Opioid Technical Expert Panel Web Meeting 3

Moderator: Kim Patterson
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1:00 pm ET

(Weiss): This is (Weiss) from NQF for the Opioids TEP Webinar 3. Just a reminder to mute yourself, if you are not speaking, so we don't hear any external noises. We are definitely going to have a robust discussion today. So I think making sure that we have to focus on the speaker that would be great. I think we'll give maybe two more minutes before we could start.

Woman: Hi everyone. This is (unintelligible). Thank you for joining the third webinar for the opioid project. We will be starting out today if I could move to next slide please, one more. Thank you.

So the agenda of today's meeting is mainly around the Environmental Scan draft we had sent that you last week, you know, in there we included kind of the purpose of it, some of the methodology we used, and some of the initial results we received about measures that are potentially out there already.

So we did share that with the committee as initial draft will be taking your feedback today to enhance that even further before we go out to public comment. I'm speaking a public comment during today's meeting. We'll also

have an opportunity for members of the public to comment towards the end of the call. And then we'll talk about next steps about what you can be expecting moving forward.

All right. With that I'll ask (Weiss) to go and do some more counsel to see who's on the line.

(Weiss): Okay. Hi everyone. This is (Weiss) from NQF. I'll do roll call. Jeff Schiff?

Jeff Schiff: Here, good afternoon.

(Weiss): Good afternoon. Brandon Marshall?

Brandon Marshall: I'm here.

(Weiss): Hi Brandon. Anika Alvanzo?

Anika Alvanzo: Here.

(Weiss): Michael Ashburn?

Michael Ashburn: Yes.

(Weiss): Antje Barreveld?

Antje Barreveld: Here.

(Weiss): Patty Black?

Patty Black Here.

(Weiss): Jeannine Brant?

Jeannine Brant I'm here.

(Weiss): Caroline Carney?

Caroline Carney: Good morning, I'm here.

(Weiss): Anthony Chiodo?

Anthony Chiodo: Here.

(Weiss): Jettie Eddleman? Maria Foy?

Maria Foy: Here.

(Weiss): Jonathan Gleason.

Jonathan Gleason: I'm here.

(Weiss): Anita Gupta?

Anita Gupta: Here.

(Weiss): Mark Hurst? Katy Jordan?

Katy Jordan: Here.

(Weiss): Navdeep Kang?

Navdeep Kang: Hello.

(Weiss): Hi. Sarah Melton?

Sarah Melton: Here.

(Weiss): Gary Mendell.

Gary Mendell: I'm here.

(Weiss): Hi, Darlene Peterson?

Darlene Peterson: I am here.

(Weiss): Laura Porter?

Laura Porter: I'm here.

(Weiss): Clay Rhodes?

Clay Rhodes: Here.

(Weiss): Darshak Sanghavi?

Darshak Sanghavi: Hello, I'm here.

(Weiss): Evan Schwarz?

Evan Schwarz: I'm here.

(Weiss): Norris Turner?

Norris Turner: I'm here.

(Weiss): Sarah Wakeman?

Sarah Wakeman: I'm here.

(Weiss): Sarah Wattenberg?

Sarah Wattenberg: I'm here.

(Weiss): Arthur Robin Williams?

Arthur Robin Williams: Here.

(Weiss): Bonnie Zickgraf?

Bonnie Zickgraf: And I am here. Thank you.

(Weiss): Great. Did we miss anyone who's on the line? I think, we were looking for Jettie Eddleman or maybe Mark Hurst. Okay, great. I think, we'll move on to the next slide I'm giving it back to Poonam.

Poonam Bal: So just as a reminder we do have (unintelligible) liaison participating as well just mostly as a resource to you and resource to (unintelligible). Maybe one quick review joined us on the line of Robert Anthony.

Robert Anthony: I'm here.

PoonamBal: Sarah Duffy?

Sarah Duffy: I'm here.

PoonamBal: Elisabeth Kato?

Elisabeth Kato: Here.

PoonamBal: SreyRamKuy? Scott Smith?

Scott Smith: I'm here.

PoonamBal: Judith Steinberg? Linda Streitfeld?

Linda Streitfeld: Here.

PoonamBal: Okay, perfect. Thank you so much. And with that we'll jump into meet our discussion today. I believe Michael will be going over the round.

Michael Ashburn: Good. Welcome everybody Michael (unintelligible) and let me just briefly say regarding the federal liaisons and others in the public. We are monitoring the chat function and specifically last time we got some very good comments especially from liaison. So we appreciate that a lot.

Just a reminder the committee that the liaisons are available for us as resources anytime that we care to ask questions of them and also they're encouraged when they think it's appropriate to chime in as well. So we do appreciate that.

So today we're going to be talking principally about the Environmental Scan. I'm going to give a brief overview of the discussion that we had last time and points that we took to inspire our Environmental Scan or our measure inventory review. And then I'll hand it off to my colleague Sam Stolpe to talk specifically about the rough draft document that we sent you pursuant to that scan. So next slide please.

So there are three principal questions that we asked and they're pretty straightforward. The first is, what measures were out there fully developed, for example, NQF endorsed measures are out there? That's Question Number one. Question Number 2 is what measure concepts are out there and this is a term that we use specifically to mean measures like NQF like measures or CMIT like measures that are not fully forms that are in development?

And then the third overarching question that we used to guide our review is looking for what the literature and our key informants and both the gray and the peer-reviewed literature suggests about ideas for new measures and areas where there are particular gaps, important gaps that need to be addressed with novel measures as well. Next slide please?

So from the last meeting, we heard you as a committee, as our TEP concur with the idea that the measure inventory needs to be related to at least two perspectives of the opioid crisis. With the National Academy of Medicine Report review last time described as the twin responsibilities of medicines to both be concerned about substance use disorder prevention and pain management.

And we try to reflect that especially with regard to the prevention team that we use as an organizing principle for our environmental inventory. And that's what I'm showing is here on this slide are some specific examples of what we

need by this and what we try to look for when we were looking for measure things like prescription monitoring perioperative pain management even things that needed a little less self-evident but that you brought to our attention things like suicidal risks.

That correlate with chronic pain and measures that might address that or things like the second to last with their tapering opioids for somebody who's been on opioid therapy for perhaps acute pain and tapering off of that appropriately. So this will all fall into that general area. I'll point out to with the bullet that one of the things that was discussed of what we in tune from the discourse last time we're staffed at NQF.

Was that although supply side issues, drug interdiction issue certainly are relevant to this problem it's a little bit outside of the purview of this committee, which is more focused on medical space. And so to the extent that measures address supply side issues they would be more with regard to dealing with illicit use and coping with that problem and illicit use of prescriptions as well as legal drugs. Next slide please.

So no surprise, another big scene that was discussed last time was substance use disorder treatment. So not purely opioid use disorder but that’s obviously the center of the committee's responsibility and interest.

But in this domain we are including fairly a broad ideas that relate to dealing with somebody who has active or who has the history of substance use disorder so comorbidities in this case both psychiatric as well as physical or what have previously been referred to as somatic morbidity. So thing like Hepatitis C and HIV to refer to somatic comorbidity and sleep respiratory disorder as well.

But then, of course, in the psychiatric domain there is and you-all seem to assent to the important notion that psychiatric comorbidities like depression, anxiety are relevance to our discourse and our measure review responsibility both (unintelligible) to opioid problems. But also as direct comorbidities and results of pathology that surrounds opioid use disorder and epidemic that we're addressing.

In this category those functional assessments are included in quality of life type assessments are included and Sam is going to talk a bit more about that particularly how many of those cognitive measures that we see. But with regard to functional assessments what we often are talking about are self-assessments of one's capabilities.

But also things that are more socially related or arguably somewhat more objective are productivity employment those kinds of things as well would be fair game as measurement principles.

And then the last two bullets on the slide here access, of course, is relevant financial or otherwise and referral issues were of interest to the committee and one specific touchstone came up to data 100,000. So the idea of how many positions, you know, achieve that we're able to prescribe outpatient phase due to morphine as one touchtone.

And then the final bullet here there were some discussion about venues and assessing quality in different types of venues and not just urgent acute care like in the ED and then venues where somebody might receive a withdrawal therapy.

But also looking at other centers of treatment more intensive - perhaps intensive outpatient centers or rehabilitation centers as well and relevant

quality indicators pursuant to those kinds of different levels of care perhaps using the assent framework. Let's go on to the next slide then.

Returning to our third of four organizational domains that we've set up before is this harm reduction domain. And I just want to point out that in the case of our report this domain refers to things that are traditionally harm reduction that is things like needle exchange or Narcan, Naloxone distribution in order to mitigate risks that are associated with substance use but also just to prevent people from dying who overdose.

And so we do use that as organizing principle and Sam is going to make one other point as well, when he talks about how we use that domain to look it just sort of fundamental outcomes of overdoses as well. And then finally last time when we met by web, we talked about interdiction and we also talked about ancillary issues.

The middle to major themes on this slide and with regard to interdiction issues what we heard you all voice as a committee is that the terminology should be shifted more to criminal justice issues not so much interdiction.

And, you know, border policing and criminal control of trafficking per se, but more to things like looking at whether or not an individual who was engaging in treatment has had criminal justice issues maybe currently engaged in the criminal justice system through drug courts.

Those kinds of things were central importance to the committee and jail involvement in general and also jail distribution of therapies as well were of greater interest to this committees an interdiction at the borders per se.

And additionally with regard to ancillary issues we actually were able to interleave those into other area. So presently we don't have this other sort of collection bucket. We move for example tobacco into the co-morbidity sub-domain of the treatment of the SUD treatment major domain that we had.

So we've managed to eliminate that. Just for, again these are just simple organizational principles that we're using to lay out for use of measures are center focus of course being looking at measures not creating a framework per se. Sam will talk a bit more about that as well.

And then finally, we heard you say and this is not a domain per se but just a source of information for us. We heard you suggest that we get some additional perspective from consumers and we are seeking that both from the literature as well as at least one key informant interview. So next slide please.

So, and then one other point about sources of information that we're using to address our overall measure inventories. We are looking at some different laws, which I put up here. Specifically, I can add one additional one that we're likely to describe for you at a California Law, which in 2017 was passed to require alcohol and drug abuse recovering and treatment facilities to adhere to new and specific standards.

The obvious implication for example of this kind of analysis will be that those standards need to somehow be measured, somehow be tracked. And so we want to be able to laid that out for you as well. So this will be a source of information for us too. Next slide please.

So I'm going to now hand it off to my colleague Sam Stolpe then to directly talk about the draft document that we sent out and talk about some early results that we're getting.

Samuel Stolpe: Thanks very much, Michael. Hi everybody, Sam Stolpe here. And with this very first slide, which we're going to spend a lot of time on. I'm going to walk through the Environmental Scan draft, which was sent to you to talk about the emerging things and that just to reemphasize one of the points that Michael made.

We wanted to listen very closely to what you had informed around our decision-making for how we grouped the original set of measures. And think carefully about the set of measurements domains and sub domains in a way that we're capturing a meaningful description and a meaningful mental model if you will for how we're going to think about moving towards identifying gaps.

And the point I want to emphasize relates to this is that the deliverable for this project does not include the development of these domain. So it's the purpose of having it in place is only for us to get to gaps and priorities since the extent of that utility is there then great. And we're really happy we have this organizational set-up domains but I don't want to spend too much time focused around.

Whether or not we got it exactly right but to the extent that it's useful for us to help identify what we're missing and to get us to a spot where we're figuring out what this problem really looks like and whether or not the current measures that are in existence are the right ones. And they are getting up towards real solutions that's where our focus as a technical expert panel.

So with those that brief words of preamble let's just jump right into it. So when we conducted this dumbness search as you know we did pretty broad. We covered everything that we could conceivably think of where we might be

able to find quality measures, pulling them from a federal repository NQF's own repository and the like. We looked at well over 2500 measures, narrow those down to focus on the sets of measures specific opioids.

And then some, what we initially termed the ancillary measures that touched on the problem in a way that we thought would be meaningful what emerge from it. Here is a 197 measures in total and 75 measure concepts. And this is not an unusual number for Environmental Scan at NQF, but it's very interesting that we're able to find so many measures, measure concepts in total specific to this problem.

Now we also reviewed a number of articles in great literature reports to try to find measure ideas, measure concepts and other measures that we might have missed to that initial scan. And that's what's reflected in this total number 197 measures, 75 major concepts getting down to the domains that we characterized them by.

And so we started with pain management, which is where we'll find the bulk of the measures overall. In fact, Michael ran the calculation for us with that slightly over 54% of the total measures and concepts that we identified fell under this particular domain. And it shouldn't come as too much surprise as a lot of the pain management issues can natively bleed into the substance use disorders issues.

But this is a starting point and many of the mechanisms that are deployed by our healthcare system to try to rectify that we try to catch it upstream at the point of prescribing. So it makes sense that this would have a lot of measures tied to it. So these types of measures both our pain assessment type measures, timely control, quality of life, pain care plan, selecting alternatives to opioid therapy and then making sure that we're prescribing appropriately.

Now as you're thinking about this notwithstanding my previous comments. If there's a domain that you're thinking that we just is a glaring omission, please feel free to speak up when we get to this discussion portion. We're going to break down each one of these domains in piecemeal fashion after I give an overview of this Environment Scan summary and our co-chairs walk us through that process.

But as I'm speaking about it, please keep that in my mind as exactly what we're going to discuss here in a moment.

Okay. So let's dive into each one of these sub domains as well to give some ideas of context around how we've defined this. So with pain assessment we found 21 measures total two concepts ancillary to those and what these are for the most part tend to be instruments of pain assessment.

But it covers a variety of things that include pain assessments that are done in setting specific or condition specific type framing of the measures themselves. So for example, pain assessment when someone appears in spite of a long-term care setting or inside of hospice. Thanks to that nature. We also have things like condition specific for thing like back pain, cancer, headache, heel pain, dementia, post-surgery or pre-surgery pain assessment and the like.

Okay. So we also have pain score change which is a little bit different. We're actually looking at more of a whether or not interventions at leading to changes in pain over time. So not just whether or not did you evaluate those pain but is there pain changing and we have measures also around time to pain management. We've done limited measures in this domain or subdomain I should say.

Four measures and one measure concept total as total time lapse until pain is addressed or brought under control. We take quality of life and function it means precisely what you think would be that using some sort of quality of life instrument, are we assessing the impact of pain in the broader context of how the patient is experiencing their life.

And also we included in this kind of an artificial conglomeration of these two ideas. We also included measures around function. We did think that those two are related. And we often see that reflect in the side of the broader quality of life issues that crop up for the instruments you need to assess it.

Next up we have a pain care plan and within this particular sub domain, there was ten measures and one measures concept. As many of you are aware, pain care plan is simply a written document that a clinician has to assess pain and then look for ways to manage it longitudinally.

There was a lot of measures that were found in this domain there were specific two conditions. And also some they were setting specific comparable to the other domains around pain score change and making assessments of pain.

So lastly, we find these two sub domains related to prescribing alternatives they will do it first which was a smaller domain and they have nearly as many measures as this largest domain appropriate opioid analgesic prescribing where we found 46 measures and 35 measured concepts. They ranged over of a broad set of prescriber behaviors that included suitable dose of formulation, duration, avoidance of opioids for certain populations and a variety of other factors that come into play.

So it's also included monitoring of opioid longitudinally. So looking for side effects, adverse drug events, therapeutic concepts associated with the

utilization of opioids as well as some concepts around controlled substance agreements between the patient and clinician outlining goals of treatment as well as baseline behavioral expectations, okay, so that's Domain 1.

Let's go ahead and take a look at Domain 2. And this is the second largest domain. This is treatment of opioid use disorders. Within this domain, there were a total of 56 measures and 26 measure concepts and we classify those by four sub-domains OUD screening, OUD treatment initiation, OUD treatment continuity. And lastly, the psychiatric or substance use disorder co-morbidity sub-domain.

Now the first of this as OUD screening we identify 15 measures total and five measure concepts. We're looking at both the detection of the disorder in its early stages but also when a patient's OUD status might not be readily accessible by a clinician but using a screen to make sure that that's actually taken place.

For OUD treatment initiation we found 13 measures and 10 measured concepts. They're looking at both pharmacological and non-pharmacological therapies focused on OUD and appropriate response to OUD once it's been initiated.

Now this the third domain - the subdomain here as there are OUD treatment continuity we found seven measures and eight measured concepts. And this covered a fairly broad range of treatment continuity including follow-up post hospitalization using medication to support withdrawal for treatment responsiveness.

Looking at continuous assessment all the way from recovery and remission as well as relapses that can interrupt those trajectories and goals. So we're

missing a couple of things inside of - aside of this that the literature suggests should be present as well as the conversation that we've had with you where we identified this as well.

Looking for distinctions between remission and recovery as well as, you know, a review of potential opioid misuse that emerges or persists months or years after a medically indicated course of treatment has concluded. So the last sub-domain within this one is the psychiatric and substance use disorder co-morbidity for 25 measures and three measure concepts.

Now the psychiatric conditions included things like depression and suicidal ideation then concomitant use of other harmful substances, which often comes along with the use of opioids included alcohol or tobacco, which can be both precursors to opioid abuse as well as corollaries to their overall use.

It's something that we wanted to keep in mind when we're thinking about the overall treatment of individuals that have opioid use disorder thinking about their overall health, mental health and physical wellbeing, as essential components to helping them to transition away from opioid use disorder.

Okay. So let's move on to these last two domains. And these are smaller domains we didn't five nearly as many measures. The first is harm reduction. The limited number of measures in this domain we've only identified six measures and seven measured concepts inside of this domain.

As Michael mentioned traditionally when we say harm reduction, we're thinking strategically around options like safe injection size needle exchange programs and respiratory anecdotes to acute overdose such as Naloxone.

And so when we characterize the measures and again somewhat arbitrarily we put overdose and harm reduction when overdose of course is something that we need to keep in mind for both opioid use disorder measures could easily have fallen there, could also have easily fallen inside of the prescription monitoring longitudinally for the - there are first domain.

But nonetheless this is where we've categorized it and inside of these overdose measures are a number of metrics that are specific to care settings as well as some other measures around the utilization of Naloxone or its co-prescription that fell into this category as well.

Okay, so last domain is what we've turned social issues and perhaps not the perfect way of naming this domain. But we found a couple of interesting things that we would characterize under this particular heading.

The first was measures around violence where the Environmental Scan yielded two measures. One was a general health care screening for intimate partner violence and violence risk at an inpatient psychiatric facility upon admission.

So the interesting thing, sorry I misspoke is, one was screening for violence. When an intimate partner presents with opioid use disorder and the other was violence screening at admission to an IPS. So forgive me, sorry about that.

And then two more social issue related sub domains. The first helpless literacy where we found a single measure around health literacy and then overall opioid burden which was more a cost resource, overall economic burden type measure that we found in our literature review as well. Okay, so that’s our Environmental Scan in total.

One thing that I'll note is that specifically we didn't find too many measures around social issues that are specifically addressed the criminal justice involvement. So that's something to keep in mind as when we originally framed this problems and sets of solutions that could emerge from it. It's not something that we've found inside of the healthcare quality measurement space at all in our Environmental Scan.

Okay. So with that, we're going to transition to our discussion. I'm going to hand it over to our co-chairs in a moment and allow them to frame it up in more detail. But we're going to walk through each one of these domains and sub domains with some care and think about how we could potentially flush this out a little bit more broadly to the identification of additional measured gaps.

So big thanks to our co-chairs Jeff and Brandon. We're going to be spending a few minutes for each domain. Of course, it makes sense for us to spend perhaps a little bit longer on some of the larger domains but we only want to be, I guess we only have until 3:00 p.m.

Man: Right.

Samuel Stolpe: So we've got some time where we'll be able to work some of these. We're a little bit ahead of schedule so that's a good thing.

Man: Yes..

Samuel Stolpe: All right, so I'll hand it over to our co-chairs. Thanks Jeff and Brandon.

Jeff Schiff: Hello, everybody. Thanks for participating today. Sam and Michael, will you help us in timekeeping some version of this?

Man: Yes, you bet.

Jeff Schiff: So I think the improvement we have in our system is that both Brandon and I can see the raising of hands. And I think what we'll do then is we'll go through first with this, the prevention domain. I also want to tell you, there's been a little chatter on the chat box, I just want people to know if they haven't done this, all of these domains are really well outlined in the draft Environmental Scan.

So, I encourage you to open that up so you can look at the book as we go along as well. So, Brandon if this is okay with you I'm thinking we should start the talking about prevention. And I think we probably want to talk about the whole category and not try to go into our pain management rather and not try to go in…

Michael Ashburn: Yes pain management, that's right.

Jeff Schiff: All the subcategories at the same time. So, go ahead.

Michael Ashburn: And what we're doing, this is Michael NQF. What we're doing to assist you as a tool is (Weiss) is going to put up the spreadsheet that we sent to you all, which is, you know, a nice tool. If you haven't used it, you can sort right do various Excel functions.

You can isolate and she has already it's noticed under Column E. She's filtered for us for the pain management domain and then you see on the screen right now the first 30 measures are there but we can go and talk about specific ones. But more to the point here is that for each of these four domains and discourse of about 10 to 15 minutes each.

Well, the ideas for you to go through and to talk about, you know, sort of the general principles, are there areas of commission things we've included that we shouldn't? Are there errors of omission things that are missing that should be there?

And that's perhaps the most important thing we do, what are sort of themes that emerged that you think are important moving forward? Those kinds of questions are all fair game for us. And we'll be taking careful notes here and using it to inspire us moving forward to finish the Environmental Scan.

And of course, ultimately to generate a product that will be directed at CMS and more broadly about the opioid measurement enterprise quite broadly and looking into the future.

Okay. So, does that make sense? Ten to 15 minutes on each, and we will have the spreadsheet available in office. Anytime you want us to go to a cell or a row or a column or anything like that, we can do that.

Jeff Schiff: Right. Yes. So Michael, I think just to be clear though, I think and Brandon feel free to jump in, but we're concern that we don't want to get into a measure-by-measure analysis because we could easily spend an hour on…

Michael Ashburn: Yes, yes, fair enough.

Jeff Schiff: So simply into it, yes. So, Brandon?

Brandon Marshall: Yes. And if people have comments on specific measures, they can send that by email to NQF staff, I believe.

Michael Ashburn: Absolutely.

Brandon Marshall: Correct, Michael?

Michael Ashburn: Yes, absolutely.

Brandon Marshall: If you'd like to do line by line.

((Crosstalk))

Michael Ashburn: Yes.

Brandon Marshall: Right. And if you like to do, you know, line by line add up to the report that was sent out that's fine too. But we were really hoping to get a more global assessment of these domains, how they look, how we could empathize some, perhaps be priorities others.

Michael Ashburn: Good.

Brandon Marshall: So maybe Jeff we could open it up to the floor if there's initial reactions to the pain management domain. I don't see any hands yet. Oh, there is one. (Jeanine), go ahead.

Jeanine Brant: Yes, thank you. I think you've done a really nice job including so many tools in pain management and the challenge is that there are so many out there maybe that we haven't captured. And I'm not sure how, you know, comprehends if you want to make this list for example like things like a brief pain inventory.

And I've got my Excel sheet open here too and it's a question, so are these categorized according to the actual name of the tool, correct where it says measure title?

Brandon Marshall: Measure title is the name of the tool such as we couldn't tune it and usually there's a formal name like with NQF measures or CMI team measures. Sam, you want to comment?

Sam Stolpe: Yes, just as a point of clarification on this. So some pain management tools have been fully specified to be included inside of a quality measure. And some of them are still loosely defined as what we would categorize as major concepts. So when we're looking at measure inventory right now, what we have on the screen are actually the measure, fully fledged measures here.

We have some of the younger in coed measures that haven't actually been specified fully for use and accountability under a separate tab. And you're right also that at some point, we didn't, I don't know how many of them we may have missed. So if we did miss something in the measured concepts as well then please let us know.

Jeanine Brant: Okay. So yes, I'll send a few of those in first. Like I said though, like the brief pain inventory is probably the most globally used tool for pain assessment. And then there're some other pain care quality measures. There are also, I noticed in the scan, there was a gap in like arthritis measures, fibromyalgia measures.

And there's a couple of the (nal fascia) scan which talks about arthritis to the hand or the WOMAC (the Western Ontario and McMaster) Universities Osteoarthritis index that has pain measures.

But again I think it's pretty comprehensive. Maybe some gaps would still be measuring some pain care quality and then also shared decisions-making. We didn't talk a ton about shared decision making with pain management because that might be something that we could consider a gap.

Brandon Marshall: Great, thank you. And Michael, you're next.

Michael Ashburn: Thanks very much. One of the issues I'm kind of struggling within the broad area of pain management is what are we trying to specific? We measure in that some of the measures that are listed are inpatient, some of them are outpatient, some of them are related to the administration of opioids for immediate acute pain, some are related towards chronic opioid administration and some are outcomes of that process or outcomes of a specific surgical intervention.

And in order to try to make sense of the large spreadsheet going forward, at some point, there may be some value into thinking about the domains in terms or sub domain in terms of what are the specific areas that we're trying to assess and then using the measurement instrument if that make sense.

And because clearly there's lot of ways of assessing pain intensity that has nothing to do with some of the other issues related to opioid prescribing and setting are some of the performance measures that are being established for chronic or acute opioid prescribing. And of course the process measures for chronic non-cancer pain is fundamentally different than the use of opioids in the setting immediately after surgery.

Brandon Marshall: Thanks. I wanted to ask a question about this category if I could ask, I mean this will prompt some conversation. I'm curious about the, there's a

large number of pain functioning measures and as somebody who's dealing with the concerns about over prescribing in the Medicaid population.

I worry that if we have too much emphasis on these pain assessments without some counterbalancing, and maybe this is sort of a gap is sort of how to balance these measures against sort of a population-based look at total prescribing for providers because assessments of pain and how they're then subsequently used for opioids.

I don't want to reopen the door with this project to say to, I guess overuse of opioids because we are over emphasizing a pain assessment. I may get in trouble for saying that but I'm curious what others think.

Man: (Gorsuch) would you like to respond to that or do you have a separate comment?

(Gorsuch): Yes, I have a separate comment, but it could build on that a little bit, which is that just looking at the spreadsheet here, there're some confusing terminology where it measures the outcome but many of the communication about pain during a hospital stay. It's not clear to me how that's an outcome in pain management. So perhaps just some clarification on whether how we're distinction process from outcome.

But I think more importantly and I think this is building on the prior comments. I agree that it's not clearly what the goal of what we're trying to accomplish with the pain management measures are perhaps some rubric of that would be useful.

One could argue that a good rubric would be, are these measures is their strength of evidence of actually these measures or QI efforts addressed it at

improving these measures correlates with something meaningful such as, you know, better functional long-term status or lower total cost of care or something else along those lines.

And that might be a helpful way to sort of start to winnow down this long list of pain management measures. And this then clarify what you're trying to accomplish.

Brandon Marshall: Somebody's not on mute if you can hear me.

Sam Stolpe: (Gorsuch) this is Samuel Stolpe, just in response to your question around the categorization of measures and process or outcomes. I wanted to just mention around communication is directly derived from like a CAT survey. So because if a patient reported outcome and that it's included as an outcome measures.

Now some of them are grouped as processes because it's just a check the box. Well, as the pain assessment occur where it's not actually reporting the pain for.

So those would be categorized as process whereas others would, they would kind of fall into more of an outcome type category. But I'll leave it to the committee to address fully, yes larger.

Man: Just a note. So, please mute your phones if you're not speaking. Bonnie, I see your hands, if you'd like to react to the conversation.

Bonnie Zickgraf: Yes, thank you very much I appreciate it, I did. And thank you very much for putting all this together. Obviously, there's a lot of information on here and I appreciate all your efforts. Obviously, it's a lot of work.

I actually took and resorted looking for keywords in this particular domain for either patient teaching or patient education which it may be covered under the contract. There's a contract. There's a measure there for contract, but that would be kind of implied I guess under that or an assumption that that might occur at that point.

Am I looking at the wrong domain? Perhaps that's addressed somewhere else but I want to be sure that somewhere we're measuring what type of patient education we're doing even at the time that these are prescribed for short-term not necessarily long-term but for short term use.

Michael Ashburn: So this is Michael at NQF. So just a reminder right now the discourse is limited to the committee members. So I just want to point that out. But in direct response to the questions and the comments that have been shoot, I want to point out and remind you that the under pain management.

So this goes back to what Jeff Schiff asked about initially, you know, is there some concern that if you just measure pain, that sheet somehow open the floodgates again to an overuse of opioid analgesics indiscriminately to address that pain.

And I want to just remind you that in addition to looking at pain measures per se, patient reported or otherwise, there's also under this and there's a large number of measures that are under the rubric of appropriate opioid analgesic prescribing. So that appropriate point would include presumably and there's also alternatives to opioids as well. So both of which would presumably be important components of a rational approach.

It wouldn't necessarily, for example, use opioids as a first line therapy for chronic pain treatment or even for some acute indications as well. And then there's also the pain care plan sub component as well which talks about educating this.

So for this last comment that we just heard impart that confounder that, educating the patient to consumer about the risks and potential benefits that go along with any kind of pain management and of course, in this case, especially including opioid use. So I just want to point those out.

Bonnie Zickgraf: Thank you.

Jeff Schiff: Jeanine?

Jeanine Brant: Yes, I just wanted to comment to whoever talked about, you know, the assessment and really kind of concerns that we're going to go down the same path. And I think that that is definitely something we need to balance. I mean, even as a pain practitioner, you know, we were so focus on 0 to 10 scales and decreasing those.

I think really focusing more discussions on and having measures on function is going to be really important. One of the things when I came to this organization, they had the 0 to 10 scale posted and they are all the numbers were listed with function like 10, you know, you're basically are going to pass out, you know, things you can't concentrate on it, try to quantify the 0 to 10 scale basically.

And I asked, "You know, well, where did you get that? And is it validated?" And of course, they said, "We made it up". And I said, "We can't use that. We don't have a validated tool" but I think that does speak to trying to

provide some context to the 0 to 10 scales that's missing from the literature. And then again to focus more on functions, measures in our approach in how can we combine those. It's just something to consider.

Jeff Schiff: (Jeanine), I'm curious if there's a balancing of measures of pain assessment with other measures, like I think Michael said non-opiate pain control appropriate prescribing so you could actually have some appropriate balance use. You wouldn't want to go out with one set of measures alone but could balance those against other measures, maybe a function maybe of other use or just a sort of a practice base population level look at prescribing.

Jeanine Brant: Yes, I think that's important too. I know when we did our study of pain care quality in 326 US hospitals, we asked questions about non-pharmacologic techniques, non-opioid measures. And the non-farm stuff was the lowest scored items in terms of weather, even nurses offered ice, heat massage alternative things.

So I think that we could do a better job by thinking of more of that most multimodal approach. And like I said, even and I didn't share my pain care quality tool off. I'll send that forward because that could be modified with, you know, some consideration to other multimodal measures strategies.

Jeff Schiff: And Katy Jordan.

Katy Jordan: Hi. Yes, as an occupational therapist that's all that I use are functional pain goals and outcome measures or function. And so I had emailed in a few different ideas of measures that could be added but I don't see them on here. So I can send them again. But, you know, I had included, someone else had mentioned the brief pain inventory

I also had included the pain self-advocacy scale, the functional pain scales and debilitating questionnaire, Oswestry Low Back Pain Disability which looks specifically at self care and ability to engage in different ADLs or IADLs. And then I also added the functional capacity evaluation

So those are the measures that I use the most because that's what I'm working on but I didn't see them added here. And so I think that might be why there, it looks like to be some things missing around functional capacity.

Jeff Schiff: Yes, this Michael at NQF, thank you for that. Please, if you don't mind push it to us again, but it's we've noted it as well. So thank you for noticing that.

Katy Jordan: Okay.

Anthony Meoni: I'm Anthony. Yes, someone was bringing as well in support of the idea of looking at functions and probably give a terms that I haven't heard very much as the whole concept of pain interference. We use that concept a lot in evaluating patients with spinal cord injury pain and know that there's very poor relationship between functional improvement and traditional pain scores.

So we look at pain interference and some of these functional outcomes like Oswestry and certainly using patient-centered outcome measures would certainly be appropriate. The other area that I think that could be more robust is looking at measures of centralized pain, which would be measures that would really direct us away from opioid management and towards more of a multimodal treatment.

So having a good documentation of the centralized pain symptomatology would be helpful as part of this work.

Jeff Schiff: So, Michael at NQF here, please just define for us a little bit more what you mean by centralized pain.

Michael Ashburn: So somebody talked a little bit about Fibromyalgia as an example, but it's just one of many pain conditions for which there is good evidence for central pain modulation that's occurred whether it's fibromyalgia or complex regional pain syndrome or patients with a failed spine surgery syndrome. But we also find patients who have an initial nociceptive cause of pain such as osteoarthritis of the knee.

And many of those patients who are refractory to treatment as it turns out have pretty strong centralized pain features to their ongoing pain issues or those patients don't respond well to opioids, but do respond more to more multimodal treatments.

So having us measure that as a counterbalance to just measuring pain and measuring response or lack of response to opioid would seem to be a bit more directive towards pushing us not just away from opioids as the treatment but pushing patients towards more appropriate treatments to the actual underlying pathophysiology of their pain problem.

Jeff Schiff: Yes, forgive me. So Michael again, just for perhaps I'm not even asking this but by centralized pain, do you mean pain that's not focused on any particular part of the Soma? Any particular part of the body? Is that what you mean? Fibromyalgia might be nociception all over the scan or is that what the term refers to?

Michael Ashburn: I think that's what people feel most comfortable with. However, we have also discovered that there are patients who started off with most nociceptive pain

problems such as osteoarthritis, who then go on to develop more generalized pain conditions.

And again, there are specific both psychological and pain major characteristics of those patients that make them unique in developing, you know, using measures that we have available now but also developing better measures to identify these patients would allow us to better identify them and direct their treatment accordingly.

Jeff Schiff: Okay. So thank you for that and I'll look into it a bit more and make it back to you for more clarification. So Michael here, so we should probably transition to the next domain maybe another minute on this. puffball

Man: I'll look into it a bit more and make it back to you for more clarification.

Michael Ashburn: Sounds great, thank you.

Man: So Michael here, so we should probably transition to the next domain, maybe another minute on this domain and then transition to the next one, Jeff and Brandon.

(Crosstalk))

Man: That's right, I just want to – yes, I just wanted to highlight couple of excellent comments in the chat. One suggestion is to look at assessment interference and pain function is within one sub domain. So there's less explicit emphasis on assessment and can include sort of the broader functionality that we've been discussing.

And the second comment is to draw attention to the HHS Pain Task Force report, which was published last week. So, thank you Ellen for that comment as well and the link is in the chat if folks would like to go to that.

I have one more question for NQF staff if you don't mind Sam and Michael, were you able to - it's along the lines of appropriate opioid prescribing, were you able to cross check these with the CDC opioid prescribing guidelines? If so, did many of the recommendations in that report get captured here or were there's differences?

Michael Ashburn: Terrific question and the answer to the question is yes. Many of them did crosswalk directly with the CDC's recommendation. So in fact, there was - I couldn't actually identify any of the recommendations inside of the CDC set that were specific to prescribing that weren't captured inside of either the concepts or the measure inventory.

Man: That's it for me. I will pass.

Man: I think we are okay to - if everybody's okay to move on to Domain 2, which is not a small domain. And it's that treatment of opioid use disorders and I'll just remind folks that the subcategories that the interior folks happily described are OED screening treatment and initiation treatment continuity, psychiatric and SUD comorbidity.

So we'd welcome discussion. Really, I think we've had this kind of merge discussion about omission and commission. So I think we could have both at the same time. Anika?

Anika Alvanzo: Hi. Yes. So looking at this domain, one of the things I did not see was something about concomitant screening for conditions that are associated with

opioid use disorder like HIV screening, Hepatitis C screening in this patient population.

Man: Okay. So, is that – Anika I'm just curious, is that in the screening part of this do you think or is that really after around OUD treatment initiation to make sure that people are being concurrently treated or both, maybe?

Anika Alvanzo: I would say definitely treatment. I think if you don't have the presence of an opioid use disorder then you - that this may be less relevant. But certainly, if an opioid use disorder is identified, then we should be assessing for this potentially comorbid conditions in those patients.

Man: Thanks.

Michael Ashburn: Michael at NQF here. So we will - it should - in our minds it should fall into that screening as well. We agree with Anika and (Ranika) I think (unintelligible). And we agree and we are looking we'll make sure that if it's not there is a measure that it becomes then either a concept of inadequate measure if we find one, which presumably we will or an idea.

So it definitely noted and we agree and certainly there's I can think of a couple of references just off the top of my head that would support that approach.

Man: Caroline?

Caroline Carney: Hi, I'm wondering if it's a function that I can't see down the whole list, but was hoping to see a measure here for PTSD as a comorbidity? As you never comment comorbidity with…

Man: Yes, sure. Back to scrolling it now. Anxiety disorder if it's done with depression and stuff. We will look for that one as well. We agree.

Caroline Carney: Thank you.

Woman: As you were scrolling, I thought I saw something in 57 that said trauma just briefly. But I find 57 I thought, maybe.

Woman: Yes, we can make sure to look later to make sure we have captured those. If not, we can make sure they are included for future references.

Man: Yes, 56?

Woman: I think we can move on to the next section I want to be mindful of that as well.

Man: Yes. So trauma somebody else noted and we are noting as well.

Man: Can we call out in this section probably under screening and treatment continuity around treatment of screening for pregnant moms, for opioid use disorder and then treatment continuity, both during pregnancy and after delivery?

Man: Yes, pregnancy perinatal.

Man: I don't see - I didn't see anything on those.

Brandon Marshall: Very good. Noted.

Jeff Schiff: Are there folks on the treatment?

Brandon Marshall: Perhaps to prompt some discussion on Jeff, I might mention I've seen some literature around developing a continuum of care for opioid use disorder and identifying methods that are then attached to that continuum.

I'm wondering if people have seen that literature if they continue to be useful framework for deafness. So if there's metrics that then are attached to each part along the care continuum diagnosis initiation retention and so forth. I think we've captured most of that maybe implicitly or explicitly. But it's – if we are missing something that would be great to hear from the committee.

Michael Ashburn: Yes, and this is Michael at NQF. So from our experience, I think the longest follow-up measure in this is a 180 days of continuous buprenorphine or methadone treatment. But generally speaking, even the follow-up measures in this area and this is true behavioral health issues is more broadly, perhaps of other issues, but I can comment on those specifically.

The follow-up periods usually are, you know, a week after discharge up to 30/34 days after discharge to allow for medication refill that kind of thing. But you don't see perhaps, there's almost certainly for pragmatic reasons, you don't see long term, you know, years after initial treatment follow-up to see how people are doing very typically.

So that's like almost the general theme across measurement but certainly evident here. So that makes it difficult to do assessments about, you know, how people do in the long term to global fund.

Brandon Marshall: Looks like we had some hands raised. Arthur, I believe you were the first.

Arthur Robin Williams: Hi there, thanks. So I first raised my hand in part to make a point, but now that you are asking about the calculated care for the opioid use disorder treatment, that's where a lot of my publication is in the last couple of years.

So I do think there's a lot to be said in terms of prioritizing measures to emphasize the central role. You know, if you look at the evidence, they sort of reduces return to use, active use, daily use but reduces overdose -- rates of overdose events that reduces acute care service utilization and reduces mortality, whether overdose or other causes of mortality.

It's really not an issue, you know, MOU, you know, medication, initiation and successful medication retention. And so, along those lines I think it is very compelling to think about measures that - in development that work as a set that helps suffer people successfully from one sequential stage to the next.

And there can be a little bit of nuance and I think, you know, looking through the attachment and now on the screen, you know, there are several versions of this idea of, you know, medication initiation or different kinds of retention. You are talking about the six months. And the - so, for instance, one of the measures that's recently been developed, the NQF endorse for the 180 days.

My understanding and this is - and I looked at it for couple of months. But for instance, that's worded in a way where - what they are - I believe what's being assessed is among people who received a medication like buprenorphine in a given measurement year. What percent of them are continuously receiving the buprenorphine for 180 days with no more than a seven-day gap?

And we've interpreted that a little bit differently that seven continuous day gap or over the course of 180 days. Are there seven or more days even if it's

not continuous at any point during the 180, where someone is not continuously covered by the medication?

And so I think that's going in a useful direction, but there are plenty of reasons clinically, right? I won't translate well, it might be misinterpreted. And I think this is something where there could also be some important idiosyncrasies between different medication approaches.

For instance, you know, with extended release Naltrexone being administered as an injection every two, three, four weeks, something like that versus a sublingual Buprenorphine product of whatever sort that theoretically would be taken on a daily basis. But where we also know people might fill a quantity of 60 for a so-called 30 day supply.

But in reality, the provider and the patient are both on the same page. And the patient may actually sold that knowing that it's going to last for well, more than 30 days for various reasons. So I think there's a lot in this area and part of, I just - it's that I don't talk too much.

One other thought is that especially around psychiatric comorbidity, which I think is so important, that we also know that a lot of symptom burden presentation, once people are successfully started on Methadone or Buprenorphine or whatever it might be. A lot of that symptom burden can go away.

And that there should be some sort of nuance or caveats in the measures that is aware of this. So that, you know, it wouldn't necessarily be superior care for someone presenting for treatment, who's depressed at the time to be started on an anti-depression just speaking broadly.

If it were the case that that patient or those populations within a, you know, few days or weeks of starting a medication, methadone view, whatever it might be. For the depression to no longer be present, in some ways it reflects more of something along the lines of a substance-induced mood disorder or at least the secondary to opioid use disorder.

And this is something that's been reproduced over and over in the literature that one of the most effective ways to treat, what appears at first is psychiatric comorbidities actually just getting people on the medication for OED treatment. So that's where I'll stop for now.

Brandon Marshall: Great. Thank you. Let's see, we have - I believe there's four Sarahs on the line and one of the Sarahs has their hand raised. Can you identify yourself, Sarah?

Sarah Wakeman: This is Sarah Wakeman.

Brandon Marshall: Great.

Sarah Wakeman: One of the Sarahs. Yes, great points that were just made, I think that was by Arthur. Just to highlight, I think one thing I reflect on looking at all of these measures, again like the pain measures, there's a lot here.

And so part of my question, I think is, how do we focus this work and sort of what our goal is in moving the measures forward.

Also lot of the measures focus on sort of outdated approaches to care. So for example, several of the sort of engagement and initiation measures start at the time of detox when, of course, we now know that detox is not really an

effective intervention for opioid use disorder and in fact, can be quite harmful and not necessary.

And so, how do we think about choosing measures to really match what we know now in 2019 about opioid use disorder care. It was really the focus being on sort of long-term chronic care management. And this concept of cascades of care as mentioned with screening.

Treatment initiation and treatment retention and clinical outcomes from a lot of HIV care and with medication for opioid use disorder being the backbone.

And I totally agree that the measures are all too short that everything we know from studies on medication for opioid use disorder is that pretty much every study where people come up with medication before a year of treatment, relapse rates are exceptionally high. And so they have no measures that stretched beyond 180 days, I think really misses the goal of long-term retention and care.

Brandon Marshall: Great. Thank you. And there's actually two comments in the chat that are related to your point Sarah. One is from another Sarah, Sarah Duffy who mentioned there may be missing measures on adequate dosing for people working in methadone and measures related to face induction, which I think are excellent points.

And then Bonnie also had a comment about measuring rate of relapse related to long-term retention OUD. So thank you for those comments.

Jeff, why don't I turn it over for you - to you to handle the next couple of questions?

Jeff Schiff: Sure. I just wanted to make one quick comment too about the continuity. The measure of 180 days continuous treatment there's a group that has been looking at altering that measure to look at 90 days, 180 days and 270 days to basically see whether or not there's, you know, you would think that a system that was perhaps running a better continuity operation would have less drop off, perhaps in that situation.

But I'll - this is my comment. I'm going to turn - I think (Jeanine) is on right now.

Jeanine Brant: Okay. Thank you. So couple of measures I thought about that incorporate some comorbidities is the opioid risk tool that could be included in the (unintelligible) forward dose. The one piece missing is possibly competency and we talked about this earlier as far as decision-making capacity of patients with substance use disorders.

And, you know, it's just starting to be touched on in the literature and we might want to think about that.

I also liked a lot of the comments about, you know, some of the clinic measures. And I wonder there's, you know, as clinics are getting programs into place, Michael Parchman has a program he's from Keiser University, Washington on Six Building Blocks and it's really about quality initiatives, you know, which you have opioid agreements in place.

What's the average opioid equivalents per patient? What about urine drug testing? You know, what kinds of clinic measures do you have in place to safeguard patients in the system bowl? So, something to think about.

Michael Ashburn: Very good. This is Michael at NQF. I just want to gently suggest that we are taking maybe another one or two minutes and that's it, and then we move on to the next domain. So, otherwise give it back to the chairs.

Jeff Schiff: Everybody's sitting on their hands. Brandon, you want to introduce the next one?

Brandon Marshall: Excellent, thanks. That sounds good. So, let's go to harm reduction. Great, so many fewer metrics here to discuss.

You know, one thing that I would note here that confused me a little bit speaking to Sam and Michael and NQF staff. I think the instance is that, we also see here measures, the key outcomes like emergence of pertinent utilization for opiate overdose stuff, grouped under harm reduction because it's quite proximal obviously to the actual events and the reversal of that event through some of these interventions like Naloxone.

But as I think Michael mentioned at the beginning, the domains here are not so critical to putting EDUs for opioid overdose under harm reduction or overdose death under harm reduction isn't so important for these purposes. Is that correct Sam and Michael, would you say that's an accurate assessment?

Man: Yes, thank you for that point of clarification. That was an important one, given that harm reduction covers the things that's related to interventions. So with opioid overdose, we kind of ran into a bit of a sticky wicket and figure out exactly where to fit it.

So we admit this is maybe a little bit artificial for a group to make it here, but for the purposes of a discussion, it's super critical.

Man: Great. So we have one chat that might help to provoke the discussion. A committee member says, how about measures regarding harm reduction and just how do we use that safely for people who are not ready to enter treatment?

So I think that might be a nice identified gap there in measuring health for people who are not engaged in treatment.

Anika, would you like to respond to that or do you have a separate comment? I see your hand is raised.

Anika Alvanzo: No, that's exactly what I was going to say. I don't know if that's just like that exists. But documentation of education about how to use more safely for those people who are not yet motivated to stop using. So, exactly that, how to be safer.

Man: Other measures I'd seen before are around coverage of harm reduction services. Syringes distributed for some denominator. For example, it has been used internationally to compare coverage of harm reduction services for people who use drugs. So that might be a potential measures down there Michael, I'm not sure.

Michael Ashburn: Yes, Michael is here. I was going to say one thing that didn't make the list because maybe it's quite new is, like fentanyl test strips that kind of thing didn't make or - we didn't find anything like that.

So something that would help somebody test the purity of their substances they were using (unintelligible).

Man: (Jeanine), I believe you are next.

Jeanine Brant: Yes, one of the frustrating things about looking at emergency department data is the lack of detail with prescription opioids. For example, you know, are these opioids, was it an overdose because they were prescribed and they took too many or was it a stolen opioid?

And even with the CDC data, I don't think we have a really great, good idea as far as how many of these prescription opioids are used by the individual it was prescribed to versus if they stole it or borrowed it or something like that.

So finding more of the opioid measures around that I think is really important.

Man: Excellent. Thank you. Other comments or thoughts? I have a question perhaps for the Committee at this, any knowledge of measure related to the Naloxone distribution or administration? I think I'm only seeing maybe one on Row 45. My sense is that there may be more measures related to Naloxone out there.

Perhaps not, so perhaps that is like…

((Crosstalk)).

Man: I'm wondering, right now I'm wondering if the use of the height of data, the over - the EMS and police reporting is on here anywhere or if that where people would find that relevant. That's the sort of those folks who can - there's a web – a mapping web app.

Michael Ashburn: I was going to say, this is Michael at NQF. So, we do know about that. I've actually met those folks and they do real-time collection on like EMT cellphones and they track prosecutors of overdose and stuff and it's a big data

and you know, a new big fast data kind of notion. So I think it's worth it and I'll certainly - I have a link too with that, we'll try to at least point out in the next draft of the report.

Man: Great.

Man: This is (unintelligible), can we talk - there was a question about the Naloxone prescription. Is it relevant for us to think about Narcan distribution from hospital setting or from any other setting?

So prescription is one thing but prescription requires follow-up action and can potentially have a cost associated with it, which then reduces the, you know, Narcan acquisition, it could be anything less than a 100%. Whereas, if you give a kit to someone, if you give them a Narcan kit then there's a 100% certainty that they receive that kit, should that be a measure? I'm curious.

Man: I ask also there should be something associated with that of who gets trained to use it because…

Man: Yes, good question. It's simple…

((Crosstalk))

Man: Something that's worth tracking for sure.

Man: Yes. And I just feel like we are worried that we can give the prescriptions of the kits. The kits are better, I understand what you are saying but we need to make sure that somebody who will, by definition, is that something you can use yourself, you know. Michael?

Man: This is (unintelligible). With regard to Naloxone measures, we have an institutional measurement that conforms with CDC guidelines that are looking for the percent of patients who have NED or morphine equivalent, daily prescribed dose greater than 50 milligrams and that have been co prescribed Naloxone.

And so we do have a performance measure that we have as an institution. And similar to say, the state guidelines have advocated for that to be a performance measure the patients who have concurrent respiratory compromise or (unintelligible) or have morphine dose greater that 50 should be co prescribed Naloxone.

And then that lends itself quite nicely to a performance measure that can be tracked. We also have an institutional requirement for patients to receive educational material on how to properly use store their opioid medications, including how to use Naloxone.

Man: Excellent. Thank you. Caroline.

Caroline Carney: Similarly, we have a performance metrics around contacting members and providers for members who are on high dose opioids, who has been notified that they should also receive Naloxone and that Naloxone was dispensed.

Man: I wanted to reflect on one. Yes, I wanted to just reflect on one comment in the chat, you know, we've been tracking ED rates for opioid overdose in Rhode Island and can be hard to interpret that data, in some ways we want it to go off. That actually represents an opportunity for intervention and that may indicate the success of policy changes such as Good Samaritan Law encouraging people to call 911 in the event of an overdose.

And so, one chat here which we have found to be more helpful are looking at measures related to services provided in the ED post overdose direct referrals to treatments to this committee member mentions post discharge. Will you do medication? Those thing initiation, that ED and provision of other services counseling, peer recovery support services like (unintelligible) care access.

And I would agree with that comment at least found tracking those more helpful than the absolute rates of ED visits for overdose.

Brandon Marshall: Okay. Brandon. I just want to ask the NQF staff just one question about the - that's in the draft report there's a number of references to a safe injection sites and also comments on their legality in America.

And I'm wondering if folks here feel like that is, I mean, I think that, you know, there's certainly some data support. That I'm wondering if folks here feel like a measure of the availability of those is something that should be worth that it should be on here in a mature if it is in a specific line or not.

Sam Stolpe: So, this is Sam at NQF. We've just mentioned that as part of a, referring to the broader literature that's called attention to that fact. Of course, there are no measure concepts or any measures inside of the inventory that reflect that directly.

Brandon Marshall: Okay.

Sam Stolpe: I can certainly ask my Canadian colleagues if there are measures and metrics related to supervised consumption service delivery.

Jeff, do you know there are guidelines that have been published for the implementation of such facilities? So that that may be helpful. I can send that

along to the NQF staff to have a look at anyways, if that were to be published in the report.

Jeff Schiff: Yes, I mean, it's already in there. So I think we ought to maybe embellish it with those - that information if it's available.

Sam Stolpe: In detail. Yes.

Jeff Schiff: Yes.

Man: That's great. I don't think we are seeing anything else on the harm reduction side. So Michael and Sam, should we go on to the last category?

Michael Ashburn: Yes, that's great. Perfect.

Man: Okay. How we doing for timing? You guys are good?

Man: Yes. --schedule, you got 15 minutes for this part and then we'll go into the public comments right on schedule.

Man: Yes.

Man: So this is an interesting category I think and the one that, you know, I guess I would say, so the category around social issues. We call the social risk factors in Minnesota, we've called them social disparities in the past but some of our communities have wanted to use them as a respecters rather than a disparity, which sounds more permanent.

But either way, I think that there's three things that are in here right now violence, health literacy and opioid burden. And I suspect that there's, you

know, depending on how small or big we want to draw the circle, there's a lot of other things that could potentially be included. But I'm really curious about people's feelings about what's on there now and whether there are other gaps to fill here. Anika?

Man: I believe we see one here.

Man: Yes, great.

Anika Alvanzo: This is Anika. Again, I think some of this speaks to the lack of longitudinal measures but I mean, when we are looking at treatment specifically, we are looking at all domains of recovery. So in terms of reduction in criminal activity, return to employment, reengagement with family and interpersonal relationships. So I don't see anything related to that.

Man: Anika, can I just ask, you know, this is almost the other side of this and it's looking at folks who were treated around the time of ours, diversion to incarceration and the recidivism rates. I know we've started to look at this in some of our counties. It's sort of the, how will I say, the flipside of more involvement in family but it's sort of an easier thing to track maybe.

Anika Alvanzo: I'm sorry, were you asking with that also be something?

Man: Yes.

Anika Alvanzo: Yes.

Man: I'm asking if you would consider that serve in the same category because I think it's an easier measure gap to potentially get at.

Anika Alvanzo: Yes, I looked into that in a comparable category.

Man: Okay. Great. Thanks. Patty Black.

Patty Black: Hi, I don't know if this fits or not but under opioid burden in my state of Oregon, if folks are having trouble because of the economic burden with that classification of drugs they are turning to Methamphetamines. And I didn't know if there was some sort of measure available to ascertain, you know, how much that was happening?

Man: Thanks. (Jeanine), I believe you are next. Do you have a comment (Jeanine) or was that sort of that you were already?

Jeanine Brant: I'm sorry, I was on mute.

Man: Okay. No problem.

Jeanine Brant: No, I just agree with the comment about the state of Oregon because we are seeing the same thing in a lot of our chronic pain patients who were on opioids. We had a pain clinic in town and many of them were stopped abruptly and we are seeing a real increase in Methamphetamines use in those patients who used to be on chronic opioids.

And so, yes the whole balance is that. And we have a Community Opioid Alliance where we are trying to look at some community issues and we are even talking to our corners. And I don't know if you've had a key informant as a corner. But they really have an understanding of, you know, what they are seeing too with overdoses in the homes and the circumstances around.

You know, some of those gaps that we don't always have all of the data on sort of trained to understand things from multiple perspectives.

Man: Yes. There are some comments in the chat here that I think are interesting from, I think it's on, you know, including looking at child abuse and elder abuse and also looking at access the court appoint in drug diversion programs.

So I think some of these are population-based alternatives, but I think there are important concepts looking at the – I mean, this could be either the co occurring social risk or it could be perhaps looking at improvement with treatment of some of these things as well.

And Caroline, you are next.

Caroline Carney: If this measure - if we are discussing social determinants as part of what's on the screen right now, I think it may be beneficial to add a screen for social determinants of health or at least to measure whether or not decodes are being coded as part of a claims analysis.

Man: Right.

Caroline Carney: We have decodes available for housing, environmentally compromises housing, food insecurity, transportation and interpersonal violence, economic difficulties and lack of social support.

Man: Yes that would be really interesting just to even start to measure the use of the Z Codes because I think they need to get brought up.

Caroline Carney: They are very important in supporting an individual thing in treatment so I think it's a critical component.

Man: Do you know if there's a code? One of the challenges we have, I'm just curious, do you know if there's a code for no risk factors and nosey codes to report?

Caroline Carney: I do not know that.

Man: Because I think one of the problems is you don't know whether somebody for failed to re thought about it and there was nothing to report or and that may be a gap too that there's no identified, which would be rare but no identified respecter.

Caroline Carney: There are guidelines from ICD 10. So I can take a look to see if that's there. So for instance comments I wanted to make was along the lines of the comments of methamphetamine. So think if you look at death curves coming out of national and state-based data, you will see a rise in deaths related not only to benzos, opioid, fentanyl, opioid. But now to cocaine and methamphetamine becoming very common.

The state of Arizona tracked this information daily and has a dashboard, a daily dashboard adapt. And drugs that are found here (unintelligible) methamphetamine, cocaine in addition to benzos or fentanyl.

Man: Yes I think there's probably some state work that needs to be done around, you know, I don't know whether all, you know, treatment sites for example, you know, they have primary substance. But unsure to me, you know, better than I do about whether they have sort of how many secondary substances that are listed on there as well.

Man: I heard a committee member mentioned housing, that's social determinants that I don't see well represented on this current list. So that might be a gap. One measure we started to use here and what I will start to track are both the number of people accessing certified recovery houses and then the percentage of those who achieve are placed in permanent housing after they leave recovery houses.

I'm not sure the extent towards these programs are nationwide. But that's one way we've tried to start getting a handle on the social determinants of housing and homelessness.

Michael Ashburn: So this is Michael at NQF. So I just want to suggest that - a couple of you mentioned dashboards, one of you mentioned Z Code lift. Encourage you after this meeting if you can to push us an email at opioids@qualityforum.org with links to those sorts of lists or you can point us especially to – if there's a public dashboard that you can point us to.

Then we'll take a look at it and add it to our inventory perhaps under concepts or if they're bona fide measures, we'll put them under measures. But I want to encourage you to connect the dots for us as you have a moment to do that. Good. Good and we just got a list of Z codes from (Jay). Thank you for that.

(Jay): Oh, great.

Man: Yes, yes.

(Jay): Nice.

Caroline Carney: Jay, you beat me to it. This is Caroline. I can't find the Z codes for no, the lack of any social determinant.

(Jay): Yes I think, I'm just trying to figure out the right mechanism to say somebody was screened and found to be negative versus not screened. Okay, good.

Man: It sounds like that. Maybe Jeff, are there any final reactions or comments?

Jeff Schiff: I want to thank the NQF staff for doing a lot of listing.

Man: Okay, pleasures all mine.

Jeff Schiff: I'm curious though, I think there's some people who have some more things they'd like to get on the list. And then there are, and I'm sure you're going to talk about this, but the next part of the process for this.

Michael Ashburn: So this is Michael, I'm going to hand it off to (Weiss) (unintelligible) at to the moment. But absolutely there are different ways you can reach out to us. You can take the report and you can redline it or put comments in there and send it back to us with a note. You can just send us an email with a note as well.

And of course, the more specific you can be if you think it's obscure and if we're going to have trouble finding it, just give us a little additional leads as to where we might find a dashboard or a measure if you want to send us even a publication or something like that. The more you can include to help us find that would be much appreciated. So we welcome that.

Of course, you can call us as well directly and we can, we're happy to talk to you about this. Especially this particular report, we're going to be working very hard over the next couple of weeks to finalize it and get something really that's quite readable, tells the full story and then gives an organized list of

measures that we can use moving forward for the subsequent meetings leading into the conclusion of this particular measure focused capital.

So with that I'm going to, unless anybody has any questions I'll hand it over to (Weiss) to open up public comments and then to close out our meeting.

Man: Hey Michael, I just had one quick comment. Could you give us a deadline or a timeframe to get comments back to you.

Woman: We'll send an email after the fact with the deadline. We do need start finalizing the report and the measures but after this, we'll give you a strong deadline. Thank you.

Man: Perfect. Thanks.

(Weiss): Hi everyone, this is (Weiss) from NQF. I am opening the call for public comment and for the opioid technical expert panel for Webinar 3. So if you have any public comments, please speak soon or you can provide your comments through the chat box. So thank you. So the best option would be to raise your hand or chat us.

But if you are not using the webinar and you still want to make a comment, you can definitely speak up. While we're waiting for those public comments to come up, we can talk about next step. Patty? Patty, did you raise your hand by accident maybe?

Patty Black: Yes. Yes, I did.

(Weiss): Okay, all right.

Man: We had a comment from Sally E. Turbyville.

Sally E. Turbyville: Hi. Yes, this is Sally. Can you hear me?

Man: Yes. Thank you, Sally.

Sally E. Turbyville: Wonderful, thank you. And thank you to the technical experts panel and NQF staff for really covering a lot of ground both in the report and the compendium as well as on today's call. One of the things that we would like to see more attention paid to explicitly throughout is neonatal abstinence syndrome and maternal care related to opioid use and abuse issues.

And if those areas in the mind of the tab are implicitly covered, it would be really important to tease that out. I'm sorry, if the report and the measures presumed some kind of implicit covering of these important populations that are very vulnerable, I would hope that we could figure out how to tease those out a little bit more.

Now, looking at measures themselves, I'm not sure how or being a clinician, I'm not sure how much different measures need to be in this space other than it is critical that children born with neonatal abstinence syndrome as well as moms who are pregnant and after they have babies require treatment screening and ongoing recovery care.

I'm happy to share any literature that we have as well as measures that we know that are in use but perhaps not standardized. I don't know where you would put them on your compendium. So we're more than happy to send those along for your consideration if they were missed. And again if there's a reason for them to be missed, we would really recommend that the report be a

little bit more explicit about these two populations. And thank you very much.

Samuel Stolpe: Sally, this is Saml Stolpe. Well, thank you very much for your comment. Just a quick follow-up question, could you tell us what organization you're with please?

Sally E. Tubyville: Apologies. I'm with the Children's Hospital Association.

Samuel Stolpe: Oh, wonderful. Well, we would very much welcome some of the literature that you referenced in your comment. And I appreciate you being so conscious about this issue. It's one that's really important to us as well.

Sally E. Turbyville: Okay. Yes, I'll just circle back and we can go from there and I can send on what you think is helpful.

Samuel Stolpe: That would be terrific. Thank you.

Sally E. Turbyville: Thank you.

Samuel Stolpe: One of our recognizing that we're in public comment, but one of our committee members, Laura Porter has offered to give us a little from the patient perspective. Laura, did you have a comment you wanted to share?

Laura Porter: Yes. Thank you very much. So I think that a couple of things came up for me when I was reading through the draft report. So the issue of, you know, using diagnosis as a basis for guidelines I think that, you know, one of the problems was saying, okay, people with X, Y and Z shouldn't get this amount or should get this amount.

And I know that that's not our main focus here but I think that part of that is, you know, the co-morbidities involved. I know several people that have been on long-term opioid. I'm a Stage 4 colon cancer survivor and very active in this Colon Cancer Community, and I'm a physician also.

And so a lot of the people that I know have been on long-term opioids and they've been having trouble getting their opioids. And so if somebody else said that, you know, just being cut off is not going to help. And so I think that I stress this, I think one of the first or second time that we had a call, but safely tapering them off, safely tapering people off of opioids even if it's for a short period of time.

I'm not exactly sure what the window would be but I think that, you know, that there needs to be some a system in place that if somebody is going to go home after a surgery on an opioid. There needs to be a discussion and a plan to do that because I personally had to take myself off of them several times after being on high doses post surgery and it's definitely not fun. So, anyway thank you.

Samuel Stolpe: Thanks very much for your comment. So I see there's a public comment from (Ellen Blackwell) suggesting - okay so there's a comment Black. You want to say something?

Okay there's a comment from (Blackwell) about including a 1115 Waiver Medicaid waiver measures on the list and that's a fair comment, we'll have a look at those kind of reporting for that managed care waiver, which is probably pretty prominent and pretty important CMS.

Reminder that the part of what this TEP will do after the Environmental Scan is make recommendations about what measures should be included for certain

federal especially Medicaid, programs with Medicaid programs as well. So we will look at that and then we received a comment from, I believe one of our liaisons about Hep-C and HIV gave us a reference to a May Health Affairs article about that important comorbidity. So we appreciate that and we will look at that as well.

(Weiss): Okay, we will now jump into next steps. But if people have any more, please feel free to raise your hand and we'll make sure to capture them. So I think our next step would be our 50-day comment period. We will get the report posted on July 12 so we do have a little days away.

We receive all your comments and incorporate them within the report. Our next web meeting is actually in August. So we have couple of months where we hear from you all, but we do hope that we hear from you guys by email or phone call.

And once again, here's our contact information the opioid@qualityforum.org for all your feedback. I'm handing it over to Sam for any closing remarks.

Samuel Stolpe: Well, it just remains for us at NQF staff to offer a big thanks both to our co-chairs for leading the discussion and to each of you both on the committee as our federal liaisons and those members of the public who are kind enough to generate your time, expertise and well thought-out comments as we strive to capture a very broad amount of information.

And we look forward to hearing more from you. If you have some things that you feel like we've missed or as you review this carefully in light of the conversations that's occurred. If you think of more things that you would like for us to close the report, we'll be following up with you directly as per

remark with the deadline behind which we'd need to receive all of your feedback.

We're going to look to wrap this up and have a finalized version here in the next couple of weeks. So now is the window of opportunity to give your comments to us. And once again, big thank from us.

So I'll turn over to our co-chairs for some concluding thoughts and words of thanks. Brandon and Jacqueline, do you want to add anything?

Brandon Marshall: Sure. Thank you. I just want to thank everyone. Sorry to jump in Jeff and again highlight that folks can send specific comments and measures to opioid@qualityforum.org or email myself or Jeff as well, and we can help facilitate that as well. And have a wonderful summer and we'll reconvene in August.

Samuel Stolpe: And it's over here. Thank you everyone.

Man: All right, thanks everybody. We'll close here for now. Bye now.

Woman: Thank you.

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