Opioid Technical Expert Panel Web Meeting 4

Moderator: Kim Patterson
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1:00 pm ET

Vaishnavi Kosuri: Hi everyone. This is the Opioid and Opioid Use Disorder Webinar 4. Thank you for dialing in.

Please keep yourselves on mute if you aren't speaking. We will give a couple of more minutes before we get started just to have any other people who are dialing in join us.

So thank you.

Hi everyone. This is Vaishnavi Kosuri from NQF. I'm joined by Michael Abrams and Samuel Stolpe as well. Welcome to the Opioid Technical Expert Panel Web Meeting Number 4. We're happy to have you guys on today. We could see a lot of people dialed in.

We just wanted to say that we sent a couple of materials, slides as well as agenda and the comment log as well as a measure concept list last week if you guys could have that open, that would make for a really strong discussion. We'll be discussing the measure concept list in particular. So if you guys have that open, that would be really useful for us.

Moving on to the agenda. We'll go over some introduction. We'll discuss draft report feedback. In particular we hosted a public comment period last month. So we're hoping to discuss the five comments that we received then. We'll then move into gaps and measure tables. We'll discuss the prioritization criteria and then we'll have an opportunity for discussion for you guys.

And now I think we'll get started on roll call. So I'll get started.

Jeff Schiff?

Jeff Schiff: Good afternoon.

Vaishnavi Kosuri: Brandon Marshall?

Brandon Marshall: Hi everyone.

Vaishnavi Kosuri: Hi, Brandon. Anika Alvanzo?

Anika Alvanzo: Anika Alvanzo is here.

Vaishnavi Kosuri: Michael Ashburn?

Michael Ashburn: I'm here.

Vaishnavi Kosuri: Antje Barreveld?

Antje Barreveld: Hi I'm here.

Vaishnavi Kosuri: Patty Black?

Patty Black; Here.

Vaishnavi Kosuri: Jeannine Brant?

Jeannine Brant: Yes thank you.

Vaishnavi Kosuri: Caroline Carney?

Caroline Carney: Good morning.

Vaishnavi Kosuri: Anthony Chiodo?

Anthony Chiodo: I'm here.

Vaishnavi Kosuri: Jettie Eddleman?

Jettie Eddleman: Yes. Hello everyone.

Vaishnavi Kosuri: Maria Foy?

Maria Foy: I'm here.

Vaishnavi Kosuri: Jonathan Gleason?

Jonathan Gleason: I'm here.

Vaishnavi Kosuri: Anita Gupta?

Mark Hurst?

Katie Jordan?

Katie Jordan: I'm here. Thanks.

Vaishnavi Kosuri: Navdeep Kang?

Sarah Melton?

Gary Mendell?

Gary Mendell: I'm here.

Vaishnavi Kosuri: Darlene Petersen?

Darlene Petersen: I'm 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: Hello. I'm here.

Vaishnavi Kosuri: Sarah Wakeman?

Sarah Wattenberg?

Sarah Wattenberg: Yes I'm here.

Vaishnavi Kosuri: Arthur Robin Williams?

And Bonnie Zickgraf?

Bonnie Zickgraf: Hello everyone. This is Bonnie.

Vaishnavi Kosuri: Hi, Bonnie. Okay. And then I think we also have our federal liaisons on the line. We have them listed here. I'll do, like, a roll call for them too.

Robert Anthony?

Sarah Duffy?

Sarah Duffy: Hi everyone.

Vaishnavi Kosuri: Elisabeth Kato?

Elisabeth Kato: Here.

Vaishnavi Kosuri: SreyRam Kuy?

Scott Smith?

Scott Smith: Hi I'm here.

Vaishnavi Kosuri: Hi. Judith Steinberg?

Judith Steinberg: Here.

Vaishnavi Kosuri: And Linda Streitfeld?

Is there anyone who joined and we didn't call your name?

Okay. Thank you. So we'll move on to the scan report and feedback.

Michael Abrams: Welcome everybody. This is Michael Abrams here. Thank you all for joining.

Just as a matter of making it easy for you to follow along, you should now be looking at a slide that says "Environmental Scan Report Feedback," a blue slide, Slide Number 5. And, Vais, could you advance to the next one?

And forgive me my colleague just remind me I should allow the co-chairs to welcome you all before I begin describing the scan. So please, Brandon and Jeff, could you say a word or two to get us started?

Jeff Schiff: Go ahead, Brandon.

Brandon Marshall: Sure thing. Welcome everyone to Meeting 4. We've got a lot to cover today and the staff at NQF had done a lot of work under the hood to prepare for it. So we'll try to move quickly through the material and we're looking forward to your input a little bit later in the presentation as well.

Jeff Schiff: Hi everybody. This is Jeff Schiff. We're looking forward to a good discussion when we get to that point.

Michael and Vais, just for - I have a - I seemed to have lost the slides. Have other people lost them or is that not - it's just me?

Michael Abrams: So we will be displaying them. That's one possibility. And you should - if the Webinar is working, you're looking at Slide Number 6 now entitled "Comment Themes."

But the e-mail that was sent to you at 5:15 on August 6th contains attachments with all the materials in it including the slides and the comment log and the environmental scan and the measure concept list. So please have those handy. In fact especially the measure concept list it would be good if you open that and have it at the ready on your desktop.

Does that help you, Jeff and others?

((Crosstalk))

Jeff Schiff: I'll work on it. I have (unintelligible).

Michael Abrams: Going pretty good. So you should be looking at Slide Number 6. And again back to me, Michael Abrams here, I'm going to do my best over the next several slides to do a succinct review of the environmental scan and where we

think we landed with that and then get us before we have any actual discussion to just review that material for you. So if I can ask that you attend to that carefully and make no reserved comments for a little bit later if at all possible.

So to begin with, what we would like to do is review for you public comments that we received as we do for all NQF reports. And we got a reasonable number. There are five specific public comments as they came in.

And this Slide Number 6 that you should be looking at or if you have the PDF you can go to Slide Number 6 entitled "Comment Themes." It can be summarized as follows and I'll just try to go through very much bullet by bullet and to keep you all anchored to the slide number again. So again you should be on Slide Number 6.

The comments that came in generally are appreciative of the unusual, somewhat clunky name that we have for this enterprise, Opioid Use and Opioid Use Disorder. That is we got several comments where people were like the fact that we were looking both at pain management issues as well as addiction-related issues. So that's the first bullet.

The second bullet, concern was expressed in one or two comments about the problem of ceasing opioid pain management therapy to abruptly absent tapering, absent for - with consideration for the burden of that potentially and the risk that that potentially places on the patient. So I think that that echoes some of the messaging that was in the report but I wanted you to be aware of that folks specifically with those kinds of comments.

There was encouragement to harmonize - as we think about measures to harmonize them with other measures. This is a longstanding NQF goal, right,

to try not to reinvent the wheel and try to consider if a measure is introduced that there isn't one that already exists. That was part of the point of the environmental scan to try to, if nothing else, give us all a cataloging of what's there before we start to think about what's missing.

There were comments as well about - or at least one comment about considering the level of analytics that might be applied to certain measure. That is whether you look at state level reporting for opioid overdose deaths versus more fine grain reporting on the county level or even on the provider level.

It remains to be seen how much detail we all get in to that but I wanted you to be aware that at least some of our commenters were interested in the committee's thoughts about that if you all feel that that's a priority area.

Encourage - there was a comment that - at least one comment that encourage the use of guidelines moving forward to aspire measurement and not a novel comment but one that we wanted to bring up.

And then there was at least one comment about the National Outcomes Measurement System which is, as I think many of you are aware, broad reporting that's used especially by SAMHSA in order to track not just specific services related to the behavioral health issues but distinctive outcomes that go along with that in a rather codified way and one of our commenters suggested it would be useful for us moving forward to consider that perhaps as we're looking at the federal programs especially the Medicare program and figuring out what constellations of measures would be useful there.

And then finally under the last bullet on this slide you see several specific measures were suggested. And I think they more or less overlap with things

that we've talked about that are represented in the environmental scan but there were potentially some novel things in particular the second bullet there, high-risk use in the elderly or kidney patients or the use of Demerol specifically in a hospital. Those are some specific suggestions that might be the targets of measurement or might be too specific for our activity. But it's noted there.

There was also a suggestion about treatment credential and it presumably relates to the, you know, buprenorphine label prescribing and things like that and structural measures that are available from SAMHSA. Again I think things that won't necessarily change the environmental scan but will be touchstones or at least things will check out for you all moving forward into the evaluation of the federal programs.

So that's a summary of the themes. Now let's move in - let's go to the next slide. We're going to Slide Number 7 now. And what I'm going to do over the next several slides is review for you mostly what we think we learned from the environmental scan and from discussions that we've had so far on these Webinars and some offline as well from comments we've received from you all related to this whole exercise that we've undertaken in terms of trying to do a scan of what measurement and measurement concepts exist related to this opioid crisis that we now face.

So just a reminder to you, right, the - for organizational purposes but also driven by what we learned from our background research for you all. We divided the report into these four domains. They're not necessarily intended to be perfect or all-inclusive and they're certainly not intended to be non-overlapping. They definitely overlap.

But just a reminder for you that we are looking at - trying to look at things and file things to keep us organize in these four domains: Pain management, opioid use treatment, harm reduction and for that let me be specific -- by this we mean harm reduction for individuals who have addictive disorders specifically if that's how we're using the term in that public health sense -- and then social issues. And some examples - some specific examples are given there.

So let's go on to the next slide.

So what staff is - has tried to do is to get a jumpstart on picking things we think come out of the environmental scan in terms of them being high priority. And so what we're trying to do is make inferences from the research we did and from the discussions that we've had.

And with regard to the environmental scan specifically, there are two simple ideas that we're applying to decide if something is a gap. It would be considered a gap if there were very few measures or zero perhaps or - as stigma is given as an example here. Or it could be considered a gap if there are measures but they qualitatively seem to fall short.

For example there might be a quality of life measures but no measures that specifically capture life satisfaction in terms of mood and work and social fulfillment to things that might be especially important for a substance use disorder issue or a quality of life measure that's specific to opioid use.

So either one of those things could make them a priority in our mind. And so we use that and let's go on to the next slide.

We use that to review the tallies and the coalescing of information that we provided for you in the environmental scan. What you're looking at now should be Slide Number 9 entitled "Pain Management." This is tabulations right out of the environmental scan report. It shows that there were something on the order of, for example, 21 pain assessment measures, measure specific to pain assessment and four measure concepts that we found and so forth.

And then staff took some liberties here and we decided based on again what you told us, what we've heard from you, what our research told us that in particular we thought with regard to pain management especially high-priority areas and as signaled in that last column that we added for these slides specifically, specifically high-priority areas seemed to be quality of life and functional measures and pain care plan measures seemed to be especially important.

And I might add that the latter, for example, could include things about pain assessment. That is pain care plans might include pain assessment and appropriate alternative prescribing, et cetera.

So in some ways these subdomains overlap anyways. But the inference we're taking here is that we thought you all as a committee were especially interested in identifying the gaps as gaps quality of life and functional measures and pain care plan measures, okay?

Moreover one other point I'll make about this slide, you'll notice at the bottom we provide, just a reminder, that this is a continuum. So when we talk about pain management, we could mean acute, post-acute, a little bit longer period and then chronic pain management and those all seem to be relevant to this discussion perhaps especially chronic pain management being an issue but those transitions from one to the other being important as well.

All right. So let's move on to the next domain which is - you should be on Slide Number 10. Treatment of OUD seemed overall to be of high importance with the exception again from staff's assessment that probably there were enough screening measures already.

And we didn't need - necessarily need more of those but with regard to treatment initiation, continuity of care and comorbidities there were qualitative concerns about those that should be addressed by specific measurement related to the current epidemic that we now face.

So we're suggesting again here overall that those latter three subdomains are of particular interest as priorities. That's the inference we're taking. So let's move to the next slide.

And here we put Domains 3 and 4 together on one slide because they fit. But we are looking at two separate domains, the top being harm reduction, looking at just overdose monitoring, and the second being use of drugs like naloxone.

So here the rationale and the inferences that staff drew and are summarizing in this last column is that overdose reversal drug prescription is a low measurement priority we argue because there seems to be widespread use of naloxone already, standing orders, all 49 states, for example, have some sort of program to promote naloxone use.

We thought it was fairly widespread, fairly noncontroversial, not necessarily something that needed to be a high priority for this particular activity, not that it's not important but not a high priority. Whereas with regard to overdose monitoring per se one of the things that we heard and inferred from our research is that monitoring the type of substance could well be important.

For example, to being able to address if we move as we did previously from heroin to fentanyl if we might be moving now from fentanyl to, say, methylamphetamine or related other sorts of addictions or overdose agents and we thought that that put it into the High column. So that's how - that's the kind of thinking that we use in order to again identify what we thought you all believe to be priorities.

The bottom part below the line here gets into the very broad subdomain or domain, major domain of social issues with the subdomains listed here. It again shows that there's very low numbers of measurements in these different kinds of areas, things looking at not just violence but other trauma, for example, health literacy. These are things that aren't - they aren't typically measure - specific measurements available for us. So we thought that made them in and of itself high priorities.

Moreover the very bottom two on this slide shows stigma and things - financial indicators, housing employment and, you know, finances more generally as having no measures that we identified. So those suggested to us. And again we're inferring from discussions we've had from you all that these are high-priority areas, okay?

So let's go on to the next slide. So what I'm doing here - what we're doing here is summarizing in words for you some things that are getting closer to flush out measure ideas or measure concepts and just to remind you all and remind myself to the lexicon here, a measure concept is something that implies a numerator and denominator could be identified but doesn't necessarily explicitly provide you with one or exclusions or exact databases and so forth that we use but that should be certainly an important target for this particular exercise.

And so here we're trying to give you in words and I'm going to go to the next three slides these words and these concepts as a way to summarize for you hopefully what we as staff think represent a very good list of measures that we would like you to try to prioritize.

And let me say it to - let me say it another way. We're going to -- between this meeting and the next -- actually send you kind of ballot -- we use the election hearing metaphor here -- for you to rank order these different specific priority concepts and to assess from you all separately but then we'll coalesce data together and discuss it what measures are important.

Thank you. So my colleague just pointed out to me there are some questions and comments coming. Maybe some questions/comments coming in. But if you could just hold on for just a couple of more slides and then we're going to get into a discussion. So we're trying to, if you will, create a full summary for you to react to.

So let's go through these now. Concepts that we think are not just concepts per se but concepts that are important. Potential high-priority gaps that again we inferred from our environmental scan and from our interactions with you are important for this activity.

So I'm going to go through bullet by bullet. Again we're on Slide Number 12.

Quality of life, level of functioning measures and I might add for both pain management cases and for cases of opioid use disorder treatments. There's a dirt of those kind of specific measures we think that you all think that's an important gap to address for this TEP.

Second major bullet there, success is a pretty broad one about treatment, successful but adds prevention as well, referral to treatment, initiation in and retention and opioid use disorder treatment because this is especially focused on OUD treatment per se as opposed to pain treatment quite frankly, okay?

Thus the sub-bullet there looking on the long term at things like recovery. And again we're not talking about recovery from a - just to be clear, a broken bone here which has pain management issues or something like that. We're talking about long-term recovery for people with opioid use disorders.

And the suggestion of the scan being that long-term outcomes and measure specific to, you know, beyond six months, for example, are not plentiful and should be.

Moreover measure should be sensitive not just to full cessation, rightful absence from the drug but to incremental changes in a favorable direction as one would expect with regard to evaluating somebody as a chronic cycling condition that's difficult to manage.

The final major bullet on this slide is pain-centered - patient-centered pain management overall. That does come out as an important point in particular suggestions of things like a comprehensive pain care plan that includes consideration and these bullets just - sequential underneath that major bullet.

Alternative pain remedies, tapering strategies and transitions from acute to chronic care with opioids especially being of importance as a measurement target or…

Gary Mendell: Hey, Michael? Michael?

Michael Abrams: Yes? Yes?

Gary Mendell: This is Gary Mendell. If we have comments or questions, should we save them for later or can we make them now?

Michael Abrams: Thank you, Gary. Please I'm almost through the slide. So please hold them. And that way you're - and you can also enter them in the chat box's memory aid as well. Thank you, Vais.

Gary Mendell: Okay.

Michael Abrams: And - but do hold them because again we want you to take a holistic view of where we think we're at and then react to that. Okay, Gary?

Gary Mendell: Sounds great. Yes.

Michael Abrams: Thank you. Next slide please.

So again we're going through just two more slides on major concepts we think you think are gaps, okay? And connecting OUD treatment to the treatment of comorbidities being an important gap area. So especially looking at even things like tobacco abuse which exists in 80% of people with opioid use disorders.

And even though it's not immediately leading to overdose it's something that's a great importance to the health of individual's opioid use disorder, suggestion that that's important, suggestion as well that a gap area is making sure that psychiatric illnesses are addressed, comorbidities to opioid use disorder, depression, for example, and physical comorbidities as well,

infectious disease, metabolic disorders and cardiovascular disease being very prevalent in individual's opioid use disorder.

I might add that some of these comorbidities are relevant to opioid use per se. And certainly that's important. Although these particular bullets are especially about treating people with opioid use disorder and those comorbidities.

So in a pain care management plan for somebody using opioids, these things are important as well and we think it's captured up there. But here we're talking about opioid use disorder specifically.

The second major bullet on the slide, again Slide 13 just to make sure you're all connected with us, special populations to OUD treatment and in particular pregnant women came up but also criminal justice…

Man: Michael?

Michael Abrams: …populations being important and homeless populations to be two others. There might be others as well but these special populations they kind of fall maybe under social issues, maybe under treatment. Again the domains are less important than addressing specific things that you all view as having a high impact on the crisis.

And then harm reduction also came up especially tracking morbidity related to alternative substances like if you're on the West Coast particularly you're probably quite sensitive to methylamphetamine death related events are catching up to opioids.

But then also contamination test kits and overdose prevention sites might as well be targets of measurement specifically.

Next slide please.

All right. And this is the last slide and then I'm going to stop talking mostly and let you guys talk. This is about - it gets mostly into the social risk factors, things that we talked about and pointed out previously, things like housing and financial issues. So measures for that are really not evident right now.

Measures for health literacy, measures for stigma, not evident. One or two measures we found for violent history generally speaking but not specific to OUD treatment as well. And although they exist, they aren't updated very regularly cost measures for overall cost measures for opioid use disorder.

This is more about public awareness issues and burden - healthcare burden. So thinking about things like quality adjusted life years lost and other economic factors, treatment cost, lost wages and that kind of thing as well.

Criminal justice involvement and that measures could specifically or more generally target whether individuals under treatment have a history of criminal justice involvement and how they're doing or could target programs that are at risk, jail diversion programs, or programs that help individuals transition back from being incarcerated into the public, getting them into Medicaid, for example, those seem to be high priority and of great importance given that these individuals are at high risk for overdose related complications and death.

And then finally neonatal abstinence syndrome came out specifically. And I might add it was our review that - estimation from our view that that was important at least two ways, pre and perinatal and parental counseling and

direct health issues for mother and child but then also long-term follow-up for the children.

But that parental counseling piece is being perhaps particularly important because you can arguably detox a child with relative success and ease but it's much harder than to make sure that they have a good environment to grow up and mature and if there's somebody who has an additive disorder in the household.

So let's go on to the next slide. And then I just want to orient you to some tools for discussion. So you should be looking at Slide Number 15 now for the moment and think about, if you haven't already, which I suspect you had, you should be thinking about the following questions - the following question: Are there any additional gaps, things we've missed, that you think are sort of quite essential that you'd like to identify that are not addressed in the previous slides?

And rather than making this a brainstorming exercise because we're too far along in the activity for that, we hope we've achieved much brainstorming to this point with you all, rather than making a brainstorming exercise, we want to just - your look and your discussion about whether there are additional high-priority gaps to be a bit more disappointing, here's how we're going to try to help you do that.

Vais, could you bring up the spreadsheet? So Vais is now going to bring up for us a document that you got a version of - can you scroll up to the very top first? I want to remind people.

So all of you received as an attachment to this meeting invite a document that was entitled "Measure Concept List." And right now -- assuming that the

screen sharing is working for you -- you should be looking at Page 1, the very top of that list although we've changed it a little bit since what we sent out to you. So we sent out something that had Column 1, 3, the Measure Gaps column, 4 and 5 but we added a Domain column. That was the fine suggestion of our chairs. We added the Domain column just to add another piece of organization.

But what this - what it's intended to be - and hopefully you've had a look at it and you've had a look at the environmental scan by now. But what this is intended to do is to provide you 26 high-priority areas that we have again selected based on input from you and the scan. And it gives you a brief description of it in Column 3 to give you an example of a slightly more specified measure concept related to that that we think is exemplary, you know, useful, a good potential measure.

And then finally to remind you that in Column 4 that there's all these other measures that are related in some way to this particular exemplary proposed measure concept. So it's not coming in a vacuum. The measure concept proffered is more specific or more directed than some of the other ones that are listed in Column 4. But it doesn't come out of nowhere.

So with this as a - as one tool, the environmental scan, of course your knowledge of the problem that we're facing. What we're going to ask that you do now in the discussion and you think about new gaps is to look at the gaps that we presented especially in Columns 3 and 4 on this particular sheet and see if you like them as a list of candidates for you to prioritize or if there's something you'd really like to add that's missing.

And we'll challenge you. If you really want to add something at this point to think about whether or not there isn't already - we haven't already considered

it in the environmental scan or that it doesn't already - isn't already represented somewhere else and then also think about if you can have some evidence for that that you can maybe send us offline that we could use to support the inclusion of that additional gap if you wish to identify them.

Finally, to guide the discussion and at this point I'm not sure if I'm going to hand it to the chairs to lead the discussion. But as just one thing for all of our brains to look at as we're going through this, Vais has placed Table X, a summary Table X up on the screen for you. And this just coalesces everything that's on that seven-page measure concept list that I just finished talking about.

Again this is a suggestion of our chairs to boil it down for us all to look at and it simply lists the domains. There's little color-coding there if you're assuming you're not colorblind there but a little bit of shading there to give you differentiation and to be able to go back up on our sheet if we want to do that.

But more importantly there's some words there that remind you what types of measure gaps we've identified. So if you're going to introduce something new, the first touchstone for you might be looking here and make sure, you know, there's no - if you want to introduce a stigma measure, for example, hopefully first you would look on under social issues and see, "There's already two stigma measures that have been suggested."

Measures 18 and 19 in the list that you have in front of you and make sure that your measure is actually a novel one or you feel adds value to the - our quest for high-priority issues, okay?

So I'm going to pause there and give it to the chairs to again address that question: Do you think there are any major high-priority gaps that we have missed that should be included in our measure ballot, list of measures we're going to have you vote on moving forward between this and the next meeting?

Jeff, Brandon, please.

Jeff Schiff: Thanks, Michael. Hi everybody. I just had a couple quick housekeeping things. Michael, how much time do we have for this discussion?

Michael Abrams: Where are we now on the - let's look at the agenda. We're trying to finish this up by when? I'm talking about - I look at Vais.

Vaishnavi Kosuri: Well you should have until, I would say, like, 2:30.

Michael Abrams: 2:30. So yes 40 to 50 minutes.

Man: You know, we've got plenty of time for discussion if we finish early. That's quite all right. So this is going to make up the bulk of our discussion today. So please take your time.

Jeff Schiff: Great. So - and so just a couple other things then, I would suggest that we talk about these by the domains you brought up in Slide - that are on side of that sheet. So we can go in that order.

We'll ask maybe that if people have a specific comment that's on topic, everybody will be unmuted and they can just go back and forth without that topic if you have something new to say. Please tell us who you are because I don't typically know your voices very well. And then if you have a new topic

in that same domain or you want to put up a placemark in one - put in the chat function. We'll monitor that. So we try to get everything.

So that - with that housekeeping, I think we're going to talk about - I got too many things on my screen.

Brandon, anything else that you want to say as far as housekeeping or are we ready to get going?

Brandon Marshall: I just had one quick question for Michael or the NQF staff. There's a couple of comments in the chat box about the current gaps that are in front of us or suggestions for small revisions which I think are good. Should we just hold those or encourage folks to type those into the chat and those will be addressed or would you like to bring those altering the discussion as well?

Michael Abrams: And so the chat box is fair game. People feel free to use that. Sometimes it's easier too when you're waiting and you don't want to forget your question. But I think as a matter of practice what we'll do is we'll look at the chat box. We'll try to call on people. And if they wish to voice their opinion, they can. But we can also just, you know, read the comments.

So per that I think two people already have chimed in and suggested adolescence or teens be included. So we'll note that. And elderly populations as well. So we can, you know, explicitly refer to that under the special populations. I think it fits there.

So under OUD treatment, Item Number 12 there, is where we'll file that and I don't see any reason why we couldn't carry that forward on the ballot as well.

Brandon Marshall: Okay great. But my understanding is the focus in general of the discussion is identification of additional gaps beyond those listed in front of us. That's correct.

Michael Abrams: Absolutely. If you feel they exist, yes.

Brandon Marshall: Great.

Sarah Wattenberg: This is Sarah. I can't get in to the chat. So just let me know when you're ready and I'll throw up a couple of things.

Vaishnavi Kosuri: Go for it, Sarah. I think we're ready for the discussion.

Sarah Wattenberg: Okay. I definitely agree we don't need more screening measures but, you know, it's a big piece of the treatment gap is that we need to increase use and uptake of the screening measures. We have a - just a very, very large swap of primary care that's not implementing the screening and all of the initiation and referral to treatment doesn't work if people are not receiving that basic initial screen.

The other thing I would suggest is that you talked about tapering strategies for opioid analgesics. I would also like to include in there tracking premature or sort of requirements for tapering people off of medication-based treatment for substance use disorder.

We still have states and others out there sort of through administrative policy telling people that buprenorphine has to be cut in half in six months and you can only do certain dosages and I think that that's something that we need to think about.

Man: So, Sarah, can I just ask, is there any measure out there or any policy tracking that you know of about policies around premature tapering?

Sarah Wattenberg: I can show you the policies. I don't think we have any measures yet of that.

Man: Okay. Thanks.

Sarah Wattenberg: Sure.

Brandon Marshall: Yes that's a fantastic point. I'm looking at the current list in front of us and I'm seeing, you know, referral initiation and retention OUD treatment. That comment to me almost is around the quality of that treatment which I'm not sure is included as written in the bullet.

Michael Abrams: Yes. So that's a fair - it's a fair inference. However assuming that quality of life level of functioning is measured properly, right, you could argue that that's a key outcome. I want to react to two things that were just said.

That's a key outcome that you would want to follow up. Even if you taper somebody too early, presumably the reason that's bad, right, is that they're not followed up and that bad things happen that that's what - that's the definition of premature discontinuity and that - and opioid treatment like that. So presumably it might be addressed there.

The other comment that I want to - wanted to make about what Sarah said if you all think that measures are not being used enough that isn't specifically the purview of this committee if the measures are there. It's a different question about getting them to be used. If however you think the measures are not good enough for some reason, that is the purview of this committee.

So to suggest how a measure might be better suited for use would be germane. So I just want to make that distinction.

What you're trying to address here, are measurement - is measurement science per se, not necessarily the dissemination of that science. That's the next step, right, of the activity. So I just want to be clear about that.

Gary Mendell: So this is Gary Mendell. I have some more comments. Is now the right time or we're still finishing up on the previous one?

Michael Abrams: I think we're good, Gary. So, yes.

Gary Mendell: Okay.

Michael Abrams: And I think we're…

Gary Mendell: So I have comments in three areas, treatment, payment and stigma. On the payment, you have one - number two there is clearly outcome based, right? We can leave it at that which is basically all the other processes that happen are being captured in number two. The middle column of number two is the outcome.

But I guess my question is, are there other - are there some indicators that would lead to outcome process measures that you want - would want to include?

Some of those are captured on the right-hand side there but some aren't. You know, things like, you know, you list just narratively on the left there, referral to treatment initiation and retention. But it's not speaking to quality. I mean,

we just were. So I have to pick up on that. But also the right diagnosis, using evidence-based assessment tools to decide the proper treatment.

Continually assessing the person through treatment or the patient through treatment to make sure that treatment is being altered based on how well the patient is doing.

Making sure that medications are used for maintenance, not just a detox, making - connecting to behavioral health. And I can keep going on and on. So I guess the question is, are we good with one measure? Number two, which is essentially capturing the results, or do you want some process measures added in that would lead to the results?

And if you did, I know we can go through them. If not, we don't have to go through them.

Jeff Schiff: So, Michael, can I ask because we have the inventory of the environmental scan which has, I think, other measures on there and I don't know off hand. I think some of these things that Gary is talking about were - are addressed in environmental scan, the 2019 measures already. But I don't know (unintelligible) point speak for that.

Michael Abrams: Yes. Yes. So - sorry go ahead, Jeff. Did you want to…

Jeff Schiff: No go ahead.

Michael Abrams: Okay. So I'm looking at - that's a good - it's a good question that Gary posted. So number two has a lot in it. So now I'm looking at the actual role of the measure concept list that we sent you, okay?

Successful referral to a treatment initiation and retention in, OUD treatment and retention of care, there's a lot in there. It's across the spectrum of disease except maybe for, you know, prevention is captured in there. So there's a lot of there, there.

We specifically suggest one concept and we proffer it this way. Number of OUD cases that show significant declines in opioid misuse at 6, 12, 18 and 24 months after treatment initiation. Okay? And we use that, as I said, as an exemplary measure.

Now Gary started to get into other more specific measures. If you look at in process measures, right, that would be germane to that. If you look at the last column of the measure concept list, several of those are there and exist.

Gary Mendell: Yes, yes. Yes you're exactly right. Some are. But some are…

Michael Abrams: Yes. And so I think - go ahead.

Gary Mendell: But actually let me hit that middle column for a second.

Michael Abrams: Sure thing.

Gary Mendell: The middle column relates to the overall, if you will, the number of cases that show significant declines at certain intervals.

Michael Abrams: Yes.

Gary Mendell: That's - once they started treatment. So first I have several questions around this. First one is, do we want to go back earlier and say the number of people diagnosed how many getting to treatment? That's a big one. That's missing.

Michael Abrams: Okay.

Gary Mendell: Because you're only referring to the people that are into treatment.

Michael Abrams: Yes. Okay.

Gary Mendell: And then the question relates to what I was talking about before. The best measure for treatment is exactly what you have, right? At the end of the day what really matters is exactly what you have as the outcomes. But do you also want to have the process measures at which many are listed in the right there but some are missing.

Michael Abrams: Okay.

Gary Mendell: And then we go back to the first question. How about of the number of people diagnosed, how many get into treatment because that's a measure of the referral system.

Michael Abrams: Yes it is. Okay.

Gary Mendell: It's also a measure of stigma. How many people don't even go near a doctor to get diagnosed because it's a stigma? But anyway I'll be quiet, sorry.

Michael Abrams: No, no that's good. Okay. So…

Caroline Carney: This is…

Michael Abrams: Go ahead.

Caroline Carney: It's Caroline. I agree with those comments. I think if you can't get out into where each episode of care is likely to occur, the first is around the diagnosis and initial referrals. The second is around what happened in the treatment setting itself. Is that the right thing? And then the third is what happens subsequent to treatment.

And so in my mind that's kind of how I chunk out what has to happen each step clinically along the way and perhaps those process and outcome measurements at each of those junctures.

Michael Abrams: Yes. So one note that I've made is maybe to create an additional column that has number diagnosed who enter treatment who end up entering treatment and following them up explicitly of new - of what we call incident cases.

Gary Mendell: Right. And that would then lead to the middle column. So if there's 100 people diagnosed, you know, right now 15 of those 100 are getting into treatment. We want to get that number to 65%, 70% like any other disease.

Then of the people in treatment you capture the perfect outcome measure. I mean, that's word for word. That's perfect. But there's all these leading indicators to it which were the quality of treatment, the process measures. Right.

Michael Abrams: So…

Gary Mendell: And then what Caroline mentioned is the whole recovery piece. I'm sorry.

Michael Abrams: Okay. So then the recovery piece - well fair enough. Let's - so I think one thing that you suggested without objection from the committee is to add a

novel concept to this list that would talk about incident cases that enter treatment and following that rate in some way.

As far as recovery, I think I will make - we'll make a note to see if we can operationalize some separate measure that might look at that per se although I think part of the implication of this exemplary measure was that, you know, arguably once you get to 12, 18, 24 months, we're talking about recovery. So, yes.

Man: And, Michael, further…

Man: Number three. So we do get to recovery.

Michael Abrams: Oh yes we do. In fact we have it. Okay, fair enough. Yes, very good. Does that address the two comments that were just made then in a satisfactory way for you all?

Man: Well - and the only other comment is, does the group want to make - if you want to go into the area of the indicators that will lead to that successful decline in use at 6, 12, 18, 24, do you want to make sure you have a full list of the process measures that would lead to that and to make sure you capture that full list?

Man: The list of process measures.

Man: Which are things like are you - is it an evidence-based tool that assesses someone in place in care? That is assessing not only OUD use but also any mental health issues and physical issues.

And ASAM has a list of eight criteria that should be assessed when someone is being assessed their first day of treatment. So that will be one thing, for example, and there's many others without going through them. So the question to you and to others is, do you want to capture that complete list or just rely on that one outcome measure which I don't have an opinion on. I'm not - it's a scope of what you want to accomplish.

Michael Abrams: Yes. And - yes. I think it's a matter of - Michael speaking here. It is a bit of matter of us thinking about our charge and specific measures - very specific measures are important as examples. We need not identify beyond the scan every novel-specific measure that we're conceptualizing here. We can be a little bit more general. But still, Gary…

Gary Mendell: Okay.

Michael Abrams: …you've made a couple of suggestions. You know, for example, in the referral - the treatment measure, it could be that part of that successfully fulfilling that measure is the deployment of a standard to consider level of placement like the ASAM criteria or something like that. That certainly seems a reasonable suggestion.

But - and we will do our best as we've done here to try to list other related process measures. But I - we don't want to get into the detail of necessarily identifying every single measure because that would be a bit too - that might be a bit too ambitious for - given the research that we had.

Gary Mendell: Sure. So let me suggest this and going to my next comment - before I move to the next comment is there was a list that was created by the National Quality Forum for us on our - the system we're creating to measure quality treatment

programs individually. You can just take that list, scan through whenever you'd like and see if there's some ones you want to pick up.

Michael Abrams: Yes we want to - you're talking about the Shatterproof stuff? Is that what you're…

Gary Mendell: Yes.

Michael Abrams: Yes.

Gary Mendell: That's up to you.

Michael Abrams: In fact I like to use that moving forward for our - when we get to the federal programs. I think your - that effort is inspirational for this committee to do that. So in the next meeting in fact we might talk about it explicitly.

Gary Mendell: Okay. All right. So let me move to my next comment. Okay. So I have two other areas. One is payment.

Jeff Schiff: Gary?

Gary Mendell: Yes?

Jeff Schiff: Just before you do that, I just want to - I want to address the comment in - or ask the NQF folks to address, you know, (unintelligible) question in the chat because I think it's relevant to all of this conversation. So I don't mean to - I just want to put you kind of on hold just for a second…

Gary Mendell: Sure.

Jeff Schiff: …and the question - my understanding is that our key deliverable is to recommend quality measures to Medicare and how does the gap fit into this (unintelligible) to CMS.

So, Sam or Michael or Vais, do you want to just answer that real quick so we're all grounded?

Samuel Stolpe: Hi. This is Sam Stolpe. I'm happy to take a crack at that. And thanks for the question. I think this will be beneficial for the entire committee just to reorient us to the exact work that we're doing.

So, Antje, you're correct that the key deliverable is to recommend quality measures for five specific programs. But this is a separate deliverable. And it's going to serve two purposes.

One, for CMS it's just overarching information that they can use to inform potential contracting through (MIDS) or another contracting effort to develop measures that where there is a clear gap that we as a committee have prioritized. That doesn't have to be done by CMS alone either.

Other measure developers may take a - make an effort to develop those metrics independent of CMS. But this is just broad recommendations from a group of experts to understand both the epidemic and quality measurement broadly to their folks to consider - including CMS.

Now there's recommendations that we've put forth as a group and as we identify these gaps will help us to - will help to inform the work that we do later in making these guidelines and recommendations to CMS specific to those programs because it may be that we have - we as the committee have a strong inclination towards one particular measure or measure type or area that

would be of special impact in, let's say for example, the Medicare Shared Savings Programs for accountable care organizations.

And we wanted to put that forward but we know that that particular measure gap has yet to be filled. But we could - but we've spent some time and thought about the measures that are out there, the gaps that are out there. So this will give us much more fodder for a robust discussion around what our guidelines or recommendations will be specific to those five programs.

Antje, does that answer your question? Or any other follow-up questions related to (unintelligible).

Antje Barreveld: Thank you. That was really helpful. It's Antje. I just wanted to understand kind of where this fits in because we do have a lot of measures but again, we identified these gaps. So I just didn't quite understand how that's going to inform sort of the next steps. So thanks for clarifying.

Samuel Stolpe: Yes, my pleasure. And of course our next exercise is going to be around determining criteria for prioritization. Then we'll be doing some homework, assignment and in the wake of this meeting to essentially force rank our gaps and to prioritize them.

Then in our subsequent Webinar we'll be reporting the results of that work and then having another longer discussion around the rationale behind why we're selecting the measures and prioritization gaps that we did.

And you had another question here. You mentioned that you feel that universal screening for OUD isn't sufficient despite tools being available.

So this I think Michael touched on briefly. It's a little bit outside of the purview of this group. Unless there's some tool, universal screening for OUD, SUD as a recommendation specific to this program as an example that we wanted to put forward.

But encouraging the uptake of that is a challenge that we can identify in our final report. But maybe not necessarily something that fits directly into the series of deliverables that we have tasked for ourselves as a committee.

Michael Abrams: Yes. I wonder, Antje, if you are - if you think like the experts sorts of things are insufficient now, I mean, there are measures available for that. They're a little better for SUD - for alcohol and depression screening than they are for opioid use disorder or somewhat untested. But you feel like a case can be made for the screening being insufficient?

Antje Barreveld: Absolutely. This is Antje. I think this is a theme - I can't remember. It was (Brenda), someone who made the comment is that people aren't screening. And so we - I think it's important for us to make a statement about what those screening tools are potentially that people can use and to implement universal screening because it really is not part of, for instance as was mentioned, the primary care standard intake.

And so it's a lost opportunity to even identify patients who are at risk for an opioid use disorder regardless of whether or not they're prescribed that medication.

So I do think that it is part of the committee's recommendation to evaluate for that and make sure to keep our - actually asking the question because if we're not asking, we're not going to be able to refer for treatment.

Sarah Wattenberg: This is Sarah. Yes. So sort of originally raised this. I mean, it is possible what we do is sort of identify, as you are saying before, identify what those statistics Medicare and Medicaid programs are and make recommendations about inserting as for other the (night) of screening (unintelligible) screener I think has evidence for OUD but you can't hold me to that.

So, you know, maybe that's the idea that we make a recommendation for other measure sets. But, you know, I appreciate the previous speaker. We can't - you know, this has been going on for at least 20 years, you know, since I was at SAMHSA and we were working with NCQA on this measure.

We can't keep backing off of figuring out how to make people do the screening. I mean, that really is just a core of getting people who don't know all the time that they have problems and getting them into treatment.

Vaishnavi Kosuri: Hi. Who was just speaking? Just to clarify.

Sarah Wattenberg: Sarah Wattenberg.

Vaishnavi Kosuri: Oh, hi, Sarah. Okay. Got it.

Jeff Schiff: So I just wanted…

Man: Go ahead, Jeff.

Jeff Schiff: I think one of the challenges we're having and I think it's a good challenge where I think it's like what's the level of accountability for the measure because if it's a provider level measure, whether you retain somebody in treatment, it's a different thing than a health plan level measure about whether all their adults are adequately screened.

So I think one of the ways we could maybe focus some of these gaps when we think about it is who's the accountable party - who's the accountable - what's the accountable level in the healthcare system for this - for that particular measure.

I'm just seeing on the - I'm seeing that Gary wasn't finished and Norris wants to - he's had his hand raised. So maybe we should go back to - if it's okay with the folks, we should go back to Gary.

Gary Mendell: Thank you. So a couple of - so, A, I have some comments on the stigma ones but also I don't see anything here unless I'm missing it related to payment. And if we're measuring the quality of treatment provided and results after 6, 12, 18, 24 months, I strongly believe that to give providers the ability to deliver the quality we have to be measuring the quality of the payment they're getting to do their jobs. And I don't see anything here unless I'm missing it measuring the quality of payment.

Unless we do that, we're asking treatment programs to do the work without the resources they need to do it.

Michael Abrams: Right. So, Gary, Michael here. So this - you could place this under different places, OUD treatment or coverage, you know, coverage for OUD treatment. You can place this under coverage for pain management alternatives.

Gary Mendell: Well, yes, I was referring - actually both.

Michael Abrams: Okay.

Gary Mendell: I was thinking more in the treatment on living and breathing…

Michael Abrams: Okay.

Gary Mendell: …but clearly you brought up pain management which is great. It should be both. And then that - I mean, just off the top of my head on pain management, it's the quality of payment systems for non-opioids, right? But for treatment, you know, all the prior authorization is in place, the reimbursement rates. All of the things that providers have to deal with every day that are limiting their ability to do good work.

Michael Abrams: Yes. So the closest we come in this scan to that is probably under social issues and financial issues you could argue is related to it. But I realized you're getting into more details about benefits packages and stuff.

So we could certainly add something like that in there. And then the question for you all would be, how important is that as a measurement, a specific measurement concept compared to something else, like perhaps more direct measure of how patients are doing vis-à-vis their pain control and their overall level of functioning or under a pain control treatment regime or under an opioid use disorder treatment regime. At some point you'll have to prioritize them that.

But we could certainly do that. You're right. There is no specific discourse in our scan about benefit limits or anything…

Man: Yes. And what I would throw out to the group is whenever you have measures, it's the measure - it's to incentivize the measure of certain constituency to do better. And asking for - and when you look at quality outcomes, people are instantly going to look at providers. And you could have a lot of providers really trying to do a great job. But if they're not given

the resources for payment, they just can't. Remember when looking at the provider system, they should be equally looking at the payment system.

Michael Abrams: Right. Very good.

Gary Mendell: So I guess - okay. So that was one comment. The other comment relates to Number - Reference Numbers 18 and 19 which relate to stigma and a couple of things. Back on the environmental scan - some of the summary pages we had before, you mentioned attitude and knowledge. And I would suggest or throw out for discussion that it's really three things. It's knowledge first. Then it's attitude. But the big thing that you're - that's missing in here is behaviors.

And I think as a quality measure, if we care about stigma, we care most about the behaviors. Knowledge and attitudes are leading indicators to get the behavior, just like process measures are leading indicators of outcomes for treatment. The main result we want for stigma is changing behaviors.

And there are specific evidence-based quality measures that I consent than - that will measure all three of those actually that are using the field for mental health and other things that can be used for stigma for OUD that measure all three categories, knowledge, attitude and behaviors. So that's one comment related to stigma.

Second comment related to stigma is you are measuring two groups here, providers and the public. But how about the media? You know, how the media - well let me back up. You hit those two groups. But I think that middle - the middle column there could be much tighter with specific measures related to the three things I just mentioned, knowledge, attitudes and behavior.

Second thing is I think you can expand the number of constituencies you're measuring. For example, under - there's nothing here for self-stigma to understand how those addicted are feeling. There's nothing here for payors. There's nothing here for employers which is a big one. There's nothing here for the media and entertainment industry.

And so I think with that going on there's two comments related to stigma. Make sure we have specific measures for knowledge, attitudes and behavior and then expand the number of groups you're measuring.

Samuel Stolpe: Very good. Please send your list of measures that your point…

Gary Mendell: Yes.

Samuel Stolpe: …about behavior is well taken.

Gary Mendell: Yes.

Samuel Stolpe: And then with regard to different targets, one thing that's - I don't want to get lost in this discourse is that we are talking about - and this is an important criteria for NQF's mission and for quality, you know, quality performance measures to the healthcare system's mission in particular.

We should be thinking about measures that can affect, you know, the practice of medicine. Okay?

Gary Mendell: Great.

Samuel Stolpe: And I think that can be a little bit broader, public health as well. So certainly medicine can influence the media and the signal that goes to the media, for example. But that gets a little bit arguably outside of the areas of control that we're talking about here when we're talking about medical, you know, or healthcare system quality measures and how those are to be implemented, okay? So I just want to caution on that. But both points taken, Gary.

Gary Mendell: Okay.

Samuel Stolpe: We can do about proffering a concept that takes them into consideration.

Gary Mendell: Great. I'll have a good list that I could send you in about two weeks that we've been going back and forth and tweaking with some public health professionals and I'll get it to you when it's done.

Samuel Stolpe: Excellent.

Jeff Schiff: Let's work on getting the other folks whose hands are raised. We have Norris and then Darshak I think. And if you have the time to do, could you raise your hand in the chat box? Thanks.

Norris Turner: Thanks, Michael. Yes. So Norris Turner. And yes, I want to - I thought we've captured a couple of really good items around recovery, you know, under our gaps. But there was one area of recovery I think warrants consideration. And that's we think about actual retention and recovery.

I know, you know, that may be a downstream type measure because if you don't really have good measures of recovery, it's kind of hard to measure retention and recovery.

But there are several inputs I've gotten over the last year that have suggested this is an important area to make sure we're keeping really good kind of mindfulness of and management around, you know.

And one was a panel discussion that I led and there was a - one caregiver who's unfortunately lost her daughter to addiction when she was 22 years old. And, you know, the mother had her daughter in various very, very effective, you know, addiction treatment programs.

But then for various reasons, you know, she pulled her out, thought she was in a good place and she relapsed, you know, and following one of those very successful periods pulled her out and then relapsed and that's ultimately what, you know, led her overdose.

And I had another member of the panel, she was psychiatric nurse addiction specialist and I'm not sure where she got this piece of evidence. I don't know if it's empirical or if it's published. I did ask her. But she said basically people need to remain in these kind of effective evidence-based treatment programs for two years in order for the neurological wiring to really take hold.

And so whether or not it's that two-year period or not, retention recovery does seem to be important. The third place where I heard inside around that was Sheldon - Senator Sheldon Whitehouse at a forum when he said the number one area that he feels there needs to be more research and also measurement management is around retaining people in recovery.

So just wanted to put that out there for consideration.

Jeff Schiff: Thank you. All right. We have another. Darshak I think was the next person to…

Darshak Sanghavi: Yes. I was just going to add just getting back to I think building on the comments around who the constituency is for the measures.

Just to add a little bit of the payor perspective from my time at CMS and now at United, the measures broadly speaking if they're just put out and there's just a huge number that are here. The way I - at least I had been developed that philosophy with is that at most only one or in incredibly unusual situations two measures will actually move through the process and influence the quality of care in any meaningful way broadly.

And the mechanism to that is not going to be through the MIPS program or the physician ones just because that is such a, you know, you can think your own measures and the amount of money stake is so small and MIPS is really not an effective way to move quality meaningfully. The only real strategy is through the IQR the hospital-based CMS program or through the Medicare Shared Savings Program.

And the IQR is probably not a great place because that's not where outpatient care is taking place. So it's really only through the Medicare Shared Savings Program. And there they have a very small number of measure that's difficult to get additional measures on. So at most you have the opportunity to have one measure on that.

So I would just sort of bring that dose of reality to this where it's very nice to have a list of all of these measures but it's unclear what the mechanism of action to actually improve people's lives will be.

The second place one could think about is through NCQA if it's being added to the HEDIS course set or to the CAHPS hospice survey because that will be

- have important implications on broad based payor based strategies. Again there may be one measure at most is sort of what would be reasonable. So I'd encourage us to rather than sort of think about solving every single social, emotional compliance and other problem here, there should be sort of a way to sort of think about an extremely parsimonious set if it's actually going to be meaningful in the lives of the people we're trying to serve.

I mean, I'm just saying that if somebody has become a skeptic of the measure industrial complex broadly that if there's just way too many of this and it's unclear how this theory translates to on the ground improvements in care.

Samuel Stolpe: Yes, Darshak, thanks for that sanguine description. It's actually a very good one. And we've already - just to quantify that, we got 26 ideas here that we put before you and we probably added a couple now. So we're talking about 30-some, you know, ideas that could be translated into potentially multiples measures for each one.

And so one - at some point the exercise will be some prioritization really thinking about what are sort of key cross-cutting high impact and we're going to talk about criteria we're going to give you to try to rank order this a bit. But Darshak is - it's much appreciated here your comments about the limits of just adding on new measures more is not necessarily better nor is it certainly effective. So thank you for that.

Darshak Sanghavi: So I'll make one more comment. Ideally a measure should be claims based. You shouldn't have to reach out and actually find people to do any kind of survey but rather claims based. Thanks.

Brandon Marshall: All right. Jeff, just - this is Brandon everyone. We've spent some time on the treatment domain. I wonder if we might move to the third and fourth domains, harm reduction and social issues. How does that sound?

Man: It's a good idea given that we're bumping against some time constraints.

Brandon Marshall: Great. Great. So I don't see additional hands raised but I just wanted to ping and encourage the group to make a comment now on if there are additional critical gaps that you see that are missing from that - those third and fourth domains.

Jeff Schiff: Brandon, I'm going to bring up something for discussion. It may not - I think one of the things that I think has been interesting in this discussion is really about - in some ways it's about stratification of populations. And things like, you know, this came up earlier in the chat box about adolescence and whether they're separate measures or whether we need just to stratify them.

And I would encourage the same consideration around the criminal justice population that retention in treatment, you know, for folks who are going through criminal justice either through - and there's different parts of that. There's pre-arrest diversion. There's post-arrest pre-incarceration diversion or there's treatment after incarceration. All those populations may have a different look at retention and treatment.

But in terms of what it does for society, I think that there's a part of - there was a lot of benefit in maybe looking at those - some specific retention measures critically for that important population.

Norris Turner: This is Norris. Just one comment is regards to - and I think with Darshak I could just mention, you know, measures from standpoint of avoiding like a lot

of survey, big data, clients based. And I don't disagree with the premise of that comment but as we think about the other comment about - I don't know. I think it's maybe Darshak's standpoint, all the different measures that are out there and the challenge of really implementing those so that they're making - having meaningful impact that as we move towards this environment of having measures and our health data being more interoperable.

It may be in our - in the final report there's some commentary on the importance of there being interoperability of these measures where possible or where we can ultimately enable them to be translatable across these different strata where that's important because folks don't just stay in the criminal justice system.

They don't just stay in the healthcare system. People are crossing across these boundaries with addiction-based treatment, healthcare, physical, behavioral health and for us to think about the infrastructure that's used to support these measures in order to really make - have meaningful change and impact.

Anika Alvanzo: Hi. This is Anika Alvanzo. Just one of the things I'm struggling with is looking at the social issues including 15, 17 and separating them out from treatment because I feel like if you have - if you're having effective treatment, you're seeing improvement in these domains. So would these also be measured as part of treatment? I'm just trying to figure out how it's - the organization here. And so I think this is some of what I'm struggling with.

Michael Abrams: Anika, so Michael here at NQF, you know, these are overlapping…

Anika Alvanzo: Okay.

Michael Abrams: …places to file things. So you're absolutely right. I mean, you know, quality of life level of functioning measures almost certainly if they're comprehensive going to ask somebody if they have a place to live.

Anika Alvanzo: Right.

Michael Abrams: And if they're working and you would certainly want to be sensitive to that if you are treating somebody. So absolutely agree. Yet they do have somewhat higher valence than they might if you were not focused on this particular problem and treating somebody for some sort of illness, an acute infection or something perhaps.

But that's why they're somewhat more highlighted here. But you are absolutely correct. There's no reason that one measure is - has to be necessarily independent from something that's measured somewhere else even as we work hard in the measurement science world to try to avoid redundancies and burden and that sort of thing as well.

So that's just the nature of problems like this is they are multi-factorial and the factors are intersecting.

Anika Alvanzo: Right. And then I'll just speak to the comment about measures being claims based. How - I think these measures again going back to housing, socioeconomic status, employment, social support, I think those are key factors in terms of measuring treatment success but I don't see where those would - I don't know how you would pull that from a claim's dataset.

So, I mean, in some ways I understand certainly measurement but I don't want these things to be lost if we're only focusing on things that can be pulled from

a claims database because these things often aren't coded but they're critical to measuring effective treatment.

Michael Abrams: So I took - this is Michael at NQF again. I took Darshak's comment to mean that - I took it a little more maybe liberally. I interpret it to mean that nice if you can have a claims-based measure because claims are generated on a regular basis. They're available. You can do nice population studies.

Darshak, did you mean anything more than that? I mean, obviously there are limits to claims based.

Darshak Sanghavi: Yes. Just open your thoughts. And so my point was that claims-based measures to some extent they allowed true population health management because you're not sampling a small set by using a survey or other base instrument. So that was my thinking.

What I was also building on and maybe my agenda is that in my view probably the most important thing a measure could do is to ensure that we use evidence-based medication-assisted treatment for people with opioid use disorder.

That could be to some extent fairly well described by claims only and I was just sort of jumping to the end, thinking what an effective measure that will be impactful would actually look like as well and one that could, you know, be used in any geography without actually having to find the patients and survey them because they're hard to find.

Man: Very good.

Sarah Wattenberg: This is Sarah. I would…

Caroline Carney: This is Caroline…

Sarah Wattenberg:…absolutely true but I would just caution that it won't capture the cash based, you know, treatment that some people get and won't capture all the people who dropped out through training and referral.

Caroline Carney: This is Caroline. I would like to speak in support of Darshak's comments that it is great to be able to use claims-based measures. It's such a way from cost effectiveness point of view in measuring.

But I do caution against only looking in that direction in part because of what was just mentioned with cash pay, in part because of flux in the system, whether that is in a Medicaid system, someone moving from a managed care organization to fee-for-service back to a different managed care organization and so on.

And then other commercial-based insurance where PBM data is carved out or separate from health plan data. And so it's not always easy to bring all of those together especially if there is flux in the system.

So claims data will give us a longitudinal view probably better than anything else but it is not without some complexity.

Norris Turner: Yes. And this is Norris. Just to also - I want to second what Caroline is saying because as a measure developer and all of our measures are literally health claims based, mainly just pharmacy claims-based measurement and we're recognizing the importance of CMS has been a strong voice in this. There was a session they had at the CMS Quality Conference on moving beyond claims-based measures.

And I think part of the point of that session was that when you're looking at clinical, this is part of what I would say we have to think about a whole series of types of data because part of the point of that CMS presentation I think was some of the clinical-based data elements that can constitute a measure.

Those can be more readily impacted at the point of care and they support more seamless and more kind of natural quality improvement as a function of the elements of the measure.

And so we are looking at on all these different data elements to start constituting our measures and there is movement with the whole area of HL7 and FHIR-enabled measures so that they can be interoperable and it's almost agnostic to the measure type. And then they can be used across different setting.

So not that we - we have to flush all this out but there is a whole area being explored and we're starting to try to better understand that so that our measures can have most impact, you know, based on their potential.

Caroline Carney: It's Caroline again. If I could jump in on that, I think a great example is a claims dataset will tell you if medication for instance was filled will never tell you if it was taken. So you may need to move into a laboratory-based measure to get a blood level or a urine drug screen or whatever that might be in order to truly validate that.

There was also an earlier comment about trying to I think use NCQA as much as possible for these measures. I do think it needs to be mentioned that a lot of small employer-based insurance plans aren't necessarily NCQA-accredited and still provide a lot of healthcare to vulnerable groups of individuals and the

reach of NCQA will miss a large percentage of the population in that circumstance.

Michael Abrams: Yes we - Jeff, Mike - Jeff and Brandon, Michael here. So I think we should probably move on. But let me just say that staff has been taking notes during this. We've also been - we captured the chat. And based on what you have discussed, we will take the list of 26 rows that we're using to make our prioritization ballot, again, using the electioneering theme for a metaphor.

And we will add a couple and provide those to you to systematically prioritize using a schema that now Sam and Vais are going to describe for you and some tools that we set up for that.

So let me hand it off to Sam to go on to the next slide about prioritization.

Samuel Stolpe: Very good. Thank you, Michael, and hello everybody. So as Michael mentioned, our next order of business over the coming weeks and the interim between this Web con and the next will be to force rank the gaps and priorities into prioritized steps, if you will.

And to do that, we need to have some prioritization criteria. And we're going to solidify these criteria through a discussion that we're going to have right now. But first I'll take a moment to introduce each of the five.

The idea being that when we have this ballot, as Michael characterized it, you'll see a list of each of the 26 or so that we have now that we're going to expand a little bit and expand further pending any recommendations that you might give us via e-mail. So we'll allow you a little bit of extra time because I know that maybe not everybody has been able to speak that would like to.

But if you wanted to give us some more feedback on those, we'd invite you to do so.

Those will all go into this ballot. And then based on each one of the criteria we'll show you in a moment a screenshot of what this will look like. But based on each of these criteria, we'll have you rank how each of the gaps that we've identified as a committee falls in that. And then we'll tally them all up and we'll present those results to you in Webinar number five.

Okay. So that's how we're going to proceed. But let's talk for a moment about the prioritization criteria. Now the staff has generated five prioritization criteria for your consideration and we'll invite a discussion around these here in just a moment. But let me just go through and describe them.

So the first, we've put it as the first because from our view, this really is at the end of the day what makes for a meaningful measure inside of the opioid and opioid use disorder domains. And that's related to the measures overall anticipated impact on mortality and morbidity associated with opioid use.

The next criteria is around feasibility to implement as a quality measure. And we use feasibility here a little bit more broadly than the strict NQF definition which includes things like burden on providers and opportunities for improvement. Also I want you to think about data sourcing for quality measures and things of that nature that might make it challenging to either develop or to appropriately implement a measure into clinical practice.

Okay, next up, our third criteria was contemporary gaps in performance, meaning is there room for actual performance improvement on the measure? Are we at a spot where something might be kept out? Or is it something that just isn't possible for a clinician to move? For example, we've talked a lot

about the nature of fentanyl-based heroin in feeding the mortality associated with the opioid crisis. But fentanyl-laced heroin might not be the easiest thing in the world to measure or for a clinician, for example, to be held accountable for.

Okay. So next up, patient-centeredness. So we at NQF highly value patient-centered measurement and I think this is true across the quality measurement enterprise. And we want to consider those values and motivations of patients and families as the key focus of the measure itself.

And then the last criteria that we identified as a staff is around fairness and equity, making sure that it's broadly available, nondiscriminatory, et cetera.

One last caveat you'll see in the bottom right here, this is - it says, "Weights, question mark." This is something that you're welcome to discuss as a committee as you wish. But we didn't actually put forward a weighting scheme for these five criteria that we have in front of us.

But we may do so at a later point. I just wanted you to have that in the back of your minds that this is - might be an important consideration. When we ask you to rank them by each of the criteria, we won't include any weighting mechanism for you to consider at that point. But if you wanted to weigh in, so to speak, forgive the terrible pun, then you're welcome to do so during our discussion.

So those are the five that we as a staff identified. And I will hand it over to our two co-chairs to lead the discussion around any expansion or retractions from these five as we as a committee make the rankings.

Jeff Schiff: So I think we've had some discussion already about some things on that list. Do you want to go back to the five? Thanks.

So I think we've already had some discussion, for example, about feasibility with regard to data collection and et cetera. But I'd be - I think we're curious to hear from you folks about whether these are the right prioritization criteria and whether you think any of these should be weighted more highly than others.

Brandon Marshall: Perhaps, Michael, just for discussion, can we put up the template ballot? That might be helpful for folks to get a sense of what this will look like?

Michael Abrams: Yes, you bet. Go ahead and Vais can pull that up in a flash.

Actually if this will generate discussion, Vais, do you want to take a minute here and describe what we have in front of us?

Vaishnavi Kosuri: Of course. So I think we actually had a conversation earlier and we might change this up a little bit so you guys can see each of the criteria. But the idea is we'll have our list of 26 to 30 - we had a couple of additional gaps come in today on the left-hand side. And then we'll have ratings which include a rating of Low, Moderate or High for each of the criteria that we discussed earlier.

So for the impact on morbidity and mortality, that would be one rating; feasibility, another rating; contemporary gaps, another rating and so on. And so for each of the measure gaps that we see, you guys will be able to rate. And then if you have any supporting evidence or any other information, you would be able to input that information and we have a box at the end of the -

we have a box at the end of this scale where you're able to provide that information.

Does that make sense? It'll be a survey monkey of sorts.

Any questions?

Patty Black: This is Patty. I have a concern. And I keep looking at this "anticipated impact on morbidity and mortality." You know, to me, if you're a member of a minority, I mean that just might make a huge difference in that alone.

Vaishnavi Kosuri: To clarify what…

Samuel Stolpe: You know what, Patty, this is Sam. I'm really interested in your thought on this. Could you help me understand a little better?

Patty Black: Well, you know, there are certain minorities in our community that let's say equity and healthcare that this person might not be equal.

Michael Abrams: So, Patty, Michael speaking here at NQF. So let's take that as an example. So let's say you're looking at a measure and you feel like it has differential implications for different populations. Maybe minorities or people in rural areas are not well represented by the measure.

But the measure overall reduces hugely morbidity and mortality in urban areas, so much so that it's quite an important thing. The way you might rank this is when you get to Item 8 for that particular measure, you might pick High just by sheer volume of people. But when you get Item Number D, the Patient-Centeredness or Item Number E…

Patty Black: Okay.

Michael Abrams: …you might then rate that as low…

Patty Black: Okay.

Michael Abrams: …to account for that and it allows you to do that. And the weights later by the way might be used to differentially sum these, if you will. You get a score, a perfect score as high on everything. That presumably means you're saying - you're telling us that the measure is of high importance on all - every single criteria.

That would be 5 times 3, 15. That's an unweighted score. The weights might adjust it so we don't care about feasibility, for example. Maybe we don't care whether it's a claims measure or not. We'll rank that as lower.

But that's a discussion for another day. But the point is that you on each criteria will rank it from 1 to 3, 1 being low, 3 being high as in terms of its importance. And it allows you to address things like equity and patient-centeredness which is I think the thrust of your comment.

Does that help?

Patty Black: Yes, I like that. Thank you.

Michael Abrams: Okay.

Brandon Marshall: Are there other questions or comments from the committee on the criteria in front of us or this issue of whether specific criteria should be weighted?

Katie Jordan, go ahead.

Katie Jordan: I actually had a question on B. Can you expand a little bit more on what feasibility means? Is that feasibility for whom? I'm - I was assuming that meant for providers to be able to engage. But I'm not sure if that's what you mean by that.

Man: It's certainly a very important consideration when we're talking about feasibility. So feasibility is to implement as a quality measure. We're - the main thing that we had in mind as NQF staff is according our own criteria which is very much focused on burden of implementation. That might be burden for providers.

It could also be for example, for patients. If you have an extensive survey that you're putting in front of them, we need to consider exactly what it needs to put the quality measure into place. But we also wanted to think about it in terms of things like data sourcing as Darshak mentioned.

There's some priorities that get placed in weighing the value of a data source for it to be accessible, for it to just be a normal part of the way the business is conducted and for its overall impact as we imply from a population standpoint, being able to measure it in a broad sense.

So feasibility to implement takes into account a lot of different things. But those were the primary ones that we had in mind.

Patty Black: So then there is some overlap and some redundancy between that criteria and some of the other ones. I'm just wondering if on the survey form, will there be a place for qualitative notes to explain, you know, why you picked that for that particular element?

Michael Abrams: Yes. Michael here. Thank you for asking that because to the extent that you can, if you do put - place something in an extreme, particularly if you place it in the high area and you can - and you say this is a really high priority and you happen to know of a fact, of citation, of study, a gray literature report that really is demonstrative of why that's so important, we do give you a text field where you can enter that sort of thing.

So we encourage you to do that. That's a - we're asking a lot. But it does help staff make sure that the final report is supportable. And it also may help in the discussions moving forward for us to decide if something really is a priority or not. So there will be text fields available.

Having said that, your main responsibility will be to go through and use this ballot just kind of same way you would be if you went into a voting booth and you hit - selected your candidates or rank-ordered your candidates in this case. So a little more sophisticated than binary voting. But we do give you a chance to write in things, including supports for the points you're making.

Jeff Schiff: Hey, Michael?

Michael Abrams: Yes.

Jeff Schiff: This is Jeff. I just think - I just want to clarify one thing that I think might come out of Patty's question. I think feasibility to implement is around feasibility of collecting the measure as a measure and C, Contemporary Gaps in Performance, I just want to be clear, is about the ability of a health system or a health plan or a state or whoever to address a gap in performance in the measure.

So it's not - so that - so B is not about feasibility to implement a quality improvement program to improve the measure. That's really C, which is can you - is it possible to impact the measure when you're making a big gap. That's my understanding.

Samuel Stolpe: Yes, you're correct. This is Sam. And my apologies if I weighted that or, like, combined the two. Those are intended to be totally separate.

Jeff Schiff: Okay.

Samuel Stolpe: Yes.

Michael Abrams: And I would add a clarification about gaps. So I gave an example earlier in the meeting. You know, naloxone availability in emergency rooms is probably pretty close to 100%. So even if that's an important thing to understand, you - you know, if everybody is doing it, it's not something you need to create - generally create a measure to follow unless you're worried people are going to recess on it.

So gap really means that there is a demonstrable room for improvement in something that's desirable and that you could measure. Okay?

Man: Any other comments? I think we're ready to move on.

Vaishnavi Kosuri: So just to provide an overview, we already addressed this but staff will prepare a list of - given our discussion today as well as some of the criteria that - or some of the gaps that we compiled earlier. And so we ask that you as TEP members add any concepts if you believe that a gap is still unrepresented and that you grade and rank these gaps. And if you have any citations, as

Michael mentioned earlier, or any facts of support, we do have a text box at the end where you can provide those information.

Michael Abrams: And let me just offer some inspiration to you all. And I'll single out Antje because she brought up a screening - universal screening measures maybe being an important addition to the list. So the challenge that I give you all is that as again if you think about adding things, then when you add them, provide some support for them and think carefully about whether or not they're - what you're adding is a priority that hasn't already been considered. Okay? And would be a priority based on the criteria that we're talking about.

So with regard to universal screening, the question for Antje is would - is this really something where there's a gap and where if you did universal screening, you would all of a sudden detect a lot of new cases that you could intervene on and really impact this epidemic in a way that wouldn't be the same as if you did something else that might be more impactful like just expand buprenorphine slots all over the country specifically. Okay?

Just to sort of challenge you to think about anything you might add and how it really fits in to the big puzzle, is it really a high priority and what's the support for that?

So you're welcome to put in write-ins. But please do a little extra thought and diligence for us before you do so we don't just get this explosive brainstorm list. That's not where we're trying to be at this point of the TEP. Okay?

Vaishnavi Kosuri: Okay. Thank you, Michael.

Now we will open up the call for a public comment. If you have any comments or questions, please send them either through the chat box or the line is now open for any public comment.

Man: It's quiet.

Vaishnavi Kosuri: Okay. It seems I think we have none for today. Our next steps, we will be submitting our final environmental scan. It will be out to the public on September 6th. And our next Web meeting will be on September 16th. We will reach out to you guys soon to send out this survey just about this ballot. So please be on the lookout. We would encourage as much participation as possible. And thank you guys for a great Webinar.

Our co-chairs, do you guys have any last words?

Man: I just have a quick question, Vais. When is our homework due? Apologies if you said that already. I just missed it.

Vaishnavi Kosuri: So we will be sending it out on the 28th. And we're hoping to get it back by the 27th.

Man: Great.

Vaishnavi Kosuri: Yes.

Man: Great. That's it for me. Thank you so much everyone. I enjoyed the conversation today and all of your insights. And thanks in advance for completing the ballot for us. It'll be very helpful for NQF staff moving forward.

Vaishnavi Kosuri: Okay.

Man: Agreed.

((Crosstalk))

Vaishnavi Kosuri: Thanks…

Woman: Bye-bye.

Woman: Thank you.

((Crosstalk))

Man: Next. Okay.

END