Opioid Technical Expert Panel Web Meeting 6

Moderator: Kim Patterson
October 10, 2019
12:00 pm ET

Sam Stolpe: Hello and welcome everyone to the National Quality Forum's Opioid and Opioid Use Disorder Technical Expert Panel Web meeting. This is our sixth meeting and the penultimate. We will be having one more. But that meeting will be to address comments. So really this is one of the final substantive discussions that we will be having as a panel.

This is Sam Stolpe speaking. I'm a senior director here at NQF. And I'm joined by my colleagues at arms around the table. Michael Abrams, a fellow senior director, as well as Madison Jung who's a project manager and we're also joined by Kate Buchanan who's senior project manager here at NQF.

Do we have our co-chairs on the line, Brandon Marshall and Jeff Schiff?

Jeff Schiff: Present.

Sam Stolpe: And Brandon I believe is dialing right now. So on behalf of the NQF staff, welcome everyone. And I'll turn over to Jeff for some words of welcome as well.

Jeff Schiff: I'm just say a couple of things really quickly. First I just want to thank everyone who's here and has followed through in this process. It's been I think an interesting process and I think just from my perspective in working with national things, this is one of those projects that will over time the importance of the work will grow as people start to realize that there's this body of workout. So I think that's important.

And then I just want to really thank Sam and Michael and the folks at NQF for somehow distilling the conversation we've had and putting it into a useful format. And I think that's been a lot of work and I think - but I think it's also because of the feedback we got from the group. So we're hoping to continue with a good exchange today.

So back to you guys. Thank you.

Sam Stolpe: Thanks very much, Jeff. Brandon, we're you able to join? And so would you like to say some words as well?

Okay. We're still waiting on Brandon. But let's just go ahead and take a look at our agenda for today. In our last Web meeting, we showed to you the result of a prioritization exercise around measure gaps we as a technical expert panel and staff had identified. We wanted to impose some order of prioritization on them.

We've written up those results based on the discussion from last time and included them into a draft final report along with the essence of the discussion from our last meeting as well around the five federal programs and recommendations from this panel on what sorts of measures should be included at them as concrete recommendations as well as general guidance

that you all were had put forward per NQF to consider - excuse me, CMS to consider as they're thinking about their overall approach to opioid and opioid use disorder quality measurement within each of those programs.

So this meeting what we intend is to review and discuss their articulation that we as staff have put together based off of use of the transcripts, the recordings, the chat and follow-up e-mails that we had received from members of the panel. And we've put those into the final report as both the measure depth prioritization and the guidance for CMS federal programs.

So today we'd want to get your reaction. And we have done our best to capture it and we want to make sure that we captured the right things. So we'll walk through what we've articulated in the final report fairly meticulously with you over the course of the next two hours and invite some discussion around what we've put in there.

So with that being said, what I would ask at this point is for us to go ahead with our roll call. I'll turn over to Madison to conduct it.

Madison Jung: Great. Thank you everyone. Again this is Madison Jung, Project Manager here at NQF. Just a few housekeeping things before we get started.

If everyone on the line could just use their own handsets, that would be extremely helpful so we don't have to mute you from our end if you are not speaking.

And then just a reminder for members of the public joining us today, there will be an opportunity for public comment at the end of the Web meeting.

Great. So now if we can roll call. So I know we have just our co-chair Jeff Schiff with us. Brandon, are you on the line yet?

Brandon Marshall: Yes I am. Hi everybody.

Madison Jung: Great. Thank you, Brandon. Did you want to say anything before we get started?

Brandon Marshall: No, just welcome and I'm looking forward to this discussion.

Madison Jung: Great. Thank you. Next we have Anika Alvanzo.

Anika Alvanzo: Present.

Madison Jung: Great, thank you. I have Michael Ashburn.

Michael Ashburn: Present.

Madison Jung: Antje Barreveld?

Antje Barreveld: Here.

Madison Jung: Thank you. Patty Black?

Patty Black: Here.

Madison Jung: Jeannine Brant? Okay. Caroline Carney? Okay. Anthony Chiodo?

Anthony Chiodo: I'm here.

Madison Jung: Thank you. Jettie Eddleman? Maria Foy?

Maria Foy: Here.

Madison Jung: Thank you. Jonathan Gleason? Okay. Anita Gupta?

Anita Gupta: I'm here.

Madison Jung: Thank you. Mark Hurst? Katie Jordan?

Katie Jordan: I'm here.

Madison Jung: Thank you. Navdeep Kang? Okay. Sarah Melton?

Sarah Melton: Here.

Madison Jung: Gary Mendell?

Gary Mendell: I'm here. I'm also here joined by (Sam Arsenal) with (unintelligible) focus group as well. We have our quality measurement programs.

Madison Jung: Great, thank you. Welcome everyone. Darlene Petersen?

Darlene Petersen: Present.

Madison Jung: Thank you. Laura Porter?

Laura Porter: I'm here.

Madison Jung: Thank you. James Rhodes?

James Rhodes: Here.

Madison Jung: Thank you. Darshak Sanghavi? Thank you. Evan Schwarz?

Evan Schwarz: Here.

Madison Jung: Evan, I know you're online but maybe you're just joining still via audio. Norris Turner?

Evan Schwarz: Yes. Can you hear me?

Madison Jung: Oh, great. We can hear you now. Thank you.

Evan Schwarz: Oh good.

Madison Jung: Norris Turner?

Norris Turner: Yes, here.

Madison Jung: Thank you. Sarah Wakeman? Okay. Sarah Wattenberg? Arthur Robin Williams?

Arthur Robin Williams: Yes, hello.

Madison Jung: Thank you. Hello. And Bonnie Zickgraf?

Bonnie Zickgraf: Hello.

Madison Jung: Okay, great. Thank you everyone and thank you for taking the time to join us today.

And just to thank you and welcome to all our CMS colleagues who are able to join us as well.

Okay. I believe the next section is we'll begin the review and discussion of the measure gaps prioritization exercise. So I'll turn it over to Michael to give an introduction.

Michael Abrams: Okay good. Welcome everybody. Michael Abrams here. And so what I'm going to do is go through the first agenda item which is to review the prioritization of work that you all have done. And of course this being related to the environmental scan. And as Sam described, this is the first half of our report essentially of the activity today to go over the prioritization work and the conclusions that came out of that. And then the second half of the discussion today will focus on these five important federal programs to talk about measure sets that could go into those based again on your recommendation.

So I'm going to try my best to keep us yoked to the slides, either the PDF or the online version. So right now you should be looking at this deck and confirm for me that we're looking at Slide Number 6. It's entitled "Prioritization Methodology." And what I want to just remind you of here is what we've done up to now in order to identify priority gaps in particular. That is area that appears to be wanting or lacking with regard to opioid and opioid use disorder measurement and measurement concept. So very much focused on gaps here and you focus on prioritizing them in some way that is rank ordering their importance for deployment in some way for CMS as a big stakeholder in the battle against opioid use and opioid use disorder but for the

broader stakeholder public interested and addressing the opioid issue and specifically interested in doing that vis-à-vis quality measurement and quality improvement activities related to quality measurement.

So looking at Slide 6, this is a reminder for you of the kind of connotation that we did based on your voting with regard to the quality measures and quality measure concepts that we isolated from the environmental scan or that from the environmental scan you all found to be missing thus, you know, clear errors of commission could be represented in the prioritization work that we did as a gap or which perhaps is more likely the case some sort of measure exists but there were some holes with regard to that measure that needed to be particularly emphasized as a priority gap, as an important gap.

So on Slide Number 6, what we're looking at are the methods and the final scores that we got from engaging you all and voting about priorities. So let me remind you how we got here to this connotation and then briefly give you some heuristics so you can use it moving forward when we look more specifically of specific measure concepts that came out of this, all right?

If you recall, the environmental scan identified something like 200-plus measures that existed from NQF's database, from CMS's database, from staff's review of the extent literature. So 200-plus measures that exist today and then another 70 or so measure concepts that is measures that were more inquorate, less developed as specific quality measures. So something on the order of 270 specific ideas were - came out of that environmental scan.

You also could look at that. We have discussions as a committee, some discussions offline as well. And from that we derived, if you recall, something like 30 -- I think it was 33 -- gap areas that emerged from that environmental scan review. Okay?

We took those 33 areas and we created a ballot for you and we sent it out to you and you ranked or you scored these gap areas to try to help us, you know, data review quantitatively into priority gap areas in such a way that we might be able to rank those priority gap areas.

And the bottom of Slide Number 6 reminds you of the criteria that we used in this form that I'm going to talk about in a moment. But if you just look at the bottom formula there, you see just a reminder to you morbidity and mortality was a key criteria that you were asked to score from 1 to 3, right? Three being it represents - the measure represents an important gap area that affects morbidity and mortality as one specific example.

Then feasibility was also a criteria you scored from 1 to 3. Performance gap, that is evidenced somewhere that the measure, the way people were performing on the measure, let's say, rates of medication-assisted treatment as an example. The way people were performing on that suggested that some were poorly performing and others were highly performing, that there was a gap there that suggested room for improvement. So that was one of the criteria we asked you to consider.

We asked you to consider patient centeredness as well and then somewhat related to that was distinctive from that. We asked you to consider fairness also. So you scored all of those from 1 to 3 and we had some of the scores. So just to be concrete about it a perfect score would have been a 15 which is to say that you would have scored it as, you know, all criteria - all five criteria times three hit to 15. A perfect average score then would be a 3.0, okay? Just again to be very clear about this.

What you see then is Table 3 on the top of Slide Number 6 are the means that came out of three different scoring methods or compilation methods we use to coalesce the responses we got from you all. Okay? On these 33 measures. And it wasn't 100% but 20 out of 28 of you actually went through this exercise. And so we got pretty good representation we feel from you about this.

And you can see there are three different scoring methods that we use and what you really need to take home from this slide and from the way it's hopefully clearly described in the report is as follows: If we just simply sum the scores that you provided us, that's the first line, the reporting line of this table, simply some item average. The average score across these 33 items was 2 to 3, 2.3. So a little bit above a moderate score of 2. And the moderate scores are listed in the last column there, okay?

Similarly, so looking at the very last row of this Table 3, if we just took morbidity, your morbidity and mortality ratings in isolation we got a similar score as well. And by the way there are standard deviations for those of you interested in dispersion there as well pretty similar. So both of those scores had pretty good, you know, what you would call conversions in terms of the results we got from rank ordering. You're given ranges there.

But the main take home message here is for the simple-sum or for the average sum across these 33 measures, 2.3 or a little bit above moderate importance as a gap is what you all rated, okay, across these 33 items. But there was some distribution that allowed us to do some rank ordering. The standard deviation is around 10%. So that is a risk that you can take moving forward as a quantitative indicator.

Then in the middle of this table titled "Weighted-Sum Item Average," I want to remind you that we deployed a pretty simple formula. It's now at the bottom of this slide, okay? Instead of just summing things directly, we gave higher rate to morbidity and mortality. That's arguably because the reason we're here is because people are dying at higher rates or experiencing higher rates of OUD especially or perhaps obtain related to it to OUD, right? And these were key drivers. And so we want to just ask the question, what if we just look at that in isolation?

But here in the weighted-sum we get higher weight to that factor in particular, a little bit less weight to performance gap, patient centeredness and fairness, multiplied by 1.5. And then the lowest weights of feasibility. I think for the simple reason that you as a committee and NQF in general feasibility while it's important criteria we don't want to discourage people from, you know, shooting for - shooting high in terms of trying to come up with an ambitious message just because it's difficult to deploy. So feasibility gets a little less weight.

That weighted average sum has a different distribution centered at around 3.3. And - but again if we look at the mean, it's a little bit above what the moderate score would be. So this even some conversions there overall with regard to the scores. So just keep these scores in mind. As we look at future slides, again if you keep the number 3, roughly 2 to 3, in mind and a 10% standard deviation in mind, you do a pretty good job interpreting the numbers that come up on subsequent slides.

So let's take a look at then at Slide Number 7. And here is a list of your top priorities. So remember I told you we took 33. You voted on them as we discussed in some detail at the last meeting. Sixteen were identified as particularly high. So those were the ones that we emphasized in our diff

scores. We do by the way report the other 33 and in fact keep in mind for those of you who might feel, oh, you really wish a certain measure had made it into the priority list and it didn't, those are prosper in the environmental scan as well and still available for you all, for public consumption, for CMS.

But prioritization was the aim here and using these scores, what this - what's shown on Slide 7 and then continued on Slide 8 are measures that via one of the three scoring methods I just described made it to the top ten. Okay? And let me say that another way. So we took the top ten if a simple-sum put in the top ten or a weighted average sum put in the top ten or just morbidity and mortality put in the top ten.

And again this slide what you've seen in some form previously you can see the scores are there as well as the rank ordering in parenthesis. So the top measure on this slide was patient-centered pain management and its rank order in total was - for the simple-sum was 1st. By comparison if you scroll over to column, its rank order for morbidity and mortality was 14th from that list. I'm going to talk more about that in a moment.

Let me just go through these and make sure you're clear on the meaning of them. At some point we're going to ask you explicitly if you feel like this is capturing things that you care about, things that are priorities. Are we - have we summarized the exercise and the endeavor well in terms of you doing this prioritization?

So the number one item on this slide is patient-centered pain management explicitly focused on tapering strategies. But when we proffered it to you on the ballot, we were explicit to include a record of full pain and quality of life assessment as well including substance use history and assessment and monitoring and sleep disorder risk. So the point is a lot went into this

particular measure concept in terms of looking at how you best manage pain and make it patient-centered. This was your number one pick based on simple and weighted measurements in particular although it dropped somewhat lower when looking at just morbidity and mortality.

The second row is - a recovery measure was processed here. And the emphasis here I think is looking for long-term follow-up measures beyond six months, for example, which is a measure that already exists, for example, for MAT therapy or medication for opioid use disorder therapy, looking for measures that go 12-plus months or even longer after treatment initiation begins.

The third item on there is special populations and this includes a number of different populations the way that we put it in the ballot: Pregnant women, criminal justice populations, homeless populations, adolescence and rural residents. So there's a lot that goes into this measure. You ranked it quite high overall.

Item Number 4 on there is benefits and reimbursement-type measures specifically recording by region or a payor for core ASAM level services. Again you ranked that one fairly high.

And let me quickly then review the next few opioid use disorder treatment comorbidities came up physical. That is physical comorbidities in this case like cardiovascular disease and diabetes.

Neonatal abstinence syndrome, Item Number 6, specifically follow-up for children. This is postnatal emphasis for this particular measure or measure concept.

Item Number 7 on this slide, patient-centered pain management certainly related to Item Number 1 but here the thrust was at least that a plan was engaged in some way with regard to somebody receiving pain management.

And then Item Number 8 on this slide again referring to benefits and reimbursement but this time looking at the payor of substance use services, looking at average coverage benefit as opposed to reimbursement. So a little bit of a subtle change from Item Number 4.

Now one other point I'll make before I advance to the next slide. The third column is something novel that we added after our discourse with you last time. It's a health tool for summarizing things a little bit further. And let me tell you how we came to this. It should be - it's not intended to be nuance or that complicated. So let me make sure that you all feel like you understand it.

What we did here simply is we took the sum of all ranks. So using Row Number 1 as an example, we took the first rank for simple-sum plus the first for the weighted-sum, one plus one, and we added it to the 14th rank for the morbidity and mortality average. We come up with the number 16th as sum of ranks straightforward. This is a way to coalesce all things together.

And then we did a rank ordering based on that. So if you look at just the sum of the ranks, then this first item on the slide actually ends up being the third highest ranked priority gap item, okay?

Now I would point out one thing that was brought to our attention by our chair. Thank you, Jeff, in particular for pointing this up. This sum of ranks emphasizes three times morbidity and mortality via the simple-sum and the weighted-sum especially and then in the sum of the ranks.

So we are overemphasizing it, if you will, in particular morbidity and mortality. You can argue in this. But you could argue - also argue which is what we try to do in the report that this is a simple and straightforward data reduction that gives you an overall rank.

So items that are starred here on the slide and then one item on the next slide are ones that via the sum of all ranks ended up in the top five. I'm going to talk more about that in a moment. But let's advance into Slide Number 8. Okay.

So Slide Number 8. And I need to advance myself here. Very good. Slide Number 8 just as a continuation going to the top 16 ranks. Remember top ten from each of three. So it was more than ten. You see Item Number 9, comorbidities this time with an emphasis on psychiatric comorbidities like depression, for example, and the importance of that for treatment. That by the way is our fifth highest ranked item using the sum of all ranks, you know, noted from the slide, the right-hand column,

Then quality of life measures, functional measures for pain and OUD both. So this is sort of a double barrel measure concept, if you will, cross-cutting both aspects of morbidity that we care about for this study.

Item Number 11 is an interesting one because the overall morbidity is low for elderly folks compared to younger persons, people on transition age years for example. But nevertheless you all prioritize the elderly as a special population worth attending to.

Item Number 12 is harm reduction stuff, naloxone treatment, safe injection sites, that kind of thing and measurements related to that.

Number 13 and 16 I want to make sure I differentiate because this slide truncates those concepts a little bit. So Number 13 is a concept that you emphasize that refers to successful referrals to treatment for those discharged from detention. Of course individuals leaving incarceration are at high risk for overdose and no doubt that's one of the reasons that you prioritize that as an important measure concept to consider.

And then 14th, social risk factors broadly social support, things like peer support, housing support, general support through social services is the thrust there.

And then neonatal abstinence syndrome comes up again, this time with an emphasis on the pre and perinatal period and in particular helping pregnant women make that transition and address their addiction and their concerns for their infants simultaneously presumably is the thrust of that.

And then we've already talked about Item Number 16.

So this is a description and we tried to proffer the same in the report that gives, if you will, the top ten or in this case the top 16 measures that (unintelligible) out of that 300-plus environmental scan exercise that we did and your discourse related to that.

Advancing them to Slide Number 9. What we're emphasizing here are those top five measures that came out of the sum of all ranks method. And let me be explicit about one of the reasons that we did this. If you recall, there's some discussion and in particular I think Darshak Sanghavi made this point during one of our last two meetings that in deploying measurement that it actually is kind of difficult to do lots of measures all at once and I think Dr.

Sanghavi, you know, suggested that if we could deploy one or two over the next year or so, that would be ambitious given what it takes to get things done.

So it could get things approved and tested, et cetera. And so we wanted to put forth for CMS and for the broader audience and we hope that you agree or else give us some suggestions about how to adjust this.

A somewhat smaller list in 16 and we thought coming up with this list of five, which I'm showing you on this slide here, reviewing ones that we've looked at we started in the previous slide, it made sense to do that vis-à-vis in particular the rank of all sums, all the methods that we did sort of coalesce together.

So again this is not to say that the other measures aren't important gaps but to try to just help somebody with limited resources in particular or who doesn't know where to start in terms of selecting important measures to - important measure gaps could go to these top five as they're starting point if nothing else.

So finally on Slide 10, I want to bring up some specific discussion points, sort of themes, if you will, that came out of all of this discourse and the report writing related to gaps.

The first two bullets have already been touched upon, you know, that opioid tapering was in particular important related to pain therapy, the second bullet being these special populations including - especially including the pain person, some pregnant women being important.

Then Item Number 3, which I touched upon briefly, that feasibility or engineering implementing a measure, you know, Slide Number 10. There we go. Okay. Okay.

Slide Number 10 we're on and middle bullet, feasibility can be challenging and the committee acknowledges that. But the measure and measure concepts proffer here are still done so by you all as realistic goals and important goals to fill important gaps related to the problem we're addressing.

As an example, long-term follow-up is something that came up explicitly certainly difficult to track a patient for a year for many years. But nevertheless we think as NQF staff that you all feel this is important and worthy measurement goal.

The final three bullets are just sort of broad things about this exercise, again reminding you that, you know, we think 16 measure gaps overall. Those measure gaps some of them quite complex. They have mapped almost certainly to many more actual specific measures that one might conduct depending upon levels analysis or the particular thrust and emphasis of the measure. So that should be acknowledged as well.

Developing and deployment measures, again this related to feasibility point is resource-intensive. That's acknowledged. But again our aim here is to recommend realistic gaps to try as well.

And then finally a bullet that we added during the writing process because we've inferred it from the discussion but we wanted to make it explicit and get the committee to buy on it, it seems to us at NQF that you won't care certainly about OUD but you care more generally as well about substance use disorder and it relates to this particular epidemic and crisis that we face as overdoses

are related to the use of other substances, benzodiazepines, alcohol and to newer or reemerging overdose agents like cocaine and methamphetamine as well. So we wanted to make that point there one such tone in particular for discussion to make sure you all agree with that.

With that, I'll advance to the question on Slide 11 and open it up for - to the chairs for some comment, open it up for discussion. And as you like of course we can shift back to a particular slide or two if you want to talk about specific issues. But the question on the tables and for us is, have we at NQF accurately captured the recommendations and guidance regarding priority gaps that you all as a TEP have advanced to.

So with that, I'll hand it back to Jeff and Brandon and in particular I think, Brandon, you're going to moderate this part of our discussion. So please?

Brandon Marshall: Thank you, Michael. So as usual I'll watch for hands to be raised or questions in the chat box. None yet. Are there any questions or comments from the committee? Bonnie, go ahead.

Bonnie Zickgraf: Yes thank you. I don't know if we could go back a slide or two or even if it's mentioned on either of those. Where does patient education flow on the ranking?

Michael Abrams: So this is Michael speaking. That's a fair question. I think in particular it would certainly be related to - so education there're essentially two types of patients we might think about. One is in the opioid use disorder treatment domain. The other of course in the pain management domain. In both cases if you think about a plan and what goes into that, there's an education component to that. I presume that may be where the committee's interest in that kind of measure, so.

And then generally speaking good OUD treatment could arguably include a measure that explicitly talks about patient engagement with peers and as well as with conditions directly and that, you know, the direct providers and their family.

And then thank you, Sam. Sam just pointed me to the area of the environmental scan and the overall measures that talk about social risk factors. It's our Appendix B actually on this - also on this current report. There are some measures that refer to education as well under social risk factors in particular is where we clustered gap.

Bonnie, does that help clarify for you and others?

Bonnie Zickgraf: Yes it did. I just assume that it was clustered somewhere. I just didn't know where. Thank you.

Sam Stolpe: Yes. So, Bonnie, this is Sam. We had identified a gap as a panel which would meet the prioritization exercise though a little lower than our top 16. And that was the social risk factors, patient and family health literacy which parenthetically we said that i.e. patient and family education regarding opioid use and misuse and pain management for all at risk both pain and OUD patients.

So that did fall a little bit lower in our prioritization. So it wasn't inside the top 16 for any of our methodologies.

Jeff Schiff: Sam, this is Jeff. I also kind of wondered of Bonnie's point whether or not when there's measure development around patient-centered management and

tapering strategies. As a step there's going to be some education component around - potentially around a measure that will be developed in that category.

Michael Abrams: Agreed. Agreed. This is Michael speaking. It's hard to imagine a patient-centered approach not engaging the patient in some way in learning activity. I mean, understanding what their treatment is about.

Patty Black: You know, this is Patty. On Page 6 of the report, excuse me, we talked about patient centeredness, i.e. considers patient desires. I think if we include "considers patient perspective and desires," I think we get more of that partnership and collaboration which is key to patient centeredness and, in turn, allows for a dialog and education opportunities.

Michael Abrams: Very good, noted. Noted, Patty. "Patient perspectives and desires." That language is useful.

Brandon Marshall: Michael, I have I guess what you call lumping and splitting question if we go to Slide 10. With the top five. Back one.

Michael Abrams: Very good. Slide 9. Yes.

Brandon Marshall: There we go. I do see that measures related to physical comorbidities are two. And then Number 5 is psychiatric comorbidities being trusted in feedback from NQF or the committee on whether those could potentially be aggregated which would then allow you to add another concept to the top five or if they should be distinctively different in both warrant inclusion in the top five.

Michael Abrams: Yes. So it's Michael here. So it - if we could, you know, (unintelligible), right, to combine the two. And yet when we did proffer them, we had them

distinct. So it, you know, it could be done either way, Jeff, and others if you like. We could make - we could alter the top five list and grab a concept for this particular data reduction exercise. No reason I can see not to do that.

Although the only perhaps argument against that might be that physical comorbidities and psychiatric comorbidities are - do have a distinctive etiology and treatment paths and so forth. And when you (unintelligible) I want us to get one or the other. So that might be a case for sort of retaining the split. But certainly we're open to that.

Do others have advices maybe you can just advise us NQF staff as to how you'd like us to proceed? Should we alter these five in that way? We're certainly open to that.

Jeff Schiff: So, Michael, if you look at the next one that would jump up into the top five would be patient-centered pain management. It's on Slide 8.

Michael Abrams: Okay. Thank you.

Jeff Schiff: And the way to - one other way just to help this discussion, one other way to look at this is right now of the top five, four of them are basically centered around OUD treatment and one centers around pain management. And if you - if we were to - if - kind of talking, advocating a little bit I guess to lump. If you did that and we have three on OUD and two on pain management.

Brandon Marshall: Yes. Good observation. Good observation. Other comments of that particular point? Do people like the idea of them adding - aggregating, as Jeff said?

Anita Gupta: This is Anita Gupta. I'll add - I'll echo that comment. I think that there needs to be a little bit more of the 360 balance to the point there. I think there's definitely a need for patients in the side of prevention and education around pain management and to the point about patient centricity, you know, there's definitely a lag, you know, of education on how pain should be managed and the expectation, you know, on those front-ends, you know.

And I think that can be very helpful, you know, for the broad populations and the special populations that you're talking about, you know, in the reference point here in the concept, you know, description.

So I think that could be very helpful in the top five, you know, and particularly when there's multiple comorbidities and, you know, preexisting psychiatric issues and other conditions.

So I think that's the sort of point I would mention.

Brandon Marshall: Great. Thank you. And, Anika, I see your hand is raised.

Anika Alvanzo: Hi, yes. I will concur I have two things. So one I concur was consolidating the psychiatric and medical comorbidities. I mean, we're treating the whole person. So we should be assessing all potential comorbidities that they are experiencing whether it's medical or psychiatric.

And then my other question was related to special populations. And, you know, I don't see anything about initiation of medication for, you know, inpatients or patients seen in the emergency department and could they be added to the special population. I really feel like we should be pushing health systems to look at initiating treatment when, you know, somebody calls in to

your EB with an overdose ideally, you are - they're getting people norphine or something before they leave your institution, likewise if they're admitted.

And so there's room to include those populations in special populations. I don't know.

Michael Abrams: So this is Michael at NQF. Let me try to respond to this because this has come up before and it's an important point. There are - I think the reason that initiation measures didn't emerge per se for MAT or MOU didn't emerge per se as a priority gap is because there are initiation measures that came out of this game, okay?

So having said that, you know, this point has come up and it's an important one. And you've made it, Anika, and Michael Ashburn has made it just recently today in his comments on the report. One way to conceptualize the gap is that you have a measure and that is not being deployed, okay?

Having said that, that's not mostly the way we did the gap analysis here. The gap analysis was looking for things that were completely missing. And so one of the things that's missing about MOUD, which is captured, is that there isn't maybe long-term follow-up. We're not talking about initiation. How about long-term follow-up related to persistence beyond that six-month window which is a measure that currently exists for MOUD.

So the place however to capture them I think isn't under gaps, priority gaps per se but instead in the next activity that we're going to be discussing today about measure sets and measure systems and it's clear to us that you all care about seeing that there are initiation and continuity measures related to mediation for opioid use or the methadone/buprenorphine principally.

So I think that that's where that's going to come. You know, again it's sort of a question of organizing your thoughts about whole in measurement and measurement signs versus creating measure sets and where those issues lie especially vis-à-vis these really important federal programs we're going to be talking about.

So, Anika and Michael Ashburn, if you're on the line as well because that sounds reasonable and does it capture your thoughts about the importance of these kind of, you know, measures, initiation and continuity of medication?

Anika Alvanzo: Yes, that captures my concern.

Brandon Marshall: This is Brandon. I do think there's a corollary there though if we go to the top five list. I could - want to fly this, Michael.

You know, lifting the special populations there's always going to be some debate as to what should be included in those parentheses. Can you just remind me or the committee, you know, is there an opportunity to revise what's in the parenthesis or what was the rationale for including these specific populations. You can easily argue that might - maybe deference, for example…

Michael Abrams: Yes.

Brandon Marshall: …being this category.

Michael Abrams: So in terms of, you know, I think we have to be transparent about our process. So in terms of proffering a voting, what you're seeing in the parenthesis, you know, when we made the ballot, this was who was on the ballot, okay? Election metaphor for.

Having said that, if there are other special populations you would like us to comment about in the report, we can certainly do that. For example it's notable here as I pointed out earlier that elderly wasn't put in this particular bracket in particular. Again I think that's supported by the fact that they're also an important population generally especially to CMS and Medicare, right? The overdose rates in the elderly population are well below 5, you know, or 1/5 the rate of younger individuals.

So that's perhaps why it didn't come in here. So there was some meaning to creating these super clusters as complex as they are. And we are open and pleased that you could know us or make comment now if you like about other special populations you think we have it in some way, tip that you think we should at least note in some way on the report. We are here to do that.

Brandon Marshall: Excellent. Thank you.

Man: Michael, is there a rationale or not a rationale per population's ratio on the communities not being specifically listed?

Michael Abrams: Yes. Social determinants and whatnot.

Jeff Schiff: Because I think in some ways, you know, sadly some of these issues obviously hit African-American and American-Indian populations a lot but they're not specifically called out in the special population. But I know in a lot of states that is a - their specific considerations for those specific populations.

Michael Abrams: Yes. So I think if we look - the interesting thing about this epidemic I think and if you look back at the environmental scan, you recall, Jeff, in particular

you - when we were drafting the report, you brought up these points to be explicit about racial issues in particular. And the interesting thing I think about this epidemic is that it's emerged and came to the attention of folks because rates in Caucasian populations were excessively high. Now things have sort of evened out and it's cross-cutting.

So that may be part of the reason that those kinds of social determinants didn't emerge from your discourse. Other social determinants like, you know, incoming equality, homelessness and economic issues did emerge a little bit more. So I think that that might be the reason.

Do others have thoughts about whether those kinds of targeted measures for specific social determinants not represented, you know, like, from those stuff that's represented here. Rural communities were emphasized as well somewhat. Any other concerns that folks have? And, Jeff, is that a reminder about sort of the epidemiology of this, the emergence of this? Is that helpful for your thinking as to how we got to this place in terms of the prioritization?

Jeff Schiff: Well there's a lot to say about that, Michael, because it…

Michael Abrams: Yes.

Jeff Schiff: … - I agree that that's how we got there but I'm not sure it's, you know, it's - it probably has some cultural and ethnic and, you know, implicit bias overtones that this crisis got more attention when an affected rural, middle aged Caucasian folks. So I'm curious from others in the group whether we want to - I don't know if we want to change our top five rank because it wasn't in there but I am concerned that we should address its impact, you know, whether somehow suddenly you more expressively address it as part of

the text of the report maybe. Curious of others - other folks' feelings about that.

Man: And, Jeff, are you referring to the differential between the crisis like the crack cocaine crisis versus this current opioid crisis and the racial differential and the level of attention this has gotten versus the prior resourcing and how one was more treated criminally and the other now more medically and just kind of making a statement of differential or are you talking about something different than that?

Jeff Schiff: I think that's an important component of it. You know, we can look back and say, "That is - they were treated differently and this is definitely," you know, I mean, I guess the good - if there's a silver lining in the way this crisis has been treated it's been that, you know, because it has cut across those sort of economic lines and race lines in a different way it has much more of a treatment focus unless of the, you know, a punitive focus but - and I'm not sure how to bring them into this report. I'm just really - I just want to be careful that, you know, the implication that it - I mean, I think the causative factor in this factor has been more of a treatment focus just because it cuts across racial, ethnic and socioeconomic lines.

Brandon Marshall: I think though -- this is Brandon -- the focus on the measure in front of us regarding treatment, I mean, there is literature of that minority Asians are less likely to receive treatment even after they've been diagnosed with an opioid use disorder. One of my colleagues published paper in (unintelligible) that in adolescent population it's commercially insured minority youth were half as likely to receive medications after diagnosis of OUD was one of the strongest in fact predictors of lack of initiation.

So, you know, I don't know how relevant that is for the specific measure related to OUD treatment. It seems relevant to me in terms of I guess equity of access.

Michael Abrams: So this is Michael back in NQF. So I'm making some notes here and I'm going to try to rework the report a little bit to talk about racial disparities and cite some work like Brandon just suggested.

If others have suggestions about racial disparities in particular, which I think was a thrust of Dr. Schiff's comment, then please e-mail them to us and we'll consider those.

We're getting very close to the amount of time we wanted to spend on this prioritization and gap summary piece. So let me just ask that we call for one last effort here on the phone if you have any final comments about the overall prioritization gap write-up and conclusions. Let's do that now in the next 5 minutes and then move on to our next agenda item.

Brandon Marshall: Thank you, Michael. I don't see any hands raised. So I might suggest we move along.

Michael Abrams: Excellent. So with that then, Michael back here in NQF, I'm going to hand it to my colleague, Sam Stolpe, to talk about the five - oh, actually before I do that, this came up a little bit. Let me direct your attention to one final exhibit here, one final slide, Slide Number 12.

And this is to set up, Sam, Sam's discourse on the five federal programs and just to give you all a little touch tone regarding measure sets in particular, from two external sources and we're fortunate to actually have people on the line who know more about this in particular in some ways than I do.

The left-hand side of Slide Number 12 gives a summary of measure areas that were the results of Shatterproof which is a not-for-profit founded by one of our colleagues here on the call today, Gary Mendell who's the founder and CEO of Shatterproof, a not-for-profit dedicated to generally reducing the burden that families experience related to addiction.

And in collaboration with NQF they recently earlier this year proffered a ambitious set of measurement domains which I have listed on the left-hand side of this slide just to - as one perhaps touch tone if you can keep up the measure sets that Sam is going to be talking about in a moment and you'll see a lot of themes related to the things that we discussed, continuity of care for example on - is on there, access to treatment measures including explicitly wait times is on there and supported services, overdose follow-up, these kinds of things which certainly were captured in our environmental scan.

But this is another way to think about it beyond the very simply organizational structure that we gave in the environmental scan as this teases out OUD treatment explicitly.

And then the right-hand side of this slide summarizes measures that I found very recently from five states listed at the bottom of the slide, Minnesota, Rhode Island and in particular I point to Dr. Marshall and Dr. Schiff for referring us to those. And then Washington, Pennsylvania and Missouri. You can see the different types of variables or measures that are being tracked in some form on state dashboard. And again things that you'll recognize with regard to overdose events and availability of certain specific types of services like pure recovery and availability.

So we put this out there as a touch tone which we hope will be useful for you. And we'd also like to hear some comment if you think it'd be useful for us to refer to more strongly than we have so far in the report. It's an appendix of the report right now as a way for people to organize their thinking around the many measures that we proffer.

So with that, I'm going to pass this to Sam to continue on with the discussion about the five programs.

Sam Stolpe: Thanks very much, Michael. So appreciate the feedback from the committee thus far.

Let's go ahead and move forward with the second item on our agenda, which is again like our previous work, a carryover from the discussion from our last Web meeting.

So the iterative process we're honing in to finalize the recommendations from this panel and we'll be reviewing and discussing the guidance that you've so far proffered to CMS for the five federal programs that you'll see listed here. This is the Medicare Shared Savings Program that (unintelligible) instead of payment system.

Alternative payment model is the complement in this, the hospital inpatient quality reporting program and the value-based purchasing program.

So let's go ahead and get started with SSP, the Shared Savings Program. The recommendations that were put forward by the committee were multiple. First there was a comment on the overall measure set. So this program has - just a brief reminder is targeting accountable care organizations which come

together voluntarily the forum groups that assume longitudinal care for a set of Medicare fee-for-service beneficiaries.

In order for the ACO to share in savings, they need to do a couple of things. And the first is to demonstrate exact savings. And then the second is to perform on a set of quality measures. So those measures are specified by CMS.

So one of them included preventative care and screening, tobacco use. It was suggested by the committee that this should be more comprehensive to include other substances. So comprehensive substance use disorder screening measure for alcohol, tobacco, opioid and other substances and include documentation of pharmacotherapy for substance use disorder being offered, initiated or an appropriate referral made to specialty care.

There were a number of other potential quality gaps that were suggested for exploration by CMS. And the reason that this is articulated this way is that we don't want topped out measures and penalty to indicate that they did not want topped out measures as being rolled into the measure set. So they were proffered as potential quality gaps under the assumption that CMS would look under the hood so to speak to make sure that these are indeed issues that need to be resolved.

So the other component of SSP is related to reports on opioid utilization that has been recently put in place by CMS. So on a regular basis, there's a handful of quality measures related to opioid and opioid prescribing behavior in particular that are given to - given under SSP.

And one of the things that CMS pointed out is that there - the numbers inside of the numerator for many of these measures were quite low. The suggestion

by the committee then was that before rolling this into reports, I mean, potential quality gaps into opioid reports that CMS could look under the - look at the actual performance rate and make sure that these are relevant and important measures for inclusion.

Now I'll just go ahead and read this to you briefly. So this is the potential quality gap between naloxone co-prescription along with opioids, non-opioid management strategies for high-dose opioid patients, long-term recovery from OUD, physical and psychiatric comorbidities to OUD and specific populations for OUD treatment.

So aside to those opioid utilization reports, as I've mentioned, this is - these low-quality gaps were identified. But there was also a number of quality gaps that were recognized for potential testing for concurrent use of opioids and benzos and the three PQA measures that are - been recently endorsed by that organization namely initial opioid prescribing at high dosage, initial opioid prescribing for long duration and our initial opioid prescribing for long-acting or extended release high dosage.

So this is where we're going to open it up. So the - just a brief word on formatting, we're going to move to our discussion portion and we'll have a discussion following each one of the five federal programs that we're going to be presenting. This will be led by Dr. Schiff.

So I'll hand it over to Jeff now to go ahead and lead the group on the discussion.

Jeff Schiff: Thanks, Sam. I just - one of the - can you go back to the slide presented if you don't mind?

So this is the - so I just want to make - so I think everybody - there are - we're looking at a number - I think what we're really interested right now is - and correct me if I'm wrong, Sam, but we're interested in talking about what our recommended gaps are to CMS to - which is the previous slide I believe on the bottom around the Shared Savings Program.

And let me just ask first everybody grounded if people have specific questions about what the Shared Savings Program is or represents if there's any people need just a minute or more on that or comfortable enough to talk about. It is sort of - I think of it as the Medicare ACO that large - that large provider organizations participate in.

I don't see any hands raised. I guess we're okay with that. So any comments then on these identified potential gaps in where the - we make recommendations to CMS around Shared Savings Program potentially inclusion of measures in these categories?

Woman: Jeff, I see there's a comment from Anthony in the chat box if you wanted to read that out.

Jeff Schiff: Yes. I think I will. And, Anthony, you're welcome to speak to it as well if you want. But he just says, "I agree with use in concomitant use of benzos. There's a quality measure that's prescribing should be only for higher dose opioids given chronically and for patients high risk of SUD."

Anthony, any specific comments you want to make?

Anthony Chiodo: On the second slide, I see in our clinic a very widespread use of naloxone prescription and oftentimes it's given for patients who are on - given opioids acutely or patients who are in fairly low dose and for those patients there if

you look at their risk of substance abuse disorder in the chart is fairly low. So thinking about adding the additional cost of this program by giving naloxone to patient who really - patients who most likely won't need it seems to be excessive and unnecessary. So, like, they're really kind of keying on which patient that should go to.

Jeff Schiff: So I think that would - most likely that would then enter into the (unintelligible) of the measure as to, you know, who is - who would be the appropriate patients for (unintelligible).

Anthony Chiodo: Perfect.

Jeff Schiff: Other comments on this list of potential quality gaps that have been identified?

Sam, can you go to the next slide just for one sec because these are - so the utilization reports are already out there. And there's - you made some comments about whether or not they're useful or not. So they're just - they're not a quality measure as much as the report that's available.

And then just for my own clarification, I'm not - these are other measures that are being - from PQA they are being considered for inclusion in the utilization of reports. Is that right?

Sam Stolpe: That's correct. So in our last meeting just to jog everyone's memory, we put forward the four measures that are currently included inside of the opioid utilization reports. So those include three measures on opioid prescribing as well as the opioid utilization management measure.

So those measures were noted by CMS to be - have low numbers in the denominator. And in our discussion as a panel we put forward some additional measures, these four that are listed on the slide. As one said, CMS should task to see if there are meaningful measurement gaps that need to be accounted for inside of ACOs. And if so, those would be appropriate for inclusion inside of the report. And that's what this slide is projecting.

Jeff Schiff: And so just to be clear, is there - or you ask the question, if their reason they would be - for inclusion in the report, which is really not a - which is really a feedback loop versus the - included in a measure of Shared Savings Program performance.

Sam Stolpe: Not one that was articulated by the committee. So - okay, if any of these measures are - the panel feels like any of this should migrate as a recommendation to the overall set of current 23 measures that are inside of the Shared Savings Program, you're welcome to make that recommendation.

Norris Turner: Yes, this is Norris Turner from PQA. Sorry I didn't raise my hand. But yes I just like to say, you know, I obviously represent PQA and we work closely with CMS. They initiated the work to take our measures in these Shared Savings reports. But yes given this kind of recent picture of really, really low rates for the existing measures, that does really kind of beg the question as to whether - maybe there are more appropriate opioid prescribing measures for this Medicare Shared Savings population and the initial opioid prescribing measures may be better kind of risk predictors for this population and you may see higher rates which suggest, you know, they're really getting at improving the quality of the population.

And then also I just want to say I had an opportunity. I have a couple of exchanges with Sam and we also received guidance from CDC, you know,

because our measures are being considered in a number of different provider base programs to just recently proposed rule, comments opportunity for MIPS and our measures were listed there.

And so we engaged CDC before we did our comments and they came back with some language here. I just want to read two sentences. But it basically says, you know, we're - MIPS is - they're concerned about the use of our measures in MIPS. This is especially true as it relates to measures related to MME thresholds. They have particular cautions for MME threshold measures being used for clinical decision-making.

They did say that non-MME threshold-type prescribing measures are potentially less problematic. And then they finally go on to say, "In general the CDC has been careful to frame their develop measures to map onto the CDC prescribing guidelines for quality improvement effort."

So they're really concerned about, you know, use - you take a measure there as a threshold at provider level and it's used as a hard edit to make clinical decisions. So I just want to provide that background.

Sam Stolpe: Yes. And, Norris, what you'd shared with me actually included some guidance adjustments from CDC that measures that include the MME component are not necessarily best suited for quality and performance programs particularly around reimbursement given that it's intended for guidance and not for strict adherence to a quality framework that could result in significant changes in how a physician or an entity is reimbursed. Is that correct?

Norris Turner: Yes. That's absolutely correct. I mean, so certainly if an MME threshold-based measure were to be used in a provider base setting given CDC is

concerned and we share them at PQA, clearly they would need it for informational purposes with clear guidance on contextually how that information is to be used relative to other information to inform clinical decision-making. Yes. So, no, Sam, your summary I thought was right on.

Sam Stolpe: Well, Jeff, that returns us back to your original question which was, is there a reason that these particular measures around initial opioid prescribing were framed in the context of the utilization reports rather than for the general measures that's used for SSP? And perhaps a recommendation from CDC fits the bill there.

Jeff Schiff: Yes. I think that's well answered and we had a comment in agreement with Norris here on the chat box as well.

So I think just one more time to the previous slide, if you will. And those are the - at the bottom are the potential quality gaps. And we talked a little bit about the naloxone co-prescribing and limitations in that.

The other ones are around OUD treatment. We haven't had much feedback around them but I think we - if we're okay, we can move on, Sam. If anybody give one more - few seconds to see if anybody has any comments on this regarding the Shared Savings then we should move on because we have a bunch of other programs to talk through.

No hands raised and no comments. So I concur moving to MIPS.

Sam Stolpe: Very good, thank you, Jeff. Okay. So the Merit-Based Incentive Payment System, as you know, this is a program for clinicians that is part of a overall overhaul as I'm going to show you of the sustained - sustainable growth rate as a result of the 2015 MACRA Act.

This program is intended to have a number of quality components, resulting in a quality score that is used for reimbursement for clinicians. There's a lot of measures inside of MIPS that clinicians can choose from. I think this year it's something on the order of 258 total. But there were only a handful, you know, a dozen or so that were either directly related or peripherally related to opioid and opioid use disorder.

So the TEP identified a couple of other options that should be considered by CMS as recommendations for inclusion inside of MIPS namely co-prescription of naloxone with chronic opioid treatment, non-opioid management strategies for high-dose opioid patients, long-term recovery from OUD, physical and psychiatric comorbidities to OUD and specific populations for OUD treatment.

Next slide around measured guidance. Now the TEP noted that there's a measure in osteoarthritis function and pain assessment inside of MIPS currently. And they recommended a broader measure of function and pain assessment and especially emphasized with a need for measures around functional improvement over measures that's just score pain or pain reduction.

And the TEP has also noted that there's a problematic nature of adding measures to MIPS that's focused on decreases on pain score and that they may incentivize prescribing behaviors by the clinician that are not in the patient's best interest and there was also the note that there's exception for measures used in palliative care.

The overall guidance from the TEP is that CMS does not include such measures around pain scoring or pain reduction within MIPS but rather stay focused on measures of functional improvement.

With that, I'll hand it over to Dr. Schiff for - to lead the discussion.

Jeff Schiff: Okay. So I think I'll do the same thing and ask if anyone needs any specific information about this program first for a few seconds and then we'll ask about whether we correctly identified the gaps and considerations for the MIPS program.

I'm not seeing any hands on the - around the program itself. So back to these - the recommendations. Are there any comments on these things that are (unintelligible) or things that you see that we have in some way not identified or missed?

You always wonder how long to be quiet for. But anyway. And then just to go back on to next slide. They show really more about the considerations. I think that, you know, my comment was I talked to the I think folks captured this conversation well but I want to make sure that we're not missing anything or if we have any other folks who want to fine-tune any comments around any of these. I know we had a pretty rigorous discussion on functional improvement in one of the past meetings.

Well, Sam, I think we're - we got one endorsement on the chat. Thank you.

So if there's nothing else, let's go ahead and keep going.

Sam Stolpe: Yes. Appreciate the allowance for uncomfortable silence, Jeff, but as always of these sorts of meetings, silence implies consent. So thank you for approving of our capturing of your conversation thus far.

We'll go ahead and move on to alternative payment models. This is a reminder. APMs are the complement to MIPS. Both part of an overarching structure that came from MACRA, resulting in the quality payment program with those two participation pathways, MIPS and APMs.

Now the thing to note about APMs is that while they are comparable to MIPS, this is a little bit different. Clinician accountability needs to be part of a set of requirements for APMs to be set up. APMs are essentially value-based payment programs that meet those series of requirements around clinician accountability to measures that are comparable to MIPS and I'll emphasize that that they just need to be comparable to MIPS, the use of certified EHR technology and that the clinician is held to certain levels of financial risk for performance.

There's multiple models categories to participate in APMs. One of the ones that we highlighted in our discussion was around advanced APMs where you see it's not only an exception to MIPS per participation but also annual 5% increase in Medicare Part B payment.

So the committee put forward a couple of things for us to consider as a staff broadly around APM recommendations and guidance. First the TEP noted that there's a challenge associated with MIPS-like measures given that there's such a wide variety of APM structures. So the recommendation to CMS is that given that APMs can apply to a variety of conditions, care episodes or patient populations, if the measurement needs to differ depending on APM structure and population.

So the suggestion was that - particularly for advanced APMs, the assessment of quality gaps for receiving or maintaining the advanced APM status should be part of it, part of maintaining it. You look at quality gaps and that

measures that are selected for clinicians should be based on gaps and risk factors for the population using the same guidance for recommendations that was offered by the TEP for the MIPS program.

Specifically we had a discussion around oncology APMs and that there should be an opioid tapering metric developed that would fit neatly inside of a sort of care goals that need to accompany treatment of this sort of population in particular which can be on opioid for an extended period of time and stand in a great need to have a tapering strategy onboard.

That's all we had for this TEP recommendation for APMs. I'll hand it back over to Dr. Schiff.

Jeff Schiff: Thank you, Sam. Are there any specific comments on this? I think this slide captures it pretty well. And I think, you know, for those - I'm curious if anybody who's on this call is operating in an APM structure right now. I think when, you know, when we start looking at this in Minnesota, it was pretty interesting to try to get your head around the relationship of MIPS and APMs. But I think that they - I think of the APMs as putting - there's more risk than potentially more gain, you know, but definitely more potential for gain for practices operating under the structure.

So anyone operating under this structure that would like to comment?

And any other specific comments on APMs? I think, Sam, you captured well that APMs can be unique because of condition episode of care or patient population.

Michael Abrams: This is Michael at NQF. I want to add one thing that came out of our previous discussion and see if the committee consents to it.

At one point I think it was Dr. Alvanzo, Anika pointed out that they're asked post the question if whether or not behavioral health homes or health homes qualify as a potential alternative payment model target and I think they do specific condition focused things, things like emerging rather aggressively from the Affordable Care Act health home provisions.

So it's my thinking that the committee would be interested in measures that advance those kinds of wraparound care, coordination care integration type of approaches for special populations that would include folks with opioid use disorder or folks with chronic pain that need broad management as well.

So let me just put that out there and see if I'm inferring your sentiments reasonably especially vis-à-vis these kinds of alternative payments. So this is a bundled payment. That's sort of the alternative that would focus on OUD treatment at the center of that, alternative payment model bundle or complex pain patients as well that would be alternative payment management approach. Please if you could comment about that.

((Crosstalk))

Woman: Oh go ahead.

Jeff Schiff: So Anika wrote in the chat box that she agreed with that statement. There's two comments from Katie Jordan and Norris Turner. Are they related to this specific point that Michael raised?

Norris Turner: No, mine is not.

Katie Jordan: Mine is kind of. So we participated in a comprehensive care for joint replacement model, the CJR, and I forgot that that is eligible for advanced APM. And so I guess kind of to his point, you know, I think you guys are trying to capture it here where this could be integrated into a lot of existing APMs but it would be contention on what the focus of that APM is. But certainly for CJR, this would be something that should be integrated.

Jeff Schiff: Great. So, Michael, I just want to go back to your - or maybe it's Anika's point too about the behavioral health home because my understanding is behavioral health home from the Medicaid point of view has measure requirements that are already part of the CMS that aren't part of our charge for this group.

But what I think you're implying is that the behavioral health home could be for Medicare a type of APM. Is that correct?

Michael Abrams: Agreed. Yes.

Jeff Schiff: Okay. All right. So, Kate, your hand is still up. So I think that's - you know, I think that was your comment unless - but I'm going to go to Norris and - for his comment.

Norris Turner: Yes, I just wanted to make a general comment of endorsement and support for other approach we're advocating for APMs and advanced APMs in terms of really recognizing the uniqueness of the different APMs and the populations that are kind of at risk and - or the focus and, you know, using the approach we've taken with MIPS is kind of a guidepost for how would you then think about making unique population-specific and model-specific decisions for that particular APM.

I do think, you know, given Darshak's comment about -- everyone I think on this call largely appreciate this -- the resource intensiveness of implementing measures and also even in the MSSP example where we see it's really low grade. So some of our PQA measures that as much as we can help guide the environment to select the right measures for the right model for the right population to address the most important gaps then we optimize efficiencies and also outcomes. So, yes, this one is the overall support and endorsement for the approach.

Jeff Schiff: Great. Good. Any other comments on this specific topic before we move inside the hospital? That's where we're going next.

Sam?

Sam Stolpe: Very good. Thank you, Dr. Schiff.

Okay. So our next program that we're going to talk about is the hospital inpatient quality reporting program. Now the follow-up to this will be the value-based payment program which the two are interrelated.

As you may recall, IQR was introduced as a result of the Medicare Modernization Act of 2003 and expanded by the Deficit Reduction Act two years later. The program itself requires hospitals that are paid under the Inpatient Prospective Payment System to report on a number of things, whether it's the processes, structures, outcomes, patient experiences of care, efficiency and cost of care measures.

Failure to meet the requirements of IQR results in reduction of payment to the hospital. So those - a couple of things that emerged from these conversations that the TEP had as far as recommendations were concerned.

The first of which was assessing whether patients were offered non-opioid options to manage pain. I'm going to pause on this one for a moment because there was a question that was put forward by an NQF measure related to the test discussion.

Let me remind you of part of our discussion from last time and was related to the use of the HCAHPS, the Hospital Consumer Assessment of Healthcare Providers and Systems, survey that is one of the data sources for quality measures that are used in IQR.

Now CMS under federal statutes several years ago was required to remove some measures around pain management from the survey. And these of course are directly related to org charts. Once these were removed, they're replaced with measures around pain communication which while fundamentally different still receives some pushback from the broader community and a variety of stakeholders that were concerned that the measures now still did not do enough to mitigate what could be downward pressure on clinicians to prescribe for opioid.

Now there hasn't been anything proposed that I'm aware of to substitute for the communication about pain measures. The question that was put forward is that assessing where the patients were offered non-opioid options to manage pain is that a specific recommendation for CAHPS from this TEP.

And if we look back to other recommendations that we - the TEP put forward, they included this recommendation for consideration inside of MIPS that rather than measures of pain score or pain score change that we look at measures of function and patient-centered pain management.

So if that's the case, then this is something for the TEP to consider as a potential recommendation with - beyond the guidance around measurement if there's a CAHPS specific recommendation for IQR.

Okay. Moving on. We'll leave that as a discussion point. I'll remind us if we don't get to it.

Patients who are identified with SUD that are offered or initiated on pharmacotherapy prior to discharge for an appropriate specialty service, the proportion of SUD patients who are linked to ongoing care in the community post discharge, the proportion of patients treated for an overdose who are in treatment 30 days later, the proportion of patients who had an opioid overdose who are given a prescription for naloxone at discharge and the presence of a patient-centered tapering plan for patients - sorry at discharge. Excuse me, presence of a patient-centered tapering plan for patients discharged with an opioid prescription. Thank you.

Okay. That is the summary of the TEP discussion of IQR. Back to you, Dr. Schiff.

Jeff Schiff: Thanks. So I think - can you go back to - do you mind going back to the slide? One more because we know the question.

But can I just ask let me first ask about the specific point duration of the first bullet there that's assessing the patients who are offered opioid options to pain management and you asked the specific question if I got it right around - this is a specific recommendation for CAHPS to include - for HCAHPS to include a question around this.

And so am I getting that right, Sam?

Sam Stolpe: Yes, thank you.

Jeff Schiff: Sure. So let me ask first for - if anybody who uses HCAHPS or who's really involved in that if they have any comments on whether we want to make a specific recommendation around that question being included in the CAHPS survey.

We're not getting anything specific on that. Katie, do you want to go ahead?

Katie Jordan: Hi. Yes. So are you suggesting that that'd be included as a question related to communication about pain?

Jeff Schiff: So those questions are slated for removal and this must actually. So the - there will no longer be any measures about pain included inside of HCAHPS once those have been removed.

Katie Jordan: Okay. Yes. So that's what I understood. I just wanted to make sure. So in that case then I think it would be really critical to have something about non-pharmacological options for pain control and management especially from a functional perspective.

Jeff Schiff: So, Sam, can I ask are those - are there questions other than field testing in that regard? Or maybe (unintelligible).

((Crosstalk))

Jeff Schiff: Okay. Got it. Okay.

Sam Stolpe: That could be a question for our colleagues at CMS if they'd like to speak up. We have a number of federal liaisons on the phone. Are there any input you can give us as far as where the current status of the - at the HCAHPS survey is in terms of field testing alternative questions for related to the communication about pain domain?

(Elizabeth Kata): This is (Elizabeth Kata) from (ARC). I could check and get back to you on that.

Sam Stolpe: Thanks very much, (Elizabeth).

Jeff Schiff: Thank you. And then, okay, any other comments on this specific touch point? Otherwise let's go on and talk about the whole - the bullets here and see if there are any specific comments or concerns.

Anika, if you're still on, I just wanted to ask you. You brought up earlier the issue around treatment at discharge. And I think that's covered here but I just wanted to ask you if you wanted to comment on that.

Anika Alvanzo: I submitted many of these recommendations, so…

Jeff Schiff: Okay, got it. Okay, good. All right.

Anything else from anybody else?

Great. All right, Sam, I think our last category.

Sam Stolpe: Very good. Thank you very much, Jeff.

For our last program under consideration is the value-based purchasing program. So just as a reminder, the Hospital Value-Based Purchasing Program came under the Affordable Care Act under which value-based incentive payments are made each fiscal year to hospitals that meet performance standards established for performance period for that particular year.

The measures that are eligible for adoption inside of the value-based purchasing program are derived from IQR from the previous program that we considered. So keep in mind that these are essentially a subset of the previous discussion.

So the recommendations that were put forward by the TEP were a little bit shorter given that that's the case. So the main things that were focused of the TEP were around the - excuse me. Emphasizing the need to have strong process measures included in VBP and measures of opioid tapering at discharge and the prescribing of naloxone at discharge as key points of emphasis.

This is a summary of the discussion of VBP and I'll turn it back over to Dr. Schiff.

Jeff Schiff: Thanks. So it seems to me that the middle point I think I'm not sure if it's exactly - we have a comment in the box from Antje which is around reimbursement around - actually our recommendations around non-opioid therapies. And that's not quite the same perhaps as strong process measures because I don't think that were process measures generally get into reimbursement arrangements but it does perhaps get into issues around access of some of the non-opioid treatments and I wonder if that's a way to get at to

just on that point. But I wanted to ask, Antje, if you wanted to speak to your point at all.

Antje Barreveld: Sure, thank you everyone. I just was reading in the document in the text and I feel like the multimodal approach to pain and personalized pain management plan is all underneath this category of value-based purchasing. I feel that there's a lot of great things that we can do even in the inpatient setting but, you know, this costs money and to ask hospitals to be providing some of these things for instance, you know, relaxation strategies or behavioral management or - there's, you know, there's some medications that are obviously not good to help with pain but those aren't really necessarily going to always be the most effective in really maximizing all the different options even, you know, hospital-based acupuncture. I mean, these are all great things to do and can really be helpful and speaks to also I think the outpatient world but it's often very costly.

And so I don't really know how to make these recommendations without being also conscious of the financial constraints as well as the ability for hospitals to even locate these types of services or individuals that can help with this.

So it's just I want us to always be realistic in this. I think there's just a bigger, broader challenge that we face in healthcare.

Jeff Schiff: Thank you. Okay. And then just to ask - so I think just to go back and ask if maybe the measures that are in the last bullet there that we came to which is around opioid tapering at discharge and then prescribe naloxone. Any other comments about those from anybody?

Okay. I think we don't have anything else. I think, Sam, I'm going to turn this back over to you.

Sam Stolpe: All right. Very good. Well we actually have a little bit of extra time. So I know Michael had a general question that he wanted to ask. But as he's asking it, what I would ask you to - the general set to think about for a moment is any other overall reactions that you might have to the final - or, sorry, excuse me, the draft final report as we currently put it together if you wanted to share any feedback for us to consider as we're finalizing new recommendations and summarizing this discussion, we welcome that.

But with that, Michael, I'll hand it back over to you for anything that you wanted to support.

Michael Abrams: Very good, yes. So one specific question I wanted to circle back on then that I close you on it and it pertains to the last bullet on Slide Number 10. So the last bullet on Slide Number 10 regarding gaps and how to describe gaps again is what we're talking about.

But there I suggested that it was my and our impression at NQF that the TEP was interested and concerned about general substance use disorder issues beyond opioids, per se, but because they're related to opioid overdose and the overdose problem more generally. I want to make sure and give you all one last chance to guess that we - whether or not we should make that point in the report or not.

Again as my - another observation here that you all care about substance use disorder generally and perhaps some of you, you know, on the western part of the country in particular have noticed and been more concerned about or concerned about emerging overdose events related to other substances,

cocaine and methamphetamine in particular, in addition to the opioid issue that we face.

And then presumably of course to the comment that the north made about how this epidemic is the epidemic of today but we've seen other epidemics in the past, overdose epidemics in the past with different substances, crack, for example, and I think it's the attitude of the TEP but again put it out there for your comment about - that you care broadly about substance use disorder, about addiction broadly and treating addictive disorders broadly vis-à-vis the - addressing this particular substance and the crisis that surrounds it. So please any comment about that?

Norris Turner: This is Norris again. I think, you know, going - for the companies that's made, Jeff, you know, the calling out of criminal justice involved population, rural, communities and maybe the function of, you know, your economic situation, you do start picking up some of the unique things with regards to race, race disparities, ethnic and otherwise.

And so I think maybe when we're making reference in the report to the criminal justice population making mention like some of the demographic - what that demographic picture looks like because you do get a disproportionate representation of African-American male at certain age, right, and I also think about where immigrants fall, you know, different special populations we've been calling out and speaking to where the racial - what the racial mix looks like with some of those special populations could help shed light on both levels. So (unintelligible).

Anika Alvanzo: And this is Anika. So I typed a comment but I definitely think we should be looking beyond just opioid use disorder and having a more comprehensive focus on substance use disorders in general, you know. And obviously my

experience is biased based upon where I practice but single substance use is often the exception as opposed to the rule.

And, you know, I think we should be looking comprehensively at how we manage substance - how we identify and then ultimately treat substance use disorders.

Anthony Chiodo: I agree and just to add to that, you know, we see this problem just migrate to another substance that we just didn't focus on and we really haven't accomplished much. So making sure that we are much more inclusive about what agents we're talking about would be a better approach.

Michael Abrams: Who is just speaking please? It's Michael at NQF.

Anthony Chiodo: This is Tony Chiodo.

Michael Abrams: Very good. Thank you.

Jeff Schiff: I got a similar - we got a similar comment from folks at Shatterproof as well. Bonnie's hand is raised. Bonnie?

Bonnie Zickgraf: No, I agree with the group and the fact that we - if we don't differentiate between OUD and SUD, if we're not singling them out, then we're combining different diagnoses, if you will, different costs. And then that might broaden the picture in the long run. So I agree it needs to be differentiation there. Thank you.

Jeff Schiff: Patty?

Patty Black: I would just like to mention that, you know, in our state we have - we legalized marijuana and we're seeing some instances with that an issue as well as, you know, combining these - the misuse of drugs.

Jeff Schiff: So I'm kind of hearing this that we should use this for clarification. We should include and take into account SUD as multiple substances besides opioids but we should be clear not to mash them entirely together which was I think Bonnie's point.

Bonnie Zickgraf: Correct. Thank you.

Jeff Schiff: Okay.

Very good. So any other general comments about the report from the committee, it can be about tone or anything, before we move into then public comment? Any other general overall comments about the report and the way it reads at this point?

Okay. Hearing - oh there is one. Go ahead, Kate.

Katie Jordan: We just received one public comment asking if there was an opportunity to provide written feedback.

Jeff Schiff: Yes, please. We welcome written feedback on the report. There will be a formal public comment period as well that begins when, Sam, sorry?

Sam Stolpe: It begins on December 6th. It will be open for 30 days, closing on January 6th.

Jeff Schiff: Okay. And then for committee members explicitly if pursuant, you know, as soon as possible after this meeting if you have additional comments you think will help us draft the final draft for the report before it goes out for public comment, we would welcome that absolutely. So yes, we encourage that.

So I guess with that, I will turn it to Madison to open it for public comment.

Madison Jung: Okay. Thank you everyone. So members of the public very good time now if you would like to make a public comment, please feel free to. Or provide a comment via the chat box as well.

Okay. It sounds like there's no public comment. So I'll just give a quick overview of our next steps that we just mentioned.

So following the sub meeting the staff we'll work on incorporating all these comments and edit into the report that is on preparation for our 30-day commenting period from December 6th to January 6th. We would just ask that possibly as members of the TEP to get their written feedback to us within the next day or two, so that's at least Monday, so we can work on incorporating those edits. That would be very much appreciated.

But following the posting of the report for public comment, we'll have our final Web meeting on January 21st to review the post comments - a couple of comments we received and just sort of a post comment call and review the edits needed for the final report. And that final report will be submitted to CMS on February 6th.

As always please feel free to reach out if you have any questions and just send us e-mail or give us a call over here.

I'll turn it back over to Michael and Sam for any closing remarks as well as Jeff and Brandon.

Sam Stolpe: Just on our end and I'll speak somewhat for Michael to add to his comments, this remains for us to say thanks. This has been a wonderful process for us as staff and very enlightening to hear from each of you on your insights around this particular epidemic and we really thank you for your time and consideration of the report and welcome any further feedback that you have as we're going to these last iterative steps to get a solid product over to CMS and to the general public for their consideration.

Michael Abrams: Great. Thanks, Sam. Michael here at NQF. Ditto on that. Many thanks to everyone participating including members of the public and especially the committee and our two chairs and I'll call on Jeff and Brandon to make any closing comments.

Jeff Schiff: Just quick thanks to everybody and a - I want to encourage everybody to spend a few minutes reading the report. It goes - reads easily and your feedback would be appreciated.

Brandon?

Brandon Marshall: Just like to echo Jeff's comments. I enjoyed reading the report last night and learned a lot. So I encourage you to do the same. And thank you everyone for your time today.

Woman: All right. Thank you.

Woman: Thank you.

Man: Bye-bye.

Woman: Thank you.

Man: Bye-bye.

Woman: Thank you. Bye.

Woman: Bye.

Woman: Thank you.

Operator: Thank you. Please stand by.

END