NATIONAL QUALITY FORUM
Driving measurable health improvements together

Discussion Guide

Opioids and Behavioral Health Option Year Web Meeting 6 Discussion Guide: Use Case

In preparation for the Opioids and Behavioral Health Option Year Web Meeting 6, this discussion guide contains drafted portions of the Opioids and Behavioral Health Use Case. In particular, information on the overarching measurement framework barriers and solutions, the narratives for each case exemplar, and Committee discussion questions are included.

Overarching Measurement Framework Barriers and Solutions

Overarching Barrier: Stigma and Lack of Person-Centered Care

Table 1: Overarching Solutions to Address Stigma

Solutions	*
Patient-Centered Care	• Promote person-centered care (e.g., use of goal attainment scales) and educate providers to elicit patient-specific goals • Bring payers, providers, peer advisors, and patients together through advisory panels/councils • Include individuals with OUD/SUD experience as part of the care team for peer support
Broaden Care	• Examine and update existing organizational policies and practices that may unintentionally reinforce stigma • Broaden expected outcomes of OUD/SUD treatment and interventions beyond abstinence • Broaden the definition of a patient's support system to include community organizations and members, peer support groups, or any individual identified by the patient

Education	• Educate providers on:
	  ○ The differences between physical dependence and SUD
	  ○ Harm reduction strategies that go beyond handing out naloxone
	  ○ Treatment strategies that go beyond abstinence
	• Implement ongoing anti-bias and anti-stigma training and support for providers who treat people with OUD and co-occurring behavioral health conditions
	  ○ Use language that humanizes individuals with SUD
	  ○ Educate on the positive and negative ways healthcare organizations may impact individuals who use drugs and their communities
	• Educate patients on how their information is shared between different healthcare providers
	• Utilize public campaigns to reduce stigma
	• Leverage micro-influencers or trusted individuals in the community as ambassadors

Overarching Barrier: Limited Resources

Table 2: Overarching Solutions to Address Limited Resources

Solutions	*
External Funding	• Apply for Medicaid 1115 waivers to expand covered services • Seek and apply for local or state funds, or foundational grants, that cover the cost of providing MOUD • Partner with payers to promote full coverage of OUD/SUD treatment and interventions to eliminate and/or reduce patient copays • Increase funding for OUD/SUD professionals
Partnerships and Collaborations	• Partner with community-based organizations to expand resources and knowledge • Use a hub-and-spoke model to increase a system's capacity to treat patients • Expand the workforce and build capacity by engaging interns, house staff, medical and nursing students, and social workers • Utilize online consultations with specialists who have a relationship with the emergency department (ED) to be a part of the care team • Offer case management services that allow for better transitions • Join an Accountable Care Organization (ACO) to encourage better management of patients, provide more treatment options, and prevent higher cost and unnecessary hospitalizations
Structural Changes	• Create structural investment in the workforce to allow sufficient time to deploy best practices, implement person-centered care, gather documents, and discuss care goals • Create a continuous education curriculum that includes training on measurement-based and outcome-driven care • Assess internal barriers for hiring staff with the necessary expertise (e.g., clinical social workers, addiction and treatment specialists, peer support specialist) and make the case for resources to executive leadership • Examine current staffing models and identify if patient follow-up processes are clearly defined, and if not, create a task force to create processes and educate staff • Use an electronic health record (EHR) system that social workers, pharmacists, providers, and case workers can all access that links data and patient information, identifies high risk uses of illicit substances, and helps mitigate use or harm

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Overarching Barrier: Payment

Table 3: Overarching Solutions to Address Payment Challenges

Solutions	*
Promote Parity in Reimbursement and Coverage	• Remove caps on billed services for screening, testing, and treatment • Expand methadone maintenance coverage to commercial insurers • Ensure pharmacy coverage for all forms of MOUD • Provide reimbursement for case management and social work services to support complex discharge planning • Increase flexibility of reimbursement mechanisms to align better with patient needs and clinical presentations (e.g., leverage Medicaid 1115 waivers to improve flexibility) • Invest in reimbursement parity for SUD/OUD treatment activities and harm reduction strategies
Expand Resources	• Educate patients and providers on payment structures, benefits, and parity to make navigation of complex systems easier • Support and implement no-wrong door policies • Improve coordination between health care OUD/SUD services and the criminal justice system • Expand telemedicine to include case management services that address housing, transportation, and other SDOH • Create a 24/7 network that provides care beyond regular business hours and includes specialists and case managers
Ensure Continuity of Care	• Create a universal referral program where any hospital or mobile treatment team can use the same referral form for multiple treatment programs • Create an accountability program or attribution model that assigns accountability to all providers who care for a patient rather than assigning accountability to one specific provider (e.g., primary care provider)

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Overarching Barrier: Data Inconsistency and Limitations

Table 4: Overarching Solutions to Address Data Inconsistency and Limitations

Solutions	*
Integration of Systems	• Integrate EHR systems across settings so that information is available to more providers • Identify how to use existing EHR infrastructure as a measurement tool instead of only using claims data • Establish all-payer claims databases and registries with consistent and up-to-date information from EHRs and other data resources that can allow for more holistic measurement
Standardization	• Include patients in the measure development process to ensure measures yield meaningful outcomes that can be used for provider accountability • Create accountability through regulatory measures • Create incentives to encourage EHR vendors to work together in a cohesive and interoperable way • Incentivize healthcare organizations to participate in measurement activities to reduce burden, decrease internal resource competition, and increase measurement • Create patient-generated surveys and leverage patient registries • Create hybrid measures using claims and clinical data that provide insights into unique challenges of this population • Standardize systems and handoffs to allow claims history to follow a patient even if they change payers

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Overarching Barrier: Rapidly Evolving Measurement Landscape

Table 5: Overarching Solutions to a Rapidly Evolving Measurement Landscape

Solutions	*
Education	• Improve residency training to incorporate information on quality measures and measure development • Engage patients, patient advocates, and peer navigators in measure development and advisory groups to inform measure development • Educate practicing providers on current OUD/SUD measures and data elements being collected to highlight how measures add value and support better approaches to care
Expansion of Data Collected	• Ensure all medications dispensed during a hospitalization are reflected in the EHR • Obtain funding to support patient-generated surveys, which will help identify and improve the gaps in care

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Discussion Questions:

- Are there any gaps in the solutions or strategies to help overcome the overarching barriers listed above?
- Are these strategies a good mix of practical and aspirational strategies?

Opioids and Behavioral Health Measurement Framework Case Exemplar Narratives

Case Exemplar 1: Equitable Access Domain Narrative

The patient is a 32-year-old white, homeless male with a history of severe OUD, frequent methamphetamine use, and bipolar disorder. The patient's family also has a history of OUD/SUD. The patient was transferred to the local ED, which he has frequented various times in the past few years, via Emergency Medical Services (EMS) with an abscess on his right forearm. The ED is exceptionally busy and crowded, with a long wait time for ED and inpatient beds. The ED is also short staffed and does not have a specific provider to care for individuals with SUD.

The patient has erythematous streaks on his forearm and reports he feels lightheaded and nauseous. The patient is started on intravenous (IV) antibiotics after blood cultures are sent to the laboratory. Upon reviewing the patient's medical record, the Resident in the ED identifies that the patient was revived at the ED six months ago after an opioid overdose. After that visit, the patient was referred for OUD treatment but states he was never able to be seen by the treatment center and could not afford transportation to visit the center frequently. He does not have any family support to assist him with transportation. The patient reports also going to another hospital within the last year, but the Resident is unable to access any records or data from that visit.

The Resident in the ED asks the Attending Physician whether they can start the patient on buprenorphine, but the Resident is told they cannot keep the patient long enough to enter moderate withdrawal before induction due to limited beds. Given how busy the physicians are, no one has an in-depth discussion with the patient about his treatment goals and preferences. The patient is scheduled to be discharged and a social worker provides a printout listing of nearby methadone program addresses and phone numbers; however, no one verbally communicates the information on the printout with the patient. The patient is unclear on how much money the treatment programs will cost him and does not think he can afford treatment, nor does he have the finances to afford transportation to get to the program. The patient ultimately decides not to pursue further treatment after he is discharged from the ED.

Case Exemplar 2: Clinical Interventions Domain Narrative

The patient is a 47-year-old non-Hispanic, African-American woman with unstable housing presenting to the ED with shortness of breath, tachycardia, and altered mental status late at night. Her chest x-ray was sent to radiology and showed an enlarged heart. During her first night in the hospital, the patient became increasingly irritable, diaphoretic, and nauseous. She had difficulty falling asleep and asked for opioids to relieve her of her lower back and leg pain. While the patient is experiencing withdrawal, the care team does not accurately recognize the symptoms, nor do they request a pain consult for the patient. Instead, the team mistakenly believes she is stubborn and irritable. By morning, her cardiopulmonary work up revealed signs of congestive heart failure and during morning rounds her team found "track marks" on her arms. The nurse realizes the patient was likely in opioid withdrawal, but the patient went untreated and no addiction medicine consultation was requested.

The patient reports becoming depressed after her mother's death a few years ago and began to occasionally use heroin with her new boyfriend, injecting up to 5-6 bags a day within a year. The physician makes a mental note that the heroin was likely adulterated with fentanyl but does not mention this to the patient. The patient also shared she has had a long history of depression since childhood and chronic back pain following injuries from a fall several years ago. She has never received any mental health services for her depression. The patient revealed that six months ago she entered a methadone treatment plan which was initially successful, but she stopped treatment due to worsening depression. Despite being referred by the same ED system, there was limited information and only one

Brief Addiction Monitoring (BAM) screening in the patient's medical history. The results of the BAM were not acted on, and there was no mention of follow-up regarding her referral.

The patient reports wanting to attempt another form of medication treatment for OUD as she found it challenging to get to the methadone program each day. While the inpatient physician is considering prescribing her buprenorphine, he is worried that her heart condition is a contraindication. The physician also only believes she can afford a methadone maintenance program; however, the patient's treatment and payment options were not explored, nor were her goals discussed at any point. The patient is monitored for another night and is sent home with an appointment in the cardiology clinic for next month and a list of nearby meetings for an abstinence-only treatment program. No additional follow-up was conducted.

Case Exemplar 3: Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions Domain Narrative

The patient is a 62-year-old married Hispanic woman with three grown children and four grandchildren, who retired from working at a local preschool a decade ago and lives in a rural area. She has a history of rheumatoid arthritis, asthma, general anxiety disorder, and long-term opioid use. She is currently taking high-dose, extended-release oxycodone three times a day with morphine as needed for breakthrough pain. Despite long term use of a high-dose, extended-release opiate, and her other risk factors, no one gives the patient a naloxone kit or discusses overdose prevention with her or her husband.

She is regularly seen in the nearby Federally Qualified Health Center (FQHC) for her primary care, and meets with a rheumatologist, who is part of a separate healthcare system, every 6-12 months to review her pain regimen. There is a long wait to be seen by her rheumatologist and the patient often needs to fill her pain prescriptions early but cannot get through to the front desk on the phone. Her anxiety has worsened over the past year as two of her children, along with all her grandchildren, moved further away and she found herself in prolonged periods of loneliness and with a lack of family support. Her husband and children are not actively engaged as partners in her care.

Although she saw a psychiatrist ten years ago for anxiety, she has not taken an anxiety medication regularly since her retirement and the FQHC no longer has a full-time mental health clinician on staff. She was referred to a psychiatric nurse practitioner (NP) over telehealth and had a virtual intake conducted, but her WiFi often cut out, she could not understand the clinician well, and she had unanswered questions about medication options. The NP does not have access to the medical records, and given the connectivity issues, the NP did not hear the patient report she is on oxycodone. The NP discussed prescribing a selective serotonin reuptake inhibitor (SSRI) or clonazepam. The patient chose clonazepam since the NP said it will help her feel better faster. There was no discussion of any behavioral interventions.

Since the patient is receiving care at three separate, uncoordinated systems, no one recognizes that she is now on opioids and benzodiazepines. She also often uses all the morphine within the first week of picking up the refill, and as a result, she has been trying to augment it with other unknown pain relief options. She gets pills from a neighbor who she occasionally visits when she feels especially anxious or lonely. The patient says she would like to take fewer medications but is scared the pain will get worse if she makes any changes.

Discussion Question

- Are there any narrative specific solutions or strategies missing?