating both literature and existing measures that we think are germane to the activity.

And part of what we're going to be doing today with you is asking you if you think we're on the right track and looking for the sorts of things, and finding the right sorts of things.

Next - oh, one other point on this slide which I'll make is that you'll notice that somewhat - I'll remind you again somewhat arbitrarily the stock for our searches especially with regard to the literature was 2013. This coincides with when the fentanyl rise - the exponential rise in fentanyl overdose death is apparent in the CDC data. That’s why we picked it, but we also picked it so that we would be able to ascertain a contemporary yet limited set of information that we'll go through.

Having said that, we did not limit our measurement searches to that date. We looked back for any measures endorsed or otherwise that we could find in the databases, so that same time constraint was not applied to measures, was instead applied to the peer review literature and the gray literature that we have isolated.

Next slide please, so just a brief and very high level overview of what we found with regard to literature review that is both gray and peer review literature using PubMed engine principally. We found over 700 sources that

met that search - that straightforward search criteria and I showed you just a couple of slides earlier.

Then we took a careful look at titles and abstracts, and narrowed it down to roughly 200, a little more than 200 sources which staff is now going through and categorizing, and in particular trying to answer such as we can from those pieces of written material, gray-sourced or peer-reviewed, trying to isolate those information that pertains to those three questions that I introduced this section of the presentation about.

So next slide please, now the other area that we searched were databases that contain specific measures which are germane to the problem at hand, again keeping in mind that both pain management and substance use disorder treatment is so far fair game we believe in terms of isolating things for you.

And what we found is summarized very briefly here on this slide, so using the NQF database, the top row of the slide there which has more than 2,000 entries in it, using the very constrained search parameters that I showed you previously, we found 51 entries that could be relevant and 29 were endorsed - formerly endorsed measures by NQF.

Then on Line 2 what I'm summarizing for you here is search - a broader search that was done on the CMS Measurement Inventory tool, and for that one we really did an extremely broad search looking for any words using a very little search strategy. So we essentially almost found all of the 2,400 or so measures that exist in that database. 2,300 had some words that were relevant.

That was somewhat strategic on our part. We understand our database - the NQF database a little bit better so we did a more targeted search there. With

regards to the CMS CMIT database, we wanted a much fuller treatment for us to then subsequently review somewhat line by line which we did do.

But prior to doing that, for step number 3 represented on this slide, we took the union of the two and you see that we found something on the order of 2,300 measures with some repeats in there.

So you can see there's a line drawn there and we did actually manual line by line, at least two of us reviewed specific titles and considered specific measures one by one, and reduced it greatly to about 136 measures, 35 of which are somewhat ancillary we think. But we're going to show you those as well to see what you think about that.

To give you just a fuller context of how we think we have summarized for you here the universe of measures that exist, I'll refer you to the very bottom of that slide. In addition to the looking into the two databases described, the CMS tool and the NQF tool, we also looked at PQA's measurement tool. We looked at - we looked at NCQA's measurement tool.

We did several relevant registry searches and we also followed up at Web sites for developers that came up in our manual review as well and found - and we did not find any additional apparent existing measures that we would add to that list. But we want you to be aware that we looked in those areas.

Another way to appreciate sort of the context here, the NQF database is something on the order of 2,500 measures, about a thousand of which are actually endorsed so that gives you some idea of what the number 51 means at the top of that slide. It's a very small subset of the NQF-endorsed universe.

And the CMS total as I said, actually the slide has a redundancy here, the CMS CMIT tool that's referred to has something on the order of 2,400 - or 2,500 current measures. So it gives you some idea of what we're talking about again when we have isolated something on the order of 100 to 230 - or 140 measures for you to consider.

Next slide please, just a reminder here about the context of the problem, this is a - this slide I didn't show you last time, but I referred to numbers like this. So this is really background information and as I indicated, likely a reminder to you all that the problem that we're talking about might be considered as follows; there are roughly 300 million Americans, about a third, almost a third of them use opioid pain reliever at some point in a given year. This is actually 2016 data that I'm summarizing here, courtesy of Soloner and colleagues from 2018 who brought us data together.

Of those 92 million, roughly 10% of them or 11 million individuals misused opioid pain relievers in some way, used them not as prescribed. And then that very small wedge is the 2 million or so people who have a formal or diagnosed opioid use disorder. The figure here then explodes it out to that 2.1 million contained in there is roughly 50,000 individuals who - in a given recent year die from an overdose that involved an opioid. It may not exclusively be an opioid, but involved an opioid.

Next slide please, and this next slide I did show you last time, just take that circle and rotate it 90 degrees counterclockwise and you see the 50,000 individuals. The reason we brought it here again for you is to remind you of the suggestion that we have about the organizational framework or organizational structure, not a formal framework that we're using to try to classify measures for you.

And principally, with regards to the medical enterprise, of course, it's the left-hand side prevention to recovery. The full spectrum of primary prevention on the public health spans to overall recovery in addressing an illness including (prodomal) and acute treatments. That's likely to be the focus of measurements - of quality measurements such as deployed by NQF and its stakeholders.

But harm reduction is relevant as well perhaps with regard to prescribing practices and potentially -- and again we will be discussing this today -- even things like interdiction or regulation of prescribing could be relevant and addressable vis-a-vis measurement as well. So we use this kind of simple scheme of organizational structure in order to then organize the measurements that we're isolating for you all to consider.

Next slide please.

Poonam Bal: And Michael, before you go on, we are hearing a lot of background noise. We're going to go and mute all the times until the discussion time. But, you know, best practice is always to mute yourself so we can make sure the speaker is able to be heard by all. Thank you. Go ahead.

Michael Abrams: Thank you, Poonam.

Poonam Bal: Sorry, one second.

Michael Abrams: Sure.

Poonam Bal: We're going to hear all lines …

Operator: The conference has been muted.

Poonam Bal: Go ahead, thank you.

Michael Abrams: Thank you. Thank you for that. All right, so the next three slides, I'm going to give you some talking points or list of information that pertains both to background and broad categories of solutions for you all to consider and to discuss.

And as I go through this, I'm not going to go through all of them, they are there, hopefully you had a scan of them prior to this meeting. But they're there as mnemonic for you all and as a listing of organizing principles both that characterize the cause, but more to our point potential solutions that might be measured or might be addressable vis-a-vis measurement, for you to consider these and to think about as I'm going through them and then in your discussion whether or not these points are seem complete or whether there are glaring errors of omission, things that are missing, or errors of a commission things that maybe are included but aren't really relevant to what we're doing.

So why don't you try to think about those as I briefly go through these next three slides to give us - through try to give us some background for discourse today.

So the first exhibit up here is a summary of the National Academy of Medicine's 2017 report that had a title "First Do No Harm," looking specifically at the opioid overdose epidemic vis-a-vis pain management prescribing and substance use treatment.

What I'm summarizing for you on the bullets on the left-hand panel, in the top of the right-hand panel are what this fairly straightforward and I think a clear report described about the epidemic in terms of just the total milieu of the

problem in the United States in particular and antecedents things that appear to be cogent and things that are relevant to addressing it in particular.

I'll jump to the second bullet and point out that they used the terminology - that this expert committee used the terminology of twin obligation of medicine to consider in addressing this problem, both the treatment of pain as well as the prevention and the treatment of substance use disorders. I don't think that's controversial among the committee. In fact, the composition of your committee has been structured as such so that they are experts in both avenues here.

Moving on to the next bullet there, this report like so many others, like for example the ongoing NSDUH reports that comes out of SAMHSA makes it very clear that treatment access for substance use disorders in particular is far too limited and this relates in fact to a later bullet where they refer to specifically financial resources for substance use treatment, that is that substance use treatment needs more support and the absence of that is part of what this NAM committee feels is important component of the problem.

Jumping to the middle bullet there, I wanted to point out that somewhat ironically per this report, right as this epidemic was heating up and well into it to substantive databases; the Drug Abuse Warning Network and the Arrestee Drug Abuse Monitoring System were actually eliminated surveillance efforts respectively. This speaks perhaps to the issue of having appropriate data in order to deploy measurements and surveillance efforts that might be germane to directly addressing this problem.

A couple more points about this (IOM) report, they bring up something that I think is evident to all of you, but I'll be specific about it. They talk about stigma in that report and even provide some data about surveying the U.S.

public, the majority of which still hold that substance use disorders are a moral failing rather than a biologic disorder. And so they - that is the (IOM) committee here, the National Academy of Medicine Committee points that out as a barrier to addressing a problem like that one we're faced.

And then, finally, I will go through the bullets on the right-hand side of this slide briefly, that this NAM study referred to as tools or specific areas where the clinicians involved in dealing with this sort of problem, and they referred broadly to not just physicians but the social workers, nurses and therapists who are involved in substance use treatment and pain management.

They offer these nine -- these are nine bullets there -- nine tools that they think are key avenues or strategies that should be deployed in order to address the epidemic that we're facing. And they involve some general things that are perhaps to conceptualize as measures but still might be useful to consider as such, team-based care being one and systematic follow-up being another bullet down there in the middle of this section.

They also - in this second bullet under the tools for 5 million clinicians arguably relates to dealing with stigma or misunderstandings about substance use disorder treatments in particular.

The report emphasizes or suggests that clinicians need to emphasize to their patients that there are efficacious treatments for substance use disorders such as medication-assisted treatment with buprenorphine and methadone, and that's an important message to convey as part of the therapeutic process, perhaps that is inspiring for certain measurements in terms of either patient-reported outcomes or specific checklists that clinicians might use when they are trying to engage somebody in substance use treatment.

There are important touch-tones as well under the tool set that relate to things that relate to diversion, in particular safe storage and disposal of medications. Again, that's something that might be related to developing a measure that involves proper counseling when pain management is initiated for example. And there are general questions about prescribing and when to deploy opioids over alternative treatments that are described in this report as well.

And then the final bullet there I'll point out is that consumer and public engagement is noted as an important component of addressing this epidemic and that means not again just individuals who suffer from pain or suffer from substance use disorder, but also the public more broadly and family members and other stakeholders as well and engaging them, and that being part of the responsibility of the clinical enterprise here, the suggestion of this (IOM) report.

Now, onto the next slide, I'm shifting here to a public health approach which has a lot of overlap, no surprise, with the slide that I just showed you, although this particular report which is in Public Health Reports in 2018 identifies specifically indicators that should be tracked in addressing the opioid epidemic.

Are the slides okay? I'm not sure if they're seeing this, okay.

Poonam Bal: They're okay, go ahead.

Michael Abrams: Okay, we're getting some power here in case you're seeing a funny message on your screen. We'll bring the slide back up.

So in this case, the indicators explicitly suggested in this public health framework involved the top 4 bullets being very straightforward assessment of

overdose rates, non-fatal as well as fatal opioid use disorder rates by the type of opioid that's used. I'll talk more about that in a moment because this particular framework suggests specific substance matters.

But also these suggestions made here that tracking opioid medication use appropriate and otherwise is an important indicator. I don't think any of that is controversial, but it was explicitly noted as obvious touch-tone for surveillance.

And then the middle bullet there is about using laboratory data to differentiate what kind of substances that we're seeing, opioids being a variety of different substances, spanning from morphine to fentanyl. And of course, I think you're all aware that fentanyl and synthetic opioids in particular have become a special part of this overdose epidemic that we've seen recently.

The harm reduction piece is more of a public health framework, I just want to remind you about that, and this principally involves things like Narcan, or perhaps in terms of the medical measurement enterprise would involve things like having structures in place to co-prescribe Narcan injectors along with an opioid prescription for people at risk for taking too much medicine.

And then the next two bullets there also are somewhat novel to the public health framework. The criminal justice involvement piece being relevant and thinking about whether they are appropriate treatments in our criminal justice facilities where there is a high correlation with the opioid abuse.

But also thinking about just tracking criminal justice involvement and what type of criminal justice events occur as an outcome measure, if you will, that might be of relevance to this effort. That falls a little bit outside of traditional

medical sphere, but certainly falls within the realm of a public health approach to this problem.

And then, peripherally, as a reminder to us about comorbidities, this particular framework specifically noted tracking HIV and hepatitis C infections as being a critical component of tracking this overdose epidemic and that, of course, relates to harm reduction approaches. And then, finally, no surprise here the last bullet suggests that access to drug treatment is critical - a critical part of addressing this.

So then, finally, on the next slide, I just want to remind us all of specific points that came up in discourse with you all in our first meeting and I'm not going to go over all of these, but just hit some touch-tones and then I think we'll pause for feedback from you all.

One that I will refer to this and after you scan the list to remind you of what was discussed last time, point number 1 had to do with the speed at which a measurement development occurred, that as was suggested last time is a little bit outside of the purview of this committee, although presumably whatever this committee recommends will at least further efforts to make things happen more quickly.

But, potentially, that could be measured measure concept especially responding to an epidemic like this which sort of took the public health infrastructure in this country somewhat by surprise, so perhaps there's something about measurement that might make things more nimble for the next epidemic, whatever it is, whether it's methamphetamine, or whatever additional substance might lead to these kinds challenges.

Jumping to a couple other points on this slide, if you jump to item number 4, the suggestion was made that patient decision-making capacity is unique for this particular problem because of the behavioral - presumably because of the behavioral problems that accompany a serious substance use disorder, so that is arguably a measurement concept that relates perhaps to the way surveillance is structured, patient reported outcomes are structure, and treatment and family involvement checklists are structured as well.

And skipping now down to item number 8, the suggestion was made that this committee think about procedure-specific opioid prescribing which we take into mean differentiating perhaps the guidelines and the measured strategies that would be used for things like acute post-surgery pain treatment versus a chronic pain for diseases like rheumatoid arthritis or other ailments that may or may not be appropriate for opioid prescribing.

And then I think I will point out just a couple other lines on this slide, jumping to the end of the slide, point 15 refers to recovery issues in particular might more broadly be conceptualized as lifespan issues in terms of treatment, not just prevention. But there is ASAM levels of care, and then helping people in recovery and in remission maintain good health.

And then, finally and arguably related to that, it was brought up I believe in particular by Gary Mendell that there are patient resources being developed that offer individuals information they can tap to help them cope with their substance use disorder in particular, but also feedback to the treatment system as well. And of these approaches even are deploying social media portals as well as more formal and secure portals as well for that.

So I'm going to pause there and hand it to the chairs to lead the discussion with the general question and broad question, you know, do you think that the

points that we've isolated here from the NAM framework, from the public health framework, and from your discourse early on identify concepts appropriately, or are there any things that we certainly should remove? Are they missing any particular things?

And as well this discourse could consider which of these particular sorts of concepts should be emphasized in our environmental scan in particular, but, of course, I'm moving forward over the next five and a half meetings that we're having together in order to create a working document and report to help move the field of measurement regarded to opioids and opioid use disorder forward then to the future. So with that, I'll hand it to the chairs to lead that discussion.

Vaishnavi Kosuri: And before that, we'll unmute all the lines. So once again, if you're not speaking, please keep your line on mute. Thank you, everyone.

Operator: The conference has been unmuted.

Poonam Bal: And also, Jeff and Brandon, at this time, we did have two comments come in on the chat as Michael was going through it. One comment was a recommendation to change the language that was being used, instead of saying detox to say medically-supervised withdrawal.

And then the other comment was about are there - you know, is there any work right now being done to track suicide resulting with not getting help with pain and pain medication. And we also had a suggestion to change the term from - I'm sorry, misuse versus abuse.

Jeff Schiff: Great. I - if it's okay, I just want to get this squared away, just maybe with a few quick ground rules that we talked about to make this as effective as possible.

There's a hand raise function that NQF folks are keeping track of, so if you want to talk, we're going to try to put people in order as far as that's concerned. There's also the chat which if you want to - I guess if you want to concur with someone else or take a topic that doesn't need to be on the line at the moment, you're welcome to use that function as well.

It's a little hard for us to get to know all 25 or so of us via phone, so hoping that when you start your comments you'll just say your name and affiliations, so maybe over time we can - we can know where you are. We'll ask people to be concise and is possible keep your comments under a couple minutes so that we can - so that we can make sure everybody gets heard and stay on topic. And if there's another topic, please let us know via chat as well.

And then the other thing I guess that we talked about is we want to hear from everybody if possible and that means that we have to - that the folks who are less likely to jump in, we want to make sure that they get their thoughts going.

I think to reiterate what Michael just said, I think our goal right now is to talk about some of the organizing principles for the environmental scan and make sure that we have all the organizing principles in place. And I think that they have nicely talked about the feedback we got. I think that I'm going to actually look at the next slide for a sec if I can - I'm not sure if we can move it up to that.

But this is one of the ways of looking at the organizing principles that I think underlies a lot of what Michael said and those - that's prevention treatment,

harm reduction and interdiction. So I think what we'd like to do now is make sure we have some conversation around this, whether what has been presented, what support, or what is missing from the current list. I think we have Jeannine Brant as our first hand.

Jeannine Brant: Hi, thank you so much for that nice overview. I think there were a lot of comments, you know, within the scan that are important. I think about the public health indicators. One of the things that I felt was maybe missing and we brushed on this in the last meeting is the patient-centered outcomes and specifically inpatient-reported outcomes.

Oftentimes, you know, looking of course the pain function, those individual adverse effects and I even think about through the recovery process. We're also seeing patients, of course, with chronic pain, with cancer pain who are misusing opioids and yet balanced with good pain management and that was touched on briefly, but just to make sure we include some of those patient-reported outcomes or assessments into the indicators as well.

Jeff Schiff: Thanks. All ready?

Woman: Sure.

Jeff Schiff: Bonnie, I think you were the next hand and if you could - I think we can …

Bonnie Zickgraf: All right, well, thank you, I appreciate that and I do appreciate the discussion up to this point.

With regard to the measure, I think it was a couple slides ago that talked about consumer engagements and I would be curious to find out what we're actually measuring at that time when scripts are written for pain management and

opioids, what types of patient engagement are we actually measuring at this point with regard to very early engagement, what kinds of education and that sort of thing, and any kind of requirements that might be around that, because I think that's where it needs to begin, at the time the script was written, at the time the treatment begins.

Of course, that's when we need to talk about discharge planning and educating the consumer itself. So I did not know the context of the specific measure and eventually that of course would be revealed. But that was the only comment that I wanted to make. Thank you.

Jeff Schiff: Great. So I apologize if I'm not getting people in the right order, but I have - I think after Bonnie, I have Arthur.

Arthur Robin Williams: Hi, this is Arthur Robin Williams in Columbia and I'm an addiction psychiatrist.

I'm looking at the current slide, the scan organizational overview, prevention, treatment, harm reduction, interdiction and I think for this kind of high level scheme, one thing that’s missing and I think this a recurring theme in a lot of the media, the clinical respondents and among experts as well is psychiatric comorbidity.

And I think somewhere between prevention and treatment, there should be a bullet related to screening, you know, tuck in treating, stabilizing anxiety, depression, trauma-related disorders because those are extremely prevalent comorbidities. And when people who do go on to develop SCDs and OUD, it's a huge risk factor for escalating, you know, problems with substance use.

Jeff Schiff: Thanks. I think this whole issue of (co-occurring) and mental health is really important, I agree. All right, I'm going to keep going here, Caroline Carney.

Caroline Carney: Hi, it's Caroline Carney with Magellan Health. I would like to add that I think we're missing looking at more of a physical comorbidity and I'm not sure where that would fall necessarily, I think between treatment and harm reduction.

There are already reports of increasing rates of hepatitis C in the population using heroin. HIV AIDS will follow that certainly like it typically does, let alone any of the kinds of medical conditions, including infection from needles so skin infections as those are the sorts of things outside of the pathogens. So I think we may want to build under perhaps treatment, that screening for the physical (deploy) might be added.

Jeff Schiff: Great. Is it Anika who's next?

Anika Alvanzo: Anika.

Jeff Schiff: I'm sorry.

Anika Alvanzo: So one of the things I didn't see was any reference to the PDMP and using the PDMP as a tool. I think somebody already mentioned that expansion of screening both for psychiatric and other medical comorbidities. And then I'd like to see a little bit more about when we addressing treatment, kind of the quality of the treatment that patients are receiving because there's a wide variation in quality with respect to different treatment programs.

Jeff Schiff: Thank you. Norris?

Norris Turner: Yes, Norris Turner from Pharmacy Quality Alliance. This comment I'm going to make in relation to the bullet on substance use treatment through recovery and it does relates to something I heard Senator Sheldon Whitehouse made the comment on (unintelligible) a couple months ago when he was asked, "What's his number one (unintelligible)," (unintelligible) commented on keeping people in recovery, knowing that this is a relapsing condition

You know, we want to make sure we're monitoring quality of people to remain in recovery because knowing that people relapse. So that was my comment.

Poonam Bal: I see a couple of comments …

Jeff Schiff: I think that's the hands raised. I wanted to add - I wanted to just add that SreyRam added something in the environmental scan which I think gets us looking at this from maybe a different sort of lens that I wanted to see if people have any comments on, and that was looking at strategies used by states around prescribing and overdose (stats), so maybe looking at I would say the - what I sometimes think of it as the level - the place of accountability. Is that at a state level? Is that at a provider level? Is that a public health level? So I think that was a point that was made

And then Evan Schwarz, I don't know if you want to say your comment yourself, Evan.

Evan Schwarz: I mean, I can - I would like to jump in about something else, but just kind of reiterate about kind of oncology care and everything as we're looking at these patients.

I think there's an editorial I want to say in the New England Journal of Medicine a couple of months ago from an oncologist who successfully treated her patient's cancer and the patient eventually ended up dying from a heroin overdose from the OUD that was created a part of, you know, the treatment that they're trying to do from that. And it kind of also ties into to kind of what that speaker was saying on the TED Talk that got sent out.

But guess to your last point about what states are doing, I think there has to be a little caution with that. I know in Missouri where the state instituted a bunch of policies and I don't know how well some of them were thought out. I mean, they definitely helped to try to prevent exposure. But I think a lot of chronic pain patients were also suffering through a lot of unintended consequences so I think you just have to be a little careful with some of those measures.

Jeff Schiff: Great. Okay, any other - I don't have any - oops, I do have more hands raised, sorry. I think it's Darlene Petersen. And if you could - I'm just going to remind people to say where they're from. I've been calling out names, but if you could just say where you're from, that would be helpful.

Darlene Petersen: So this is Darlene Petersen, I'm from - so I'm Addiction Medicine and Family Medicine. And as far as state-specific issues, I'm from the State of Utah and we just actually passed here in Utah recent legislation that requires when there has been an overdose death regarding opioids or opioid with benzodiazepines, and this was warm reception by physicians, but it requires a natural mandatory chart review.

So the DOPL, so the licensing agency for physicians requires that they will either by telephone or an in-person visit, the physician then has to at least

pause and have a review of the death whenever that occurs and then opioid has been identified. So that's something that's new, that's been enacted now.

Brandon Marshall: Hi, everyone. This is Brandon. I just wanted to probe if there were any other questions regarding what's in front of us with this organizational overview in terms of this framework.

To sum up, I heard that there were comments around incorporation of behavioral and physical comorbidities into the slide, and then maybe also identifying where recovery can best fit. Are there any other comments or questions on this current deck?

Poonam Bal: Hi, Brandon. I'm not sure if you can see this, Evan's hand is raised. I don't know if the last drawn from earlier though.

Brandon Marshall: I'm not able to see the hand raise feature, but I'll let Jeff pitch in on that.

Jeff Schiff: It got lowered. But I have Sarah, I'm not sure which Sarah it is.

Sarah Wakeman: Yes, this is Sarah Wakeman, I'm at MGH. Just sort of about the comment on the interdiction side, but I think we want to be pretty thoughtful about that and there's been a fair amount of people who are - I've heard on this area focused on sort of the harms supplied by the intervention, particularly in terms of the poisoning of the drug supply would increase prevalence of, I mean, interdiction of fentanyl. So if we plan on diving in interdiction, I think we need to be very thoughtful about what our aim there is.

Jeff Schiff: I'm curious about the other people's feedback about this. In Minnesota, we have called that group justice-involved populations and probably spend less a little less time on the supply side and more on providing or working towards

getting appropriate treatment either pre-arrest diversion, post-arrest diversion, or treatments on discharge from criminal justice.

Sarah Wakeman: I think that's crucial and aspect to evidence to treatment for justice-involved population is huge. I just want to consider that interdiction, but maybe it's my misunderstanding of sort of what's meant by that term.

Jeff Schiff: Got it, I think that we can - I'm curious - I thought that we could maybe change that term to something more around criminal justice-involved populations or criminal justice issues.

Sarah Wakeman: Yes, I like that.

Michael Abrams: Yes, this is Michael at NQF. So, yes, feel free to suggest changes like that. So what I'm - the drug course, for example, could very much be considered a treatment approach and might fall into that second arrow on the organizational overview that we're looking at, so feel free to make the kind of suggestion.

Jeff Schiff: Yes.

Brandon Marshall: This is Brandon. I wanted to loop back to the recovery, the comments on recovery as well, maybe this is coming from me coming Rhode Island and Sheldon Whitehouse's comments.

We have recovery as a separate pillar in our plan and that's what we have interventions around recovery supports. We track employment for people in recovery. We're even tracking wages among people in recovery. So that represents a separate pillar and there are interventions within that.

I wanted some feedback on the group of whether the extent to which recovery should be on its own box, or could be incorporated into treatment is a longer-term goal as such.

Jeff Schiff: Brandon, that's the - so we see first whether it's challenged. We have some hands - so we have some hands raised, so let's - maybe if your hand is raised for this particular issue, I'll just go through them. Let's talk about that, otherwise we'll get to the other issues that people may have had. So, Norris, Bonnie, or Arthur, are your hands raised - if your hands are raised for this issue, why don't you jump in.

Norris Turner: Okay, this is Norris, yes, Norris Turner of PQA. Yes, I'm kind of indifferent lumpers and splitter, but I do think having kind of a depth of - or kind of the richness of the challenge and the importance of recovery - of maintaining people recovery.

Someone earlier had made the comment and I know Gary Mendell's, you know, which I'd approve he's very much focused on this which is what's the state of equality of the treatment programs, and certainly that is very strongly intermixed with recovery. But there's always that whole host of factors that impact people's retention and recovery of falling out of it. So, yes, however we structure it, I just think having that depth and context that we've all mentioned recovery is important.

Michael Abrams: So this is Michael at NQF. So, Norris, what I think you just suggested, but you correct me if I'm wrong, is that recovery might be one of the priority issues.

So I just want to remind you of that one other thing, you know, we've given you a broad list of things. Think about if there are certain ones there of

particular importance to be emphasized as I think Norris just suggested with regard to, you know, suggesting the richness - I'll quote him "the richness of the challenge that is faced in trying to facilitate good recovery strategies by the healthcare system."

Bonnie Zickgraf: This is Bonnie, registered nurse. With regard to splitting the recovery into a separate (part), I think the thing that should still remain in the treatment bucket as far as measurements are concerned, yes, the depth and the richness can be determined. But I don't know that it would require a separate bucket all together. That's just one opinion. Thank you.

Jeff Schiff: Thank you.

Arthur Robin Williams: This is Arthur Robin Williams at Columbia, and just to build on that comment, I think, you know, it's a bit of a controversial area I think in some ways because recovery can be a term that's used with a lot of different meanings and sometimes it's a (mechanism) frankly for OUD treatment, you know, sometimes meaning not using medications.

And so I don't want to offend anyone on the call, I think people will probably have a lot of different perspectives, but I think that is - you know, realistically, I like what Bonnie was saying in part because if we think about treatment for other disorders across the healthcare landscape, usually we don't separate - separate, I mean, there are examples. But in general we think of recovery as part of treatment and some other process. But I'm sure people have a lot of different thoughts on that.

Norris Turner: This is NAV Kang in Cincinnati. To kind of branch off of some of that, this is an opportunity to even look at terminology on how we apply the term "recovery" and this is an opportunity to talk more about remission and

relapse, and the associated duration in treatment, or retention in treatment which is related but still separated, and all still underneath the umbrella of treatment. So treatment access, time to access, and of the nature of the treatment that's being accessed, how long the patient is in that treatment, and then what - you know, describing the nature, the pattern of - periods of remission and potential relapse.

Whereas I think recovery is oftentimes is used like a single occurrence type of thing, like you have achieved this threshold and now you're all set. And I think that there's opportunity to have more depth even just around the concept and what functionally what happens when folks have a chronic relapsing condition.

Gary Mendell: Hi, this is Gary Mendell, I have a quick comment. I'm wondering if to bridge all the comments, possibly treatment is relabeled chronic disease management and within it you have treatment and recovery or - and screening and monitoring, just a possibility throughout there.

Jeff Schiff: Thanks. Other comments on this topic?

Evan Schwarz: Sure, this is Evan Schwarz from Washington University in Missouri. I think one thing that may complicate this little bit is we're kind of lumping a lot of treatments all together and I think it's very different in the outcomes and measures that you're looking at especially with whatever you account as exactly recovery or remission if you're talking about that at, you know, a formal addiction center or starting something in the emergency department, or in the hospital where you may really be looking at can I get them engaged in the treatment after they leave.

Jeff Schiff: Great. It speaks to the continuum, so that means we'll get one here. Any other comments on this treatment recovery chronic disease management side of this …

Norris Turner: Yes, this is Norris one more time. Yes, this is Norris Turner from PQA one more time. And you know, there was the commentary about the high prevalence of comorbidity with behavioral health conditions and I just wanted to mention, you know, some of the same terminologies used there, you know, in terms of remission, relapse, recovery. I think someone mentioned the chronic relapsing conditions.

So I think as we're thinking about for substance use disorder how we would define these terms, thinking about the highly prevalent conditions that intersected like the behavioral health conditions and like how you do you look at that whole picture in the concept of recovery I think would be important.

Jeff Schiff: Yes.

Man: I have a separate question, have we talked all about the DATA 2000 waiver and like the - for lack of a better term, like the penetration rate or the adoption rate of the waiver like nationally extends at 7%? Is that something that we should be talking about as part of this conversation like organizationally, you know, what percentage of providers have the waiver on a state level and then nationally?

Michael Abrams: Yes, so this is Michael at NQF. So it did come up last time about the number of, you know, limits on physicians and rules related to buprenorphine prescribing and so forth.

So certainly, as a concept, this committee can think about particular approaches that are in place to try to promote in the case - in this particular case, MAT and what measures exist or are needed in order to track and see how that kind of response to the problem is working.

Jeannine Brant: This is Jeannine Brant. I just have one more comment on full concept model. So pain assessment management isn't a prevention and we know that a lot of times patients with chronic pain have accompanying substance use disorders, and so it's kind of part of the treatment in yet it's preventing.

So I'm just, you know, trying to weigh out where that would go because I think there's definitely some, you know, tools that can be used to manage patients successfully and whether we keep it in assessment - purely in assessment or in prevention, I'm sorry, or whether it's really part of the treatment as well when patients do have chronic pain disorders.

Jeff Schiff: Jeannine, I wanted to ask the question about whether pain should be - is a separate organizational construct here, because prevention has its implication of pain, you know, related - treatment related to prevention of opioid use disorder. But I'm wondering if it deserves its own arrow or bullet.

Jeannine Brant: Yes, because it really isn't different and the focus here, you know, seems to be on substance use disorder which, of course, that's really the concurrent environment, what we're really working on, and yet I think a lot of us on the phone who manage chronic pain can attest that there's such a balance and there's such a challenge to have good indicators outcomes for, you know, patients with chronic pain involved and maybe this is a separate bullet.

Jeff Schiff: Okay, I have Katie.

Katie Jordan: Yes, I'm Katie. I'm from Oregon. I believe that it is - it should be a separate bullet. You know, I manage several patients on the advisory council and I hear from our patients all the time who are experiencing the chronic pain as opposed to acute pain, and how important it is to be able to go to pain management specialist and talk about their concerns with substance use disorders in relationship to the pain. So I don't know, I just - that's my two cents.

Michael Abrams: So this is Michael at NQF. So let me - let me summarize what I'm hearing about this and try to clarify based on the NAM report in particular. If you recall, they specifically talked about the twin responsibilities of medicine to make sure patients aren't in pain as best that they can, but also to make sure that people aren't becoming addicted to opioids as well.

What I hear you are saying is that both of those are important, and there is the suggestion that perhaps the pain management and assessment piece isn't purely just of concern to this committee because it prevents addiction. It's of concern to this committee because it prevents pain and that makes it somewhat of a separate entity.

So correct me all if I'm wrong and then let me again try to - we should try to close out this discussion I think at this point to get to specific measures that Sam is going to be talking about.

Let me know when you've already done this, but let us know if you think there are any glaring - in particular glaring errors of omission that you think we've made, other things that you think we have missed. I think that's probably the biggest single question to sort of wrap up this discussion up with. But you could also - if you really think there's something we've included, although I

haven't heard anything, that really is way off the mark as well, that would be useful too.

Brandon Marshall: To go - to finish the pain point -- this is Brandon -- could you consider - and based on the earlier discussion we had, could you consider a separate arrow for pain and other co-occurring conditions, you know, other substance use disorders or both the risk factor for opioid use disorders, but there's a prevention angle with SCD that also obviously need to be treated.

So the same kind of problem that I heard with regards to pain also comes up with some of these other behavioral health conditions, or am I off the marks there not being clinician and not having to treat this on a day-to-day basis?

Michael Abrams: Yes, again Michael here at NQF, certainly co-occurring, I hear that messaging. In fact, it was brought up by one of the committee members and it's quite evident in the literature that we're reviewing for you, that comorbidities matter, that even this epidemic is, you know, part of the cycle of the deaths of despair, right?

This involves suicide, alcohol use, depression economic issues and so forth. So certainly those things are relevant to - antecedents to the issue but also to how the issue would be treated. And maybe it might be sufficient to make sure in treatment, for example, and in screening, there are comorbidity issues that are directly addressed. But, alternatively, we could create a separate set of measures - you know, measures for you to consider that, address them. We're open to either.

Jeff Schiff: Yes. There are some comments running in the chat that are supportive of being separate as well and maybe we could get a better sense from the group.

Michael, I'm just thinking - and Brandon, I'm just thinking to move on. I just - I had two quick points. One is I think that people have concerns or want to - or about the naming conventions here and we've heard some of them I think that they want to make sure they send them into you guys at NQF, so that we can make sure that the naming conventions that we're using are as sensitive and inclusive as they should be.

And then along the line of co-occurring, I just wanted to add that I wonder if we need a - at least a placeholder somewhere around social risk factors because there are quite - there are significant differences like, for example, in the LGBT community or populations with color that I think we need to make we - even though they may not be special specific measures, it may be a way of constructing measures that will be important to address to those communities' needs.

Woman: Genetic predisposition might be another.

Jeff Schiff: Yes.

Michael Abrams: And we are - Michael here at NQF, we are going to keep track of the comments that you're submitting now. But you should all feel free to - and we encourage you to send us comments and ideas to us directly as staff, or to our opioid inbox which we will be checking regularly and that will help us fine-tune the terminology and the direction of the environmental scan and of the project generally.

So definitely that's a useful way to communicate with us if you don't get a chance to speak during the call and address all of your comments in that format.

Jeff Schiff: Okay, so Michael, I think you - I'm wondering if we want to wrap this up so - if that's okay with everybody else to move on to the next part of the conversation.

Michael Abrams: Yes, I think that - I think that's good, and I will hand it to my colleague, Sam Stolpe to talk specifically about measure sets that we've identified from the CMS and the NQF tool that I described earlier.

Samuel Stolpe: Very good, thank you, Michael. Everyone, Sam Stolpe here, I've been listening to the discussion thus far with great interest and I appreciate the thoughtful remarks that went into considerations of how we're framing this up.

And I want to spend a moment before I walk through the measures that we've found thus far in our environmental scan to ruminate for a moment on what we're actually doing. Because what I'd like for you to so as we going through these slides together is think about these measures in the context. So this is just what we've pulled so far.

We've had a conversation now about what we think is important to measure and Michael did a terrific job of walking us through both some of the larger thought landscape as it currently exists around the issue itself and potential solutions to the issue.

So our charge, as a group, is to take a look at the existing measures not necessarily to create a framework for them, but have just a way of discussing them so that we can identify gaps and priorities. And those gaps and priorities will necessarily emerge as solutions to what we understand as problem.

So thank you for that discussion thus far and I think that it's putting us in the right mindset to consider this list of measures because necessarily we're going

to be using measures as the solutions. So once we identify those gaps and priorities broadly, we need to get through solutions specifically to a series of federal quality performance programs and I'll just remind you briefly what those are.

So those are from MACRA, MIPS, and AMP measure sets, and we have the ACO measure set for the shared savings program. We're going to making recommendations for the inpatient quality reporting program and then also for the value-based payment program.

So keeping that in mind and where we're looking to go, I'm going to tell you a bit about how we organize this and why, which I'll get to some of the points that you've brought up, as well as the actual results that we have thus far for you to consider. And then my - the co-chairs will lead us through discussion of what we found, and then let's talk some gaps and priorities, all right, so just as an early part of that discussion which will continue as we move out later into our future meetings.

Okay, so let's stay on this slide for just a second please. All right, so the scan organizational overview, we didn't call this a framework specifically for a reason.

We just wanted ways of thinking about the measures that help us to organize it and what has come out from the discussion of how we organized it is some of the ways that you all are thinking of priorities as well as gaps, and that we're more interested in identifying those things than we are in making sure that we have the problem perfectly mapped out, because some of these areas that we've - as we've defined as I'm sure you've noticed, have some overlap.

They're mutually exclusive and some of it you could say, “Well, hey, this is actually harm reduction.” Everything that we do with treatment is harm reduction. But it's just one way that we were considering for how to actually organize this. Then we put subgroups behind them.

And you probably also noticed this is framed entirely in terms of opioid use disorder. When we talk about prevention, what we're preventing is opioid use disorder. When we're talking about treatment, again substance use disorder and some of the ideas around comorbidities, all of that is going to play into it. Recovery has been part of treatment.

And then our harm reduction, we were thinking of that from the inpatient standpoint of all of overdose and (ADD). There are a lot of measures that had popped up from the inpatient standpoint. But some other harm reduction measures come up as well.

Interdiction didn’t yield nearly as many as you might think and there were fairly few and far between quality measures that are applicable to healthcare settings that connect to interdiction and the opioid issue.

So let’s go ahead and dive into some of the scan. Vaish, can you advance the slide please?

Our first sub-domain that we found inside of prevention is for opioid prescribing and monitoring. We found a total of 33 measures and I've listed a couple of examples on the slide for you to consider which I'm going to go ahead and read.

The appropriate prescribing for first fill opioids is exactly what you think it might be, alignment with CDC guideline and appropriate prescribing.

Concurrent use of the benzodiazepines and opioids has been discussed a couple of times amongst us. This is how important it is to curtail that. That measure exists and is used in a couple of quality reporting programs.

Another example that I wanted to highlight is the use inside of total hip arthroplasty and total knee arthroplasty of opioids at an extended rate, so opioid extended use, so again thinking about prescribing to the issue as the means of curtailing potential addition and misuse.

And then the last one on this we have overuse of opioid containing medications for primary headache disorders. So there is lot of the measures that emerged around using opioids appropriately when they might not be first line or even in cases where they are first line limiting the treatment.

Let's go to the next slide. Our next sub-domain, we had a lot of measures that we just grouped under pain assessment and management. So we found a number of tools that are currently utilized, sort of been tested and validated to analyze the degree to which patients are experiencing pain, as well interventions once the pain assessment has been complete.

So those measures, just to highlight a couple examples, included care for older adult pain assessment, pain interventions documented inside of a plan of care. And then the other one than that I wanted to point out was the pain assessments and target setting for patients with osteoarthritis. So of them get very specific to the disease in question.

Let's go to the next slide, this is something in the treatment domain and the first sub-domain we had was under substance use disorder screenings and monitoring. We had a lot of different measures that emerge from that, a total of 14 measures that we found.

Highlighted are a couple of examples here; opioid therapy follow-up evaluation; bipolar disorder and major depression, appraisal for alcohol and chemical substance use; IPF which is inpatient psychiatric facility drug use screening completed within one day of admission.

Then we have the sub-measures, so SUB-2, SUB-4 alcohol use brief intervention provided or offered; and then alcohol and drug use, assessing status after discharge.

Next slide please, so we also included this separate sub-domain for SUD treatment. So there were sufficient numbers of measures that could be comfortably be grouped into screening and then some other that could be comfortably be set aside as treatment, even though there are some measures that were doing more both, screening and treatment.

But there was a total of 20 measures that we identified under treatment, first of which I'll highlight as the use of pharmacotherapy for opioid use disorder. Continuity of care after detox, I know we didn't love that term, but it's the title of this measure.

We have substance use disorders, percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial and pharmacologic treatment options for opioid addiction within the 12 month reporting period. It's a rather lengthy title, but the nice thing is it tells you exactly what it is.

Alcohol and other drug use disorders treatment at discharge, then initiation and engagement of alcohol and other drug abuse or dependence treatment. So

this is just looking at ways that we are treating substance use disorder, a little - right around 2o measures, excuse me, included in that sub-domain.

Next slide, when go to the harm reduction, we only found a total of three measures, so we've comprehensively have them captured here; emergency department use due to opioid overdose; hospital harm, opioid-related adverse events, then hospital harm performance measure; opioid related adverse respiratory events specifically.

Next slide, we also had a list of ancillary measures, a total of 35 of those and some of these topics you may not feel are necessarily germane to our conversation around opioids and others, you might think while those tie directly to it.

And we have a number of topics that were included in those; some of them are very broad. But we didn't want to leave off concept so we've aired on the side of perhaps being overly inclusive for the ancillary measures and you can tell us if we're wrong or if we've missed something.

All of those - all of these are available in separate appendices as well as - I should say the appendices to the slide deck and we have comprehensively listed out each of the measures that we found as well as the example topics which I won't go through and read all the example topics, only to look that over.

Let's go to the next slide please, so we are …

Jeff Schiff: Maybe we should - do you want to pause and talk about the ancillary measures for a moment?

Samuel Stolpe: No, not yet.

Jeff Schiff: Okay.

Samuel Stolpe: So what I'm going to do, Michael, we'll wrap this - we'll go through all of these and we'll go back and we'll revisit each of those areas, including the ancillary measures.

So for our - just to let you know what else is going on the side for us, identifying key areas of measurement, the priorities, that things that we perhaps may have missed in the environmental scan. So we have key informant interviews that we're currently conducting.

So the key informant are intended to supplement the lit review and the big focus, of course, is on this knowledge gaps and what we should be looking at and how we should be trying to solve the problem. So we have up to nine interviews that we'll be conducting and we've probably done four at this point. Yes, so we've got a few more to go.

Next slide, so we've spoken with the health services researcher, with the measure developer, with pharmaco-epidemiologist, with a Medicaid expert. And now we're looking to identify a few more potential folks that could supplement what we know and we would also welcome recommendations on your end.

If there's some holes that y feel like we've had, that you may not feel like you're able to supplement yourself, we welcome your recommendations on others that you think might help fill those gaps.

Next slide, so we've also spent some time going through state laws to identify some important areas for us to consider as we're developing these priorities and gaps. And the state laws that we're thinking about has to do with jail-based treatment with the PDMPs, the expansion of treatment options, making sure naloxone on standing orders are in place. State-law-based training and interdiction programs, drug courts, as well as some of the laws that have emerged for safe injection sites to support those.

Now, concepts in this area are ones that we'd also welcome your feedback on, if there's a state law that you're familiar with in your area that you want to highlight as an example of a best practice or something, an emerging trend. We'd welcome your input on those approaches as you become aware of them.

Let's go to the next slide, okay, this is where I hand it over to our co-chairs. They're going to walk us through some of the discussion questions. And the plan of attack is, first, to revisit each one of those areas for your feedback. So I'll hand it over to Brandon and Jeff to lead us through our next area of the discussion.

Brandon Marshall: Great, thank you. So I think the plan, and Jeff, correct me if I'm wrong, was to get back to Slide 17, is that correct?

Jeff Schiff: Yes, yes, I just want …

Brandon Marshall: Of course, that's the slide that has Appendix A - sorry.

Man: Yes, thanks, we're cruising back, one just moment.

Jeff Schiff: So I want to just ask questions to NQF before we started the switches. Some of the things that we could talk about so, for example, penetration of drug

courts in counties, or penetration of Suboxone or medications as the treatment in jails could be a measure because - but it's really a measure of the infrastructure capacity. Are those concepts or measures fair game for this as there are sort of measures of the state-constructed infrastructure?

Samuel Stolpe: Jeff, this is Sam. And yes, I think that's fair game. What I want us to do and what are charge is, is really to essentially boil the ocean here. Now, we're trying to think of what the solutions to the problem may be and the task is not for us to actually devise a new measure. We're just trying to come up with the priority areas for measurement.

And we don't necessarily need to indicate who will be accountable for it, to the extent that we're able to. I think that's a good thing for us to do. If we as a group can say, "Hey, we know who has stewardship over what solutions and we know how to hold them accountable," the more details we can get, the better if we just have something where we have a sense of how it should be accomplished and can't get it perfectly, that's okay too.

So I think what you've outlined actually makes sense. It's something for us to potentially include at our list of priorities - inside of our list of priorities.

Jeff Schiff: Great. So, Brandon, I can run the hand-raising if you want to coordinate the conversation.

Brandon Marshall: That would be great. Thanks, Jeff.

Jeff Schiff: I think I have Anika on the first.

Anika Alvanzo: Hi, this is Anika from John Hopkins. For this domain here, I think I would again add - this is where I would add the PDMP and appropriate tracking of the PDMP as part of appropriate prescribing and monitoring.

Jeff Schiff: Jeannine?

Jeannine Brant: Yes, for post-surgical prescribing guidelines, Mayo Clinic did publish some guidelines in the Annals of Surgery and it includes the general surgery, surgical oncology. So in addition to TKA (ATJ), there are other surgeries. So to take a look at those might be helpful.

Jeff Schiff: I think Kate was next on the list.

Katie Jordan: Hi, Katie Jordan, occupational therapist from USC. I was - I'm wondering about as special measure, the opioid risk tool that's provided by the National Institute on drug abuse. It's kind of related to the number 26 on the appendix which is potential opioid overuse, but it's a tool specifically listed.

Jeff Schiff: Good. Anika, did you have another comment? You have your hand raised again.

Anika Alvanzo: I did, I'm sorry, I forgot.

Jeff Schiff: That's okay.

Anika Alvanzo: So one of the things actually when we're talking about surgical procedures, I would like to mention about management - perioperative management of buprenorphine because I think there is an increasing evidence that we should be maintaining patients on buprenorphine.

And there are still a large number of people in clinical practice who are having patients with substance use disorder come off of their medication prior to surgery, but that increased with what they're trying to use and potential overdose. So I think that we should have something about perioperative buprenorphine management when we're talking surgical procedures.

Jeff Schiff: Great. Not as co-chair, but I wanted to add a measure here that we have used in Minnesota which is a measure of folks who are opioid naive and moving them to become chronic users. It's really a population health measure. It's actually now part - there's a version of it that's now part of the (unintelligible) that's called - it's risk of continuing opioid use. So found that a really helpful measure regarding our prescribing.

Then there is a comment from (unintelligible) I just wanted to put out that there's I'm probably more in the infrastructure category in this area, that in Louisiana they were able to achieve a 40% reduction opioid prescribing among new opioid prescriptions. So it's sort of a - probably a little bit more of an environmental scan about how state laws on prescribing have affected prescribing rates.

And then Gary had a question on here too, I just want to ask maybe for the NQF folks if this is - if right now are we looking - I think right now we're looking at current measures and not gaps, is that correct, Sam?

Michael Abrams: Yes. This is Michael. Sam stepped out the room for a moment. Yes, we are looking at current measures that we found on our database searches. So gaps are of interest in the future, but right now what we're trying to do is put together a puzzle for you or a cake, if you will. That has the full collection of measures for you to react to.

Poonam Bal: And I would just add, this is Poonam from NQF, that specific measures that you are mentioning, if they already exist, please email us the details so we can make sure that we're capturing them. While we're taking notes, we want to make sure that we're capturing the right one.

Brandon Marshall: Are there any other comments on this domain, otherwise, Jeff, I'd like to suggest we move on to Appendix B.

Jeff Schiff: Yes, no other hands raised so …

Brandon Marshall: Great. If we could get the Slide 1 forward.

Jeff Schiff: Is there a way - there we go.

Brandon Marshall: And I just want everyone to be aware of the full list of items in the appendices at the end of the slide deck which was emailed to you just so you can see the full list.

Jeff Schiff: Okay, I have Maria and Katie. So Maria? Maria, are you there and not on mute? I guess we'll go to Katie and then go back to Maria. Katie?

Katie Jordan: Sure, so on this one I kind of struggled with trying to think if we should be focusing on more global measurements of pain or diagnostic or population-specific. So in the appendices I did notice that there were - there were several directed towards certain populations, but there are other populations that were missed.

So I am not sure if - and I can email you list of all the specific ones that we use, but there are several for headache management, migraine. There are

specific to different neurological diagnosis and then just specific musculoskeletal conditions that were not listed.

And then kind of related to that, the other area that we focus on is pairing some of those patient self-report measures with functional capacity evaluation, so that we have objective measures to go with them, and I'm wondering if that should be included as well.

Samuel Stolpe: Hi, this is Sam from NQF. So just one point of clarification that's maybe helpful for everybody. These are just simply measures that we found in our search and if there's something we missed that you're aware of, no need to ask why it wasn't represented, it's just we missed it.

So we'd love to have any of those measures that you're familiar with that you want to share with us and it's missing from the list. So let's go ahead and add it, and to the extent that you're able to share any of the measure details, let's go ahead and send those over as well.

And then, lastly, if there's something that you're familiar with that if it's missing, where you think, "You know what, that should be a measure," then let's list that as a gap and a potential priority for us to include within our measure concepts that we're going to be documenting as well.

So we have both of those as a charge, as comprehensive list of everything that we found related to opioids and opioid use disorders, and making the list of gaps that we identify and then prioritizing those gaps.

Jeff Schiff: Great.

Poonam Bal: And Jeff, also …

((Crosstalk))

Jeff Schiff: Go ahead.

Poonam Bal: Sorry. Jeff, again I'll just note that while Maria wasn't able to speak, she did put a comment in saying that in Appendix A, the fourth example, is any reason that only headaches are cited versus pain condition? So I think that's what she was trying to comment about, but not able to. I just wanted to add that clarification.

Jeff Schiff: Great. I don't have any other hands. We don't have any other hands raised, Brandon, for pain assessment.

Brandon Marshall: Okay, great. And keep in mind, folks, that another charge we have in addition to those that Sam mentioned is to identify any measures in the list that should not be included as well.

Shall we go to Appendix C then, Jeff? Great. So this is on screening and monitoring within the treatment sub-domain. Are there any questions, Jeff, coming from the panel?

Jeff Schiff: I have no hands raised so we'll look in here. I had - people are digesting. I do want - I wanted to mention one thing while we're having the conversation about this, I also have the (privileges) sitting on the course set which is the Medicare course set and actually I guess this relates to the next one.

But the measure around opioid use continuity - of use of pharmacotherapy for opioid use disorder was one of the measures recommended for inclusion in the

Medicare course set. I'm sorry I jumped ahead to D because I was really excited about it.

But - so anyhow back to screening, I don't - do we have folks with other comments on what is here and not here for screening? I suspect that some of the measures could also relate to the co-occurring conditions.

Brandon Marshall: I do see an item relating to the PDMP actually in Appendix C Item 10. So there is a mention of the PDMP there, I just realized that. I'm not sure this is a question, not as a co-chair, I'm not sure what 14 refers to, verify opioid treatment agreement? Does anyone in the panel know or someone from NQF?

Michael Abrams: So, yes, Michael at NQF. So I assume and I'm basing it on the name that this is a straightforward process measure that says that there's something that's been placed into the record on a patient, that they have identified and have been informed about potentially to become addicted to opioids and come up with a strategy for seeking regular contact with their provider to deal with their pain and then presumably taper it off.

So there's some sort of potentially even a schedule, but there's actually sort of a formal signed documentation that addresses that specifically in medical record.

Brandon Marshall: Great, thank you.

Jeff Schiff: Good. There is one hand raised, let me find it. Whosever hand is up, if you want to speak, I don't - I'm still finding you on the list.

Laura Porter: Hi, it's Laura Porter, the advocate. I just - I think that part of a plan and this goes to what I personally experienced and also what was talked about in the

TED Talk is that there needs to be some sort of a plan for coming off of the opioids when you're on them.

I mean, you know, so once the treatment is over, what's been happening is that people are left to their own devices to try to come off. So I think that that needs to be included somewhere in the measures.

Brandon Marshall: That's a great point. That sounds like a gap. I don't see anything - nothing on to that domain in Appendix C. So if we could note that as a gap, that would be great.

Samuel Stolpe: Yes, noted, absolutely.

Jeff Schiff: Brandon, I'm wondering if in this one also there's a place for preoperative pain education. The "verify opioid treatment agreement" may represent that, but we've had some good success in Minnesota with our orthopedics. And it sort of gets into what Laura says as the plan to lean, but it also talks about the necessity of preoperative education, so people will know what to anticipate in their recovery especially from some of the orthopedic procedures.

Jeannine Brant: And this is Jeannine Brant. In the article in Annals from Mayo that talk all of that as well, it's just very helpful about that transition post-surgically in opioid tapering.

Jeff Schiff: Great. All right, we have a couple of hands raised. Patty Black?

Patty Black: Hi, yes, we use an opioid treatment agreement in our organization and it is a formal agreement between primary care physician or especially clinician and the patient outlining really standards of content around the whole opioid arena and what the patient will and will not do.

Jeff Schiff: Great. Okay, Caroline?

Caroline Carney: Hi, I think this is the area where I would like to say screenings for hepatitis C and HIV AIDS add in.

Jeff Schiff: Great, so…

Michael Abrams: Everybody, this is Michael at NQF. What I want to encourage you at this point is that we move a little bit more quickly through these specific appendices, but encourage you all to later review especially the full appendices and send us notes again about errors of omission or commission you think that we've made, that would be very helpful.

But I want to make sure we get a chance to especially talk about the ancillary areas on the line here, and then quickly make sure we're on the right track the informants - the informant interviews and so forth. So does that sound okay with the chairs?

Maybe we'll try to quickly get through the next couple of appendices through the ancillary piece, and then talk about that for a few minutes - a couple minutes and then move on to the key informant interviews and the state laws just to make sure that there's little bit of time to talk about those in-person today before close out.

Brandon Marshall: That's great. So let's go to the - this is the treatment sub-domain. Any questions or hand raised, Jeff, here?

Jeff Schiff: I don't have any.

Brandon Marshall: And number - E, harm reduction, there might be some comments with this one given that there are only three measures here. Are there any gaps that the panel would at least try to identify at this point? Then we can perhaps follow up.

Man: Can we go back to D really quick?

Brandon Marshall: Yes.

Man: There's a couple of measures around of continuity of care and the use of pharmacotherapy for OUD. You know, I think again they kind of hint at the adoption of evidence-based practice and the capacity in the system, but did not directly touch on it.

And so I just want to bring up the penetration rate of the DATA 2000 waiver, whether it's kind of institutional or on a community level. I think it's a salient number for us to understand and have like a routine hand on so just putting that out there.

Brandon Marshall: Great, thank you.

Jeff Schiff: I'm looking at the number of people who are DATA 2000 waived to the number of people who have that and/or prescribing.

Man: Both, and I think that's an excellent distinction to make. One can certainly have the waiver and then they're not doing anything with it, and so both.

Jeff Schiff: Okay.

Brandon Marshall: We simply look at both in Rhode Island and they both tell interesting stories so …

Man: Yes.

Brandon Marshall: Yes.

Jeff Schiff: I want to go back up to E.

Brandon Marshall: This is Brandon here. I see in the naloxone maybe as a gap in these measure sets. Both are in regards to measuring distribution of naloxone and/or administration.

Jeff Schiff: Great. I think - I think we ought to put on there the high intensity drug treatment area, use of over - the overdose use perhaps.

Samuel Stolpe: Hi, this is Sam - go ahead, sorry, finish it up.

Jeff Schiff: Go ahead.

Samuel Stolpe: This is Sam from NQF. I just wanted to respond to Brandon's comment. We did find some other measures related naloxone and we put those actually under - I'm trying to remember exactly where we put it. I think we actually put it under the - we had one that was - actually, sorry, go back, that was it.

It's actually on here. So the opioid-related adverse respiratory events, the way that they flag that measure when the use - when naloxone is used in the inpatient setting. But I think that you're right to identify this is an important area for us to consider beyond just the inpatient setting.

Brandon Marshall: Thanks, Sam.

Jeff Schiff: Okay, we have four hands up, Anthony?

Anthony Chiodo: I guess I'm not aware if there are any measures, but one gap is the patients who are at risk for sleep-disordered breathing and adverse events related to also being prescribed opioids.

Jeff Schiff: And then Anika?

Anika Alvanzo: Yes, Anika again from John Hopkins, Addiction Medicine. So I see here and again I'm not sure what measures exist, but I see for example 12, percent of Medicaid beneficiaries receiving buprenorphine, but there are other medications, so just making sure that we're inclusive of all suite of medications including methadone and naltrexone as well.

Certainly, we have a lot of data on the efficacy, effectiveness of methadone as well. So I just want to make sure that we are including all medications.

Jeff Schiff: Good. Jeannine?

Jeannine Brant: Hey, yes, so the ED overdose, I think it would be really helpful to indicate whether the opioid was prescribed or whether it was stolen. It might help to get us the root cause and see where to put efforts for future quality needs.

Jeff Schiff: Great, okay, and Patty?

Patty Black: Yes, on Appendix E, I noticed that we've got emergency department and hospital visit. Should we include urgent care?

Jeff Schiff: Yes, or EMS, thank you. So that's all we have on Appendix E.

Brandon Marshall: Great. Let's move to Appendix F then and close out this discussion and spend a couple of minutes on F. And as a reminder to the panel, we can send specific questions regarding items to the NQF folks afterwards. Any hands raised, Jeff.

Jeff Schiff: No, no hands raised right now.

Samuel Stolpe: So it might be helpful for us to just keep this up a little bit. This is Sam and Michael. What we're actually asking you to react to is whether or not this makes sense. So if there's anything on there that we're putting - that we put that may seem out of place, then both sins of omission and commission on our discussion.

Michael Abrams: Yes, especially things that are perhaps not relevant, you know, physical activity counseling is arguably peripheral to this, but maybe not, especially when you think about pain management strategies. But, you know, that's one bullet right there in the middle that we deliberately put in there to be a little bit suggestive and provocative to see if you thought we should be looking for those types of measures or not.

Tobacco, may or may not be something that's directly germane and also your view to this particular problem, but there are lots of reasons why that might be included. So consider this as a list you quickly review and give us the actions about whether you think we should be looking for these kinds of measures.

Jeff Schiff: So, Michael, I'm wondering physical activity counseling might be controversial. But alternative pain management strategies and occupational

therapy, physical therapy, you know, some of the complementary alternative strategies may be important in looking at pain, or any availability of those.

Samuel Stolpe: Those actually did emerge in other areas where we found measures specific to that type, Jeff.

((Crosstalk))

Jeff Schiff: And I don't have any hands raised. We do - I don't have any hands raised. We do have a comment from the (unintelligible) about making sure that the measures related to (unintelligible) syndrome (unintelligible) here. And somebody's background noise, if you could …

((Crosstalk))

Woman: Good, good, (unintelligible), but I don't think that we've actually gotten some news to.

Woman: Someone needs to mute their line.

Poonam Bal: Yes, we're going to go ahead and try to find that person.

Woman: We're almost done.

Woman: Getting there, getting there. Okay, how can I help you, (Emily)?

Woman: Can you mute your line? Hello?

Samuel Stolpe: Whoever is talking to (Emily), we can hear you.

Brandon Marshall: All right, I think they may be muted. I see we have five minutes left until the end of the call. I know we need time for public comment. Sam or Michael, would you like to go through the key informant interviews or should we go right the public comment portion?

Michael Abrams: Yes, thanks. Thanks, Brandon. We should go to public comment portion. But please look up - take another look at those last couple of slides and send us any ideas or thoughts you have about the key informant interviews and specific state laws. And thank you to that person who talked about the Utah law in particular, we have noted that so …

But let's move on to public comments. Then if there is anybody on the line, we'll have Poonam to address that.

Poonam Bal: Yes, if you would like to make a public comment, please raise your hand or go ahead and give us a chat in the chat box. We did have a couple of comments come in already beforehand. There is an option that if you want to type those comments in the chat, we can do that here as well.

We'll go ahead and read some of those. We have one from (Helen) that the 10th - we wish to review the HSS pain management task force report. And then also we should be aware of provisions of Section 6032 of the SUPPORT Act which requires a certain coverage payment of those items.

Let’s see here, what else can do we have? There’s also a comment that - from the same person that, you know, within the stakeholder interviews, the patient (unintelligible) is important and we should consider that. Perhaps interview a person with OUD, a person with chronic pain disorder, or a person with both.

And then we have another public comment come in from CHA, (Sally), who said (unintelligible) consider what aware (NSAS) - I'm sorry, (MAS) treatment outcome for (unintelligible). It's not clear from the (unintelligible) point or discussion, similar to treatment outcome for (unintelligible) from mom to babies.

I think that's all the ones we got - received in the chat. I'm not currently seeing any hands raised. Were there any other public comment mentioned? Okay, Jeff and Brandon, I think that's it for our public comment.

Jeff Schiff: Excellent. I think the last, this belongs to you guys.

Poonam Bal: Yes, thank you. We'll go ahead and do next steps. So we do have another webinar on June 4th, 2019. We will be sharing more developed environmental scan with you based on the discussions we had today.

You know, please make sure to email us with any measure do you think we have missed. I know we didn't get - spend any time with the key informants, but if you have any suggestions on areas we should focus, or individuals that you think would be a good resource, please email us that information so we can reach out to those individuals.

And yes, so we'll be sending a draft report to you in advance of that (meeting), all that detail, so we can give you a more - a better timeline on what we would need, any information (unintelligible). And then once we close that web meeting, we'll go into a 150dday comment period on the environmental scan. I know we did a lot of gap discussions during this call as whatever you shared.

Right now, we're really just trying to figure out what else is there already, and so that's where the focus of this meeting and the focus of the next meeting

will be. But after that, our focus will be on where do we need measures, what we should consider to be focused on.

Again, it's not measure development, but we will at least be doing measure concept development of those areas that currently we have now. And you know, from there, we'll focus on really building that out and then taking those measure concepts and measures that we've identified and then seeing them with different federal programs.

And those are the next steps. Were there any questions about next steps, or just generally what we've talked about? Again, here's a slide with some information about how to contact us, our email.

For those public numbers, you can use the project page to keep in track. For our committee members, you can use the SharePoint page to see the documents.

Samuel Stolpe: All right, well, that's going to close us out here. So this is Sam Stolpe, on behalf of the NQF staff, our thanks for your time and attention, for your contributions to the conversation. I'll hand it over to co-chairs for final remarks.

Jeff Schiff: Thank you all as you're closing off.

Brandon Marshall: Yes, indeed, thanks, everyone. We appreciate your time and we'll chat on June 4. Bye.

Jeff Schiff: Great.

Samuel Stolpe: Thank you very much. Bye for now.

Jeff Schiff: Bye.

Brandon Marshall: Bye-bye.

END