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# Addressing Opioid-Related Outcomes Among Individuals with Co-Occurring Behavioral Health Conditions: An Environmental Scan of Quality Measures

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*DRAFT REPORT*

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## Executive Summary

Through this environmental scan, the National Quality Forum (NQF) offers the Centers for Medicare & Medicaid Services (CMS) and other stakeholders a review of healthcare quality measures relevant to addressing polysubstance use involving synthetic or semi-synthetic opioids (SSSO) among individuals with co-occurring behavioral health conditions. The environmental scan considers issues related to use and misuse of opioids and other substances (e.g. methamphetamines), behavioral health, and where these areas intersect, serving as a complimentary effort in follow-up to measurement recommendations to CMS and the general public proposed by the 2019-2020 [NQF Opioids and Opioid Abuse Technical Expert Panel \(TEP\)](#) as the “fourth wave” of the opioid epidemic related to polysubstance use. This effort and the previous Opioid TEP are funded by CMS.

This environmental scan was guided by three questions: (1) What current or emerging quality of care measurements (i.e., metrics, indicators) exist that address overdose and mortality resulting from polysubstance use involving synthetic or semi-synthetic opioids among individuals with co-occurring behavioral health conditions? (2) What are the major current and emerging concepts regarding opioid use and misuse which can be used to evolve associated quality measurement that could inform future measurement? (3) What directions should quality measurement science take to advance the battle against the U.S. opioid overdose epidemic. For example, where are the apparent and important gaps?

The environmental scan builds upon a broader environmental scan conducted by the previous NQF Opioid TEP. This scan continues the work through a complementary focused review of relevant existing quality measure repositories, peer- and non-peer-reviewed literature, as well as state laws and regulations related to polysubstance use involving opioids in the presence of concomitant behavioral health conditions. Additional considerations included all-payer measures and measure concepts not addressed by the previous Opioids and Opioid Abuse TEP, social determinants of health, and measure concepts related to non-medical levers or medical-non-medical partnerships. As a result of this research, over 150 measures and measure concepts were identified related to the aforementioned areas of focus, as well as a number of measurement gaps. Utilizing these results, the Opioids and Behavioral Health Committee (comprised of but not limited to physicians, social workers, pharmacists, patient/caregiver representatives, and federal government liaisons) will deliberate on the current state of quality measures related to polysubstance use and co-occurring behavioral health conditions to identify and prioritize gaps and recommendations for inclusion in the Committee’s final report with the overall goal of reducing mortality and morbidity among this population in the United States.

## Introduction and Background

Opioid-related overdose deaths and morbidity have emerged as a complex and evolving challenge for the U.S. healthcare system. The Centers for Disease Control and Prevention’s (CDC) March 20, 2020 Morbidity and Mortality Weekly Report confirmed that in 2018, there were nearly 47,000 U.S. deaths attributable to opioid use, both prescription and illicit.<sup>1</sup> Moreover, a large proportion of those deaths are tied to heroin that is laced with illegally manufactured fentanyl, a substance available in patch form by prescription to treat severe pain. While this represents a decrease from 2017 in deaths involving all opioids by 2 percent, heroin by 4 percent, and prescription opioids by 14 percent, death rates associated

with synthetic opioids increased by 10 percent.<sup>2,3</sup> Quality measures related to opioid use are a key component to holding care providers, payors, and policy-makers accountable as direct purveyors or indirect sponsors of the best possible care regarding pain management and substance use disorder treatment and prevention.<sup>4</sup> The 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act outlined the creation of a TEP to address a series of quality measurement goals related to the opioid crisis. The TEP composed of 28 members, including physicians, nurses, patients, pharmacists, and others with expertise in pain management and opioid use disorders (OUD) to address opioid measurement challenges. The TEP made a series of recommendations related to identifying and prioritizing gaps in quality measures needed to be filled in order to reduce OUD and opioid overdose deaths without undermining effective pain management.

In addition, the TEP made recommendations for appropriate opioid-related measures and measure concepts to be recommended in five federal quality and performance programs administered by CMS.<sup>5</sup> The TEP discussed the initial three waves of the opioid crisis, beginning with the first wave of increased opioid prescribing in the 1990s, followed by a second wave of increases in heroin use in 2010, then complicated by a third wave beginning in 2013 characterized by dramatic increases in synthetic opioid-related overdose and death. The TEP also recognized an emerging “fourth wave” of the opioid epidemic related to polysubstance use.

Increasingly, individuals with OUD are more likely to use psychostimulants such as amphetamines, use opioids with other substances during the same use period, and have concomitant mental disorders such as anxiety, depression, and suicidal ideation.<sup>6</sup> In 63 percent of opioid overdose deaths, evidence of co-occurring prescription or illicit drug use was also present.<sup>7</sup> Because of the clear connection of concomitant behavioral health (BH) conditions with OUD and the impact of polysubstance use on opioid mortality and morbidity, the TEP prioritized the identification and development of measures that address comorbidities of OUD with psychiatric conditions and substance use disorders (SUDs). The [NQF Opioid TEP](#) made a series of recommendations related to identifying and prioritizing gaps in quality measures needed to be filled in order to reduce OUD and opioid overdose deaths without undermining effective pain management. In addition, the TEP made recommendations to CMS for appropriate opioid-related measures and measure concepts for five federal quality and performance programs administered by CMS.<sup>8</sup>

In a study that compared 2013 and 2017 baseline characteristics among treatment-seeking patients who use opioids with co-occurring BH conditions, researchers found that while the 2017 cohort used less prescription opioids than those from 2013, the 2017 cohort was more likely to use psychostimulants concurrently with opioids than the 2013 cohort.<sup>9</sup> These individuals in 2017 were also more likely to have anxiety, depression, and suicidal thoughts.<sup>10</sup> It is clear that these at-risk individuals underscore the responsibility of the healthcare community to deploy a targeted approach.

The ongoing opioid epidemic has been compounded by the COVID-19 public health emergency with research indicating increases in opioid-associated morbidity and mortality.<sup>11</sup> People with substance use disorder have found themselves increasingly isolated and with fewer distractions from dependency behaviors due to COVID-19 social restrictions, placing them at increased risk for setbacks.<sup>12</sup> COVID-19 has also resulted in decreased access to treatment for opioid use disorders and other substance use

disorders. With increasing use of telemedicine, clinicians may be challenged to ensure appropriate screening is conducted during routine appointments.<sup>13</sup>

Quality measurement has emerged as an important driver to implement best practices for addressing a range of behavioral health conditions. Quality measures for behavioral health have been implemented in many accountability programs, resulting in incentives for healthcare providers to focus their quality improvement efforts on commonly held goals and metrics. Ensuring that the totality of existing measurement tools and the apparent gaps in quality measures are well-understood by policymakers and other healthcare stakeholders is a critical step to addressing opioid and polysubstance use for those with co-occurring behavioral health conditions. Such an understanding could then be used to develop a measurement framework that can inform stakeholder groups across the healthcare industry on how best to meet the challenges for this key population.

Through this project funded by CMS, NQF has convened the Opioids and Behavioral Health Committee, consisting of stakeholders representing patients and caregivers, measure developers, behavioral health clinicians, pharmacy, health plans, social work, public health, criminal justice, and academia. The initial work of the Committee was to conduct an environmental scan of measures addressing opioids and polysubstance use occurring with concomitant behavioral health conditions. Within this report, the Committee has reviewed the current landscape of quality measures focused on substance use disorders, assessed the connection with behavioral health and polysubstance use, and developed recommendations to guide performance measurement related to the quality of opioid use disorders. In work subsequent to this report, the Committee will identify and prioritize measurement gaps and develop a measurement framework specific to polysubstance use involving synthetic and semi-synthetic opioids (SSSOs) with concomitant behavioral health conditions.

## Environmental Scan Aims

With guidance from the Committee, the NQF staff conducted an environmental scan of healthcare quality measures and measure concepts as the first step to the development of a quality measure framework specific to opioids, polysubstance use and co-occurring behavioral health conditions. This framework will be provided within the final report of the Committee's work. Such a framework, once constructed, will aim to comprehensively organize the ecosystem of quality measures and measurement concepts related to the topic. Additionally, the framework will be part of a quality measure gap identification and prioritization exercise to inform decisions specific to the priority of measures that should be developed to address challenges with co-occurring opioid use, polysubstance use, and behavioral health.

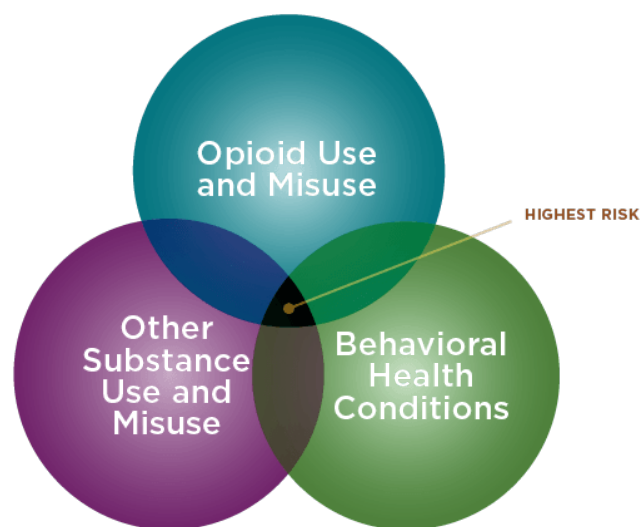
Though the search to identify healthcare quality measures for the scan has an all-inclusive scope, the Committee focus leans especially toward all-payer measures—measures for both public and private providers of health insurance—as well as measures that could potentially support the care for those with social risk factors (SRS) that may impact their care needs, including marginalized populations that may be particularly vulnerable to challenges of opioid misuse, other substance use, and behavioral health conditions. CMS has an interest in all-payer measures to facilitate alignment across payers and programs, to promote focus on commonly held quality priorities, and to reduce provider burden

associated with measure reporting. The Committee took particular interest in identifying measures that could prospectively connect medical professionals and non-medical professionals with common goals of addressing behavioral health issues, opioid use disorders and polysubstance abuse, such as criminal justice, public health, and social work.<sup>14</sup>

## Methodology and Approach

To inform the work of the Opioids and Behavioral Health Committee, drawing on the approach and results from the previous Opioid TEP, NQF staff conducted an environmental scan to assess the current state of quality measures surrounding polysubstance use involving synthetic or semi-synthetic opioids (SSSO) among individuals with co-occurring behavioral health conditions, using a search strategy with inclusion and exclusion criteria. The primary goal of the environmental scan was to assess the current landscape of quality and performance measures and measure concepts that could be used to assess opioid-affiliated polysubstance use among those individuals with co-occurring behavioral health conditions. This search did not produce any resulting measures. More specifically, as the NQF staff did not identify any existing measures that address opioids and polysubstance use among individuals with co-occurring behavioral health conditions, a conceptual model (See Figure 1) was formulated based on feedback from Committee members to identify measures and measure concepts within the three domains that include opioid use and misuse, other substance use and misuse, and behavioral health conditions. Such measures were considered by the Committee to be potentially helpful in developing measure concepts to address polysubstance use, including SSSOs among individuals with co-occurring behavioral health conditions.

### Opioids, Polysubstance Use and Behavioral Health Conceptual Model



*Figure 1. Opioids, Polysubstance Use and Behavioral Health Conceptual Model*

The Committee noted that a person who may fall within a given domain of Figure 1 is at risk to move into the intersection points of the domains; a person with behavioral health conditions is at increased risk for opioid and other substance use and misuse, as are people with opioid use and misuse at greater risk for developing other behavioral health conditions. It was further noted that the nature and disposition of each the intersection points in Figure 1 is such that the risk of associated mortality and morbidity is known to increase. The Committee considered individuals at the central intersection point—those who would be characterized with all three conditions—as having the highest risk for poor medical outcomes and overdose associated mortality. This model was therefore also considered as potentially useful in identifying upstream behaviors and conditions within behavioral health conditions, opioid use and misuse, and other substance use and misuse that may potentially prevent individuals from moving into areas that overlap within Figure 1.

For the purposes of the scan, the following questions guided research efforts and ensured that the information sources collected are relevant to the project objectives:

- What are currently available all-payer measures or measure concepts that accomplish the following?
  - Address overdose and mortality resulting from polysubstance use involving synthetic or semi-synthetic opioids among individuals with co-occurring behavioral health conditions
  - Consider pertinent social risk factors related to opioids
  - Measure or provide measure concepts related to non-medical levers or medical-non-medical partnerships, i.e., social work, criminal justice, public health
- What current or emerging quality of care measurements exist that address overdose and mortality resulting from polysubstance use involving synthetic or semi-synthetic opioids among individuals with co-occurring behavioral health conditions?
- What are the major current and emerging concepts regarding opioid use and misuse which can be used to advance associated quality measurement?
- What directions should quality measurement science take to advance efforts to address opioid overdose epidemic? For example, where are the apparent and important gaps?

Information was synthesized from peer-reviewed scientific literature, grey scientific literature, quality measurement databases, and state laws responding to the opioid crisis. [Appendix B](#) offers more information on the methodology of the environmental scan. Before this document will be finalized, members of the Opioids and Behavioral Health Committee, Committee federal liaisons, CMS staff (see [Appendix A](#)), and the general public will be given opportunities to provide factual and subjective feedback. Accordingly, the finalized document will be an NQF-synthesis of multiple sources from within and outside of the Opioids and Behavioral Health Committee.

## Results

The environmental scan focused on specific search criteria in multiple areas of research: measure repositories, peer-reviewed literature, non-peer-reviewed literature, and state law and regulatory databases. This scan was intended to supplement a [broader environmental scan](#) performed by the NQF staff who conducted an extensive search in these areas and found no conclusive evidence of any quality



measures that address polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions. Though the NQF staff found no measures, recognition of the challenges associated with opioids and polysubstance use with other behavioral health conditions were clear in the literature and state law and regulatory search results. For example, at least portions of regulatory language in several state-level departments of health and human services provided thoughtful commentary on the challenges that face this target population. For instance, regulators in Maine adopted a 2020 rule that directly addressed the growing concern on treatments for persons with OUD:

...The Board recognizes the body of evidence regarding the effectiveness of Approved Medications in the office based treatment of OUD, when such treatment is delivered in accordance with current standards of care, the requirements of the Drug Addiction Treatment Act of 2000 (DATA 2000), and this joint rule. Overdoses and deaths due to approved medications can occur and have been reported. Most overdoses, especially fatal ones, involve the concurrent use of another central nervous system (CNS) depressant such as benzodiazepines, other opioids, or alcohol. Approved Medications such as buprenorphine also pose a significant risk to non-tolerant individuals, especially children. The goal is to provide appropriate treatment of the patient's OUD (either directly or through referral), while adequately addressing other aspects of the patient's functioning, including co-occurring medical and psychiatric conditions and psychosocial issues...<sup>15</sup>

The Committee considers the scan results that produced no specific measure of opioids meaningful since it should be an indicator to policymakers, healthcare providers and other stakeholder groups that further measure development is needed given the heightened risk for this category of substance use. Furthermore, NQF's February 2020 Opioid TEP [Final Report](#) on opioids and opioid use disorders included searches of components of the topic at hand. No relevant measures specific to this scan focus could be found in that environmental scan as well. It was noted in the report that the TEP considered measures of opioids and polysubstance use co-occurring with behavioral health conditions to be a measure gap that should be prioritized and addressed.

## Measure Repositories

Measure repositories were scanned as a baseline procedure to find any existing measures related to polysubstance use involving synthetic or semi-synthetic opioids among individuals with co-occurring behavioral health conditions. Although no measures were found specific to SSSO polysubstance use in patients with comorbid BH conditions, the NQF staff found 89 existing measures ([Appendix C](#)) and 71 measure concepts ([Appendix D](#)) that will be used by the Committee to develop a framework for this project.

## Peer-Reviewed Literature

The NQF staff conducted a search of peer-reviewed literature which yielded 12 articles connected to polysubstance use involving synthetic or semi-synthetic opioids among individuals with co-occurring behavioral health conditions.

PMID	Title	Journal
25800105	Evaluation of the current opioid misuse measure among substance use disorder treatment patients	Journal of Substance Abuse Treatment
31361592	Retention in care as a quality measure for opioid use disorder	Substance Abuse Journal
26275980	Validation of the Full and Short-Form Self-Help Involvement Scale Against the Rasch Measurement Model	Sage Journals
32050143	Trajectories of retention in opioid agonist therapy in a Canadian setting	International Journal of Drug Policy
25462662	The association between impulsivity and alcohol/drug use among prison inmates	Addictive Behaviors: An International Journal
30534101	Validation of the Substance Use Risk Profile Scale (SURPS) With Bulgarian Substance Dependent Individuals	Frontiers in Psychology
28815789	Cost-effectiveness of emergency department-initiated treatment for opioid dependence	Society for the Study of Addiction
28226334	Prescription Opioid Abuse in Chronic Pain: An Updated Review of Opioid Abuse Predictors and Strategies to Curb Opioid Abuse (Part 2)	Pain Physician
31478965	Individuals With Opioid Dependence Using Polysubstances: How Do They Experience Acute Hospital Care and What Are Their Needs? A Qualitative Study	Journal of Addictions Nursing
30646016	Health, Polysubstance Use, and Criminal Justice Involvement Among Adults With Varying Levels of Opioid Use	JAMA
30156454	Prescription Opioid Quality Measures Applied Among Pennsylvania Medicaid Enrollees	Journal of Managed Care & Specialty Pharmacy
29925323	Risk of opioid misuse in chronic non-cancer pain in primary care patients - a cross sectional study	BMC Family Practice

## Non-Peer-Reviewed Literature

The NQF staff scanned a series of web material and grey literature from government sources to other health advocacy groups to find potential measure concepts. Though no concepts were found, the NQF staff discovered a series of guidance documents originating from the Government Accountability Office (GAO) that critically discuss the apparent measure gaps in this space.

Item Number	Title	Summary
<a href="#">GAO-18-205</a>	ILLICIT OPIOIDS: While Greater Attention Given to Combating Synthetic Opioids, Agencies Need to Better Assess their Efforts	A number of federal agencies have documented specific strategies to combat illicit opioids. However, only three of the five strategies we assessed—ONDCP’s Heroin Availability Reduction Plan (HARP); HIDTA’s HRS; and DEA’s 360 Strategy—included performance measures to gauge the effectiveness of the efforts described in each strategy, and only HARP included outcome-oriented performance measures.
<a href="#">GAO-18-44</a>	OPIOID USE DISORDERS: HHS Needs Measures to Assess the Effectiveness of Efforts to Expand Access to Medication-Assisted Treatment (MAT)	GAO recommends that HHS take two actions: (1) establish performance measures with targets related to expanding access to MAT, and (2) establish timeframes for its evaluation of its efforts to expand access to MAT. HHS concurred with both recommendations.
<a href="#">GAO-19-628</a>	HEALTH CARE QUALITY: CMS Could More Effectively Ensure Its Quality Measurement Activities Promote Its Objectives	GAO recommends that CMS (1) maintain more complete and detailed information on its funding for quality measurement activities, (2) establish procedures to systematically assess measures under consideration based on CMS’ quality measurement strategic objectives, and (3) develop and use performance indicators to evaluate progress in achieving its objectives. HHS concurred with all three recommendations.

## State Laws & Regulations

LexisNexis was utilized to search for existing laws and regulations that could be pertinent to the topic at hand. The NQF staff could not find any existing laws or regulations that specifically discuss the target population of polysubstance users who abuse synthetic or semi-synthetic opioids and experience co-occurring behavioral health conditions. However, the search discovered 13 state laws and 43 state-level regulations that touch on some aspects of the subject matter, though the NQF team ultimately determined them to be immaterial for the purposes of this scan.

Members of the Opioid and Behavioral Health Committee acknowledged the NQF team's assessment of the search but commented on the usefulness of parts of an Ohio regulation that requires physician assistants to be in compliance with approved FDA "Risk Evaluation and Mitigation Strategies" when administering buprenorphine products to opioid withdrawal patients. Another Ohio rule passed in 2020 provides further evidence of measure concepts when addressing patients who consumed opioids:

...(3) Prior to providing ambulatory detoxification, the physician shall perform an assessment of the patient. The assessment shall include a thorough medical history and physical examination. The assessment must focus on signs and symptoms associated with opioid addiction and include assessment with a nationally recognized scale, such as one of the following: (a) Objective Opioid Withdrawal Scale ("OOWS"); (b) Clinical Opioid Withdrawal Scale ("COWS"); or (c) Subjective Opioid Withdrawal Scale ("SOWS")...<sup>16</sup>

Further summaries of the state-level laws and regulations can be found by referencing ([Appendix E](#)).

## All-payer Measure Concepts Not Addressed by Previous Opioid Technical Expert Panel (TEP)

During meetings, Committee members actively discussed best practices that could be used to inform quality measurement ideas, especially at the health plan level.

One emerging best practice is the full integration of all BH disorder treatment into a single team and program. Integrated programs ensure that individuals receive care from a team that has experience with concomitant psychiatric and substance use issues. A potential all-payer measure concept that could emerge from this is time to initial appointment with an integrated BH program for beneficiaries with identified multiple behavioral health conditions.<sup>17</sup> Seminal events such as emergency department (ED) visits due to overdose or new BH diagnoses could trigger entry into the denominator. When combined with care retention measures and recovery measures, a care initiation measure could focus health plan efforts to ensure that beneficiaries are receiving timely, coordinated care for concomitant BH conditions. Integration of behavioral health services was also a measure gap identified by the previous NQF Opioid TEP, especially between SUDs, mental disorders, and somatic illnesses.

The Committee will revisit this theme and explore additional measure concepts during the development of the measurement framework.

## Pertinent Social Risk Factors

The Committee emphasized the role of social risk factors in the opioid epidemic. The Committee noted that research has suggested that the opioid crisis is fundamentally fueled by economic and social influences and that its etiology is closely linked to the role of opioids as a refuge from physical and psychological trauma, concentrated disadvantage, isolation, and hopelessness. Each of these challenges are directly connected with poverty and other social risk.

Mortality associated with polysubstance use with SSSOs in persons with BH conditions has been shown to be heightened when SDOH-related risk factors are present. In one recent study using 2015 data from a northeastern U.S. state, comorbid BH conditions were found to be a contributor to mortality, but persons older than 24 years, non-rural residents, non-Hispanic black residents, and persons with recent homelessness were also more likely than their counterparts to die from the combination of opioids and stimulants than opioids alone.<sup>18</sup> The Committee also noted a recent observational study that shows substantial disparities exist in the use of medications to treat OUD with marked efficacious treatment when such medications are prescribed. Across a population of just over 3,600 adolescents to young adults—an age group at high risk for OUD and overdose—black non-Hispanics receive medication treatment for OUD treatment at about half the rate of whites, and people who receive such medications are approximately twice as likely to remain in SUD treatment 180 and 360 days after initiation.

The Committee recognized that multiple social determinants may influence OUD and polysubstance use, including food insecurity, education, under- and unemployment, exposure to crime, violence and social disorder, and many others. However, the Committee emphasized the important role that homelessness, unsafe housing, and criminal justice involvement play in fueling the opioid epidemic and substance use disorders more generally.

## Homelessness and Unsafe Housing

The Committee emphasized the connection between issues of homelessness and unsafe housing and polysubstance use with SSSOs. Homelessness has been directly connected with higher rates and severity of opioid and other substance use disorders, as well as opioid overdose.<sup>19</sup> Other studies have indicated that relapse into concurrent opioid and stimulant misuse is correlated with both homelessness and incarceration (discussed further in the next section).<sup>20</sup> In addition, one recent study found that homeless persons with SUD who entered housing intervention programs had greatly reduced (by 53 percent) financial needs (for temporary housing, jail, and treatment services) compared to those who were wait-listed controls for the same housing program.<sup>21</sup> These findings compound the severity of SUD and behavioral health conditions among this group, suggesting that housing supports and other social programs are imperative to reducing relapse and morbidity and mortality associated with polysubstance use with SSSOs.

The Committee stressed the potential of quality measures to screen for homelessness and identification of SUDs for people who present to healthcare settings, and to refer such individuals to appropriate social programs. The Committee recognized that such measures presuppose adequate access to these types of programs, which was noted to be a challenge.

## Incarceration and Other Criminal Justice Involvement

The findings from the previous Opioid TEP report suggested that priority gap measures that should be included in this framework comprise those related to specialty populations that involve those with a history of criminal justice involvement. Moreover, the Opioids and Behavioral Health Committee experts commented on this issue throughout their discussions of polysubstance abuse involving SSSOs among individuals with BH conditions.

Data challenges most significantly affect quality measures that could prospectively connect criminal justice and healthcare collaborations. For example, the Committee commented that most governmental agency data collection (such as Department of Justice data collection) is very limited and only addresses federal settings.

The Committee further emphasized that measures for incarceration settings and reentry would be likely to make significant contributions to abating opioid misuse and relapse but require incentives and face basic data collection issues. It was noted by the Committee that many people “treat” their own behavioral health conditions by self-medicating, which sometimes results in their entry to the criminal justice system where officers are often not equipped to handle behavioral health issues. While some people may begin treatment for behavioral health conditions while incarcerated, many never do. Jails and prisons often take an abstinence only approach to managing OUD rather than using treatment modalities that are known to be effective, including medication-assisted treatment (MAT)—the use of medications in combination with counseling and behavioral therapies, which is effective in the treatment of OUD and can help some people to sustain recovery. Studies have suggested that use MAT treatment initiation while incarcerated is effective in promoting long-term recovery from OUD.<sup>22</sup>

The Committee plans to further explore measure gaps that can connect data sources used by healthcare professionals and criminal justice.

## Urban-Rural Disparities in Access to Buprenorphine Providers

Buprenorphine is an effective medication for OUD; however, access to buprenorphine prescribers is often limited in many rural locations. In an effort to address this disparity, the Comprehensive Addiction and Recovery Act of 2016 has improved access by extending the ability of nurse practitioners (NPs) and physician assistants (PAs) to obtain a Drug Enforcement Administration (DEA) waiver to prescribe buprenorphine. Research published in 2018 showed increased availability of a physician with a DEA waiver in rural areas since 2012; however, more than half (56.3 percent) of all rural counties still lack a waived provider.<sup>23</sup> Furthermore, this research demonstrated that almost one-third (29.8 percent) of rural Americans live in a county without a buprenorphine provider as compared to 2.2 percent of urban Americans.<sup>24</sup> Additionally, the U.S. Department of Health and Human Services Office of Inspector General’s (OIG) January 2020 report titled *Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder* noted that while the number of providers who have obtained waivers has increased significantly since 2002, the figures likely overstate the availability of buprenorphine treatment as studies show many providers do not treat up to their approved patient-limit capacity and access to buprenorphine services through waived providers is not distributed evenly across the United States.<sup>25</sup> More specifically, this OIG report found that 40 percent of counties in the nation did not have a single waived provider in 2018 and that waived providers were not necessarily found in areas

where MAT access is most crucial. The OIG and the Substance Abuse and Mental Health Services Administration (SAMHSA) jointly agreed that SAMHSA should geographically target high-need counties to increase participation of waived providers.<sup>26</sup>

## Discussion

The four search components of the environmental scan—measure repositories, peer-reviewed literature, non-peer-reviewed literature, and state law and regulatory databases—yielded significantly varying results. The results of each of the components of the scan are discussed in the sections below.

### Measure Repositories

The search of measure repositories initially returned no results for measures of SSSO-associated polysubstance use in patients with BH conditions. This was not an unexpected result given that the prior NQF Opioid TEP, having found no such measures in a comparable environmental scan, had identified this area specifically as a high-priority quality measurement gap. A modification of the approach to identify measures and measure concepts that could potentially inform the Committee's discussion of measure gaps specific to the scan topic resulted in 89 unique healthcare quality metrics and 71 measure concepts related to separate distinctions of opioids, substance use disorder, and behavioral health. This initial result further informed the approach taken in discussions with the Committee as well as other searches to include best practices to inform measure gaps.

### Peer-Reviewed Literature

The peer-reviewed literature did not produce any healthcare quality metrics directly associated with the scan focus. Nonetheless, review of the articles identified returned some valuable results to guide Committee consideration of measure concepts and gaps. An 11-item screening instrument, the Current Opioid Misuse Measure (COMM), was identified.<sup>27</sup> Higher scores on this instrument were associated with greater drug use severity, greater endorsement of positive, negative, and pain relief outcome expectancies related to opioid use, increased pain intensity, and decreased physical and mental health functioning. This measure, or one like it, could potentially be used as a patient-reported outcome measure to screen for OUD risk and tailor care for patients with BH conditions or known high-dosage utilization of opioids. Moreover, it was noted in the study that COMM was significantly associated with key substance use characteristics, making it potentially a useful instrument for applications addressing polysubstance use involving SSSOs.

Another potentially useful scale is the Substance Use Risk Profile Scale (SURPS), a 23-item self-report questionnaire that assesses four well-validated personality risk factors for substance misuse (impulsivity, sensation seeking, anxiety sensitivity, and hopelessness).<sup>28</sup> Comorbidities are common among those who misuse prescription opioids: 85 percent or more have chronic pain, 55 percent or more have mental disorders, about 40 percent to 56 percent have an alcohol use disorder, and 60 percent or more are nicotine dependent.<sup>29</sup> Presently, a combination of strategies is recommended by clinicians to stratify risk, to identify and understand aberrant drug related behaviors, and to tailor treatments accordingly. Such a scale could be considered as a screening measure for patients with BH conditions to address risk associated with OUD and polysubstance use, or to potentially identify patients not suitable for opioid therapy, or identify those who need increased vigilance or monitoring during therapy. It was noted that



SURPS would need to be tested and validated for those specific uses prior to deployment as a patient-reported outcome measure.<sup>30</sup>

Additional articles focused on the concept of measuring retention and recovery. One such article extended a quality measurement concept found in the treatment of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) to OUD.<sup>31</sup> An HIV/AIDS care model known as the “cascade of care” model led to the concept of “retention in care” initially deployed in methadone-based OUD treatment. The article notes that not only is retention in care associated with improved morbidity and mortality, but it also offers strategic approaches to improving care for OUD. The concept of quality measurement of recovery in the short-term, long-term and after-care transitions (for example from inpatient to outpatient behavioral healthcare) was prioritized as a top-five priority by the previous NQF Opioid TEP. This could be a measurement idea that can be further extended as a prospective means of stabilizing patients in care who have known SSSO polysubstance use and BH conditions.

Another article was identified as a source for a potential measure concept. The article serves as the basis for a potential facility-level measure related to an emerging best practice in treating people with OUD who present to the ED. The study reported on a randomized trial where patients with opioid dependence receiving brief intervention, ED-initiated buprenorphine, and ongoing follow up in primary care with buprenorphine were found to be twice as likely to be engaged in OUD treatment compared with referral to community-based treatment or brief intervention and referral.<sup>32</sup> Moreover, evaluation of the relative cost-effectiveness of these methods of intervening on opioid use disorders in the ED suggested that initiating buprenorphine prior to leaving the facility was also more cost effective than other interventions. A quality measure that holds facilities accountable to initiate appropriate MAT for people who present to the ED with OUD could potentially lessen the risk of overdose associated mortality, especially for those patients with concomitant BH conditions. What may further indicate the importance of initiating buprenorphine for patients receiving care in the ED are the previously discussed waiver requirements for buprenorphine providers. Access to buprenorphine remains a challenge. According to a May 2020 data brief published by OIG, of all Medicare Part D beneficiaries at serious risk in 2017 who were diagnosed with OUD, only 7 percent received MAT through Part D. Any quality measure would need to ensure providers operating under existing limitations are not inappropriately penalized.<sup>33</sup>

## Non-Peer-Reviewed Literature

A review of the non-peer-reviewed literature produced results that were largely duplicative of those from the previous [Opioid TEP Environmental Scan](#) from September 2019. However, the NQF staff identified opioid-related GAO reports that were informative to the Committee’s objectives but not included in the original Opioid TEP Environmental Scan.

One GAO report assessed international coordination efforts to curb importation of SSSOs, domestic opioid reduction strategies and prevention and treatment approaches, as well as federal agency approaches to drug control policy. GAO recognized the complexity of the shifting trends in dominant opioid uses over time, noting that SSSOs have emerged as a key driver of opioid-related mortality and morbidity in the U.S. in recent years.<sup>34</sup> U.S. opioid misuse has been transformed through a broader illegal opioid market, dominated first by prescription opioids, then complicated by heroin, and now also



by fentanyl and other synthetic opioids. This has been further complicated by concurrent use of opioids with psychostimulants and other substances. GAO's report reflects the Committee's view that the collective understanding of OUD amongst clinicians, academics, policymakers, and justice officials has evolved from opioid use and misuse being viewed as a driver of crime to a behavioral health condition where people need treatment. The Committee recognized that this creates new challenges and opportunities for healthcare providers to collaborate with the criminal justice system. Addressing inmates' OUD is a core responsibility, including preventing overdose after release. Treatment can be supported by diversion programs (e.g., drug courts, among others) and by providing medication-assisted treatment while incarcerated. Such an approach contributes to crime-control strategy but also meets core responsibilities to provide ethical healthcare.<sup>35</sup>

This GAO report also recognized that the Government Performance and Results Act Modernization Act of 2010 requires federal justice agencies to develop measurable goals and performance indicators. Outcome-oriented performance measures are necessary for federal agencies to assess efforts to respond to the synthetic opioid threat. The report notes that federal law enforcement agencies are increasingly coordinating with the public health sector to share overdose information, but both sectors reported ongoing data sharing obstacles and related challenges with the timeliness, accuracy, and accessibility of overdose data. This suggested to the Committee that data sourcing for quality measures that directly connect criminal justice and health plans may pose a significant challenge.

Of the recommendations related to measurement for Customs and Border Patrol (CBP), the Office of National Drug Control Policy (ONDCP), the Department of Homeland Security (DHS), and the Department of Justice (DOJ), two recommendations were especially relevant to the Committee's aims:

The Director of ONDCP, in collaboration with law enforcement and public health counterparts, should lead a review on ways to improve the timeliness, accuracy, and accessibility of fatal and non-fatal overdose data from law enforcement and public health sources that provide critical information to understand and respond to the opioid epidemic. Such a review should expand on and leverage the findings from previous federal studies. It should also assess the benefits and scalability of ongoing efforts to leverage data systems, such as the Washington-Baltimore High-Intensity Drug Trafficking Areas' (HIDTA) Overdose Detection Mapping Application Program (ODMAP) and examine ways in which laws that restrict access to public health data to protect patient privacy have exemptions for law enforcement entities that could be more widely leveraged while protecting patient privacy.<sup>36</sup>

While this recommendation clearly has implications for potential measurement connecting public health, healthcare providers, and criminal justice, ONDCP took issue with the recommendation in its response to the recommendation in the report, suggesting that current ONDCP actions are taking steps in this direction and that federal agencies should not wait to act before effective data exchange between justice agencies and healthcare is well-established. In a separate recommendation, GAO called upon the executive director of Organized Crime Drug Enforcement Task Forces (OCDETF) to work with the National Heroin Initiative Coordinator to establish outcome-oriented performance measures for the goals set out for National Heroin Initiative. Data from these efforts could be used in performance indicators within state-level dashboards to hotspot high drug trafficking areas and focus efforts to enhance access to care and appropriate social work and public health initiatives within those areas.

Similarly, in September 2020, OIG released findings of their audit on the DEA's community-based efforts to combat the opioid crisis, finding that the DEA lacked an outcome-oriented performance measurement strategy to assess the effectiveness of its community outreach efforts, and recommended that the DEA clearly define the goals and expected outcomes prior to implementation.<sup>37</sup>

Another GAO report urged the Department of Health and Human Services (HHS) to deepen its efforts related to MAT. In this report from October 2017, GAO alludes to five key efforts that HHS has undertaken since 2015 that focus on expanding access to MAT for opioid use disorders—four grant programs that focus on expanding access to MAT in various settings (including rural primary care practices and health centers) and regulatory changes that expand treatment capacity by increasing patient limits for MAT prescribers. While the report specifically encouraged HHS to establish measures of MAT access, comparable MAT structure and access measures could be used for health plans and pharmacy benefit managers (PBMs), particularly for patients with known concomitant BH conditions.<sup>38</sup>

## State Laws and Regulations

While the first three components of the scan produced results that will inform further work of the Committee, the state law and regulatory database searches generated no information deemed contributory to the measurement scan.

While not part of the scan results, the recent decriminalization of all illicit drug possession and use in Oregon was noted as an emerging legal feature that may impact the stigmatization associated with substance use disorder. In November 2020, Oregon became the first U.S. state to decriminalize the personal possession of illegal drugs, including cocaine, heroin, oxycodone, and methamphetamine.<sup>39</sup> This is a significant paradigm shift from previous policy approaches which have viewed behavioral health challenges from illicit substance use as serious criminal activity to be primarily addressed by the judicial system. Personal consumption of illegal substances has been collectively addressed in the same efforts to curb illegal drug trafficking in the War on Drugs campaign that dates to the 1970s.<sup>40</sup> The Committee recognized that the impact of this decriminalization approach will take some time before it can be assessed. The Committee viewed criminal justice-related data and measurement of drug trafficking to be intrinsically different than personal consumption data, with the latter easier to connect to direct healthcare provision. The implication that states may be increasingly moving toward decriminalization of personal consumption of illicit substances is that data sources for measurement connection of healthcare to criminal justice may be fewer in the future.

## Scan Summary and Next Steps

Measurement is an essential tool to address the opioid overdose crisis nationwide in relation to polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions. Performance measurement offers an opportunity to assess, support, and incentivize the reduction of the adverse impact of opioids in U.S. healthcare that have contributed to the opioid crisis, specifically among individuals with co-occurring behavioral health conditions.

This environmental scan was conducted to identify impactful measures and potential measure gaps associated with use and misuse of opioids and other substances, behavioral health conditions, and

where these areas intersect. The scan identified over 150 measures and measure concepts that directly or indirectly relate to opioid and polysubstance use among those with behavioral health conditions presently challenging the U.S. Though many measures were found across multiple domains of opioid use and misuse, other substance use and misuse, and behavioral health conditions, many gaps were also identified, including a dearth of measures that are available to assess treatment initiation best practices, long-term care retention and recovery, criminal justice, social work and public health connection to health plans, and economic and cultural issues including housing supports and stigma.

Over the coming months, the convened NQF Committee will use this environmental scan as a tool moving forward in its deliberations about measurement of opioids, polysubstance use, and behavioral health. This document will also be available for broader public use. Additional gaps will be identified and then prioritized for inclusion in the Committee's final report for the public. The overall goal of this measurement endeavor is to identify measures to reduce mortality and morbidity related to opioid use in the United States, specifically among persons with co-occurring behavioral health conditions.

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## Appendix B: Environmental Scan Strategy

### Purpose

This appendix details the NQF team's approach to conducting the environmental scan of measures related to individuals who experience opioid use disorder (OUD) and have concomitant polysubstance use or behavioral health conditions. The environmental scan addressed the current state of opioid-related and behavioral health quality measures to support the work of the TEP. The TEP will use the scan to identify gaps and provide recommendations on the inclusion of measures in various federal programs and on future measure development efforts regarding challenges posed by opioid use with concomitant polysubstance use and behavioral health conditions in the U.S.

### Research Questions

The following three research questions guided the environmental scan. These questions helped to focus the NQF team's research efforts and ensure the information sources collected are relevant to the project objectives.

- What current or emerging quality of care measurements (i.e., metrics, indicators) exist that address overdose and mortality resulting from polysubstance use involving synthetic or semi-synthetic opioids among individuals with co-occurring behavioral health conditions?
- What are the major current and emerging concepts regarding opioid use and misuse which can be used to evolve associated quality measurement?
- What directions should quality measurement science take to advance the battle against the U.S. opioid overdose epidemic? For example, where are the apparent and important gaps?

### Scope

The environmental scan began with a broad search and gradually decreased in scope as certain settings, types of measures, or concepts were prioritized. Prioritization of searches were guided by CMS' task order instructions to initially focus on the four sources below. The NQF team only collected measures for which there is enough information to understand how the measure should be used (For example, What is being measured? Where does measurement occur? Who is the target for measurement?). This report synthesized information from the following four sources:

1. Peer-reviewed, scientific literature (capturing elements found in Table 1)
2. "Grey" scientific literature (i.e., technical reports, books, etc., from reputable sources) (capturing elements found in Table 1)
3. Quality measurement databases (e.g., the NQF Quality Positioning System (QPS) (capturing elements found in Table 2)
4. State laws responding to the opioid crisis (capturing elements found in Table 3)

### Sources

The NQF team conducted various searches and reviews as specified in this appendix. The search was an iterative process with constant opportunities for feedback from the project team and the Opioids and Behavioral Health Committee. The environmental scan included, but was not limited to, a review of the peer-reviewed literature and grey literature and:

1. PubMed (National Library of Medicine)
2. Internet searches at the following sites:
  - a. HHS
    - i. Administration for Children and Families
    - ii. Administration for Community Living
    - iii. Agency for Healthcare and Quality
    - iv. Agency for Toxic Substance and Diseases Registry
    - v. Centers for Disease Control and Prevention
    - vi. Centers for Medicare and Medicaid Service
    - vii. Health Resources and Services Administration
    - viii. Indian Health Service
    - ix. National Institutes of Health
    - x. Substance Abuse and Mental Health Services Administration
  - b. National Academy of Medicine
  - c. Commonwealth Fund
  - d. Kaiser Family Foundation
  - e. NQF
  - f. General Accountability Office

The following publications were also reviewed to compile a compendium of relevant measures and measure concepts:

1. NQF Quality Positioning System (QPS)
2. CMS Measures Inventory Tool (CMIT)
3. Qualified Clinical Data Registries (QCDRs)
4. Medicaid Waiver Programs
5. Center for Medicare and Medicaid Innovation (CMMI) Models
6. Accreditation Programs
  - a. National Committee on Quality Assurance (NCQA)
  - b. Utilization Review Accreditation Commission (URAC)

## Search Parameters

The NQF team used the parameters defined in Table B1 to conduct the search. The team used specific “terms” or “strings” to search for information sources. Databases were searched using combinations and variations of the example search terms below. NQF also used relevant MeSH terms. The NQF team refined the search parameters when appropriate as additional information was gathered.

Included	Excluded
<ul style="list-style-type: none"> <li>Published/passed on or after January 1, 2013</li> <li>AND</li> <li>Contains the strings: “opioid” OR “opiate” OR “substance use disorder” OR “addict*” OR “polysubstance”</li> </ul>	<ul style="list-style-type: none"> <li>Published before 2013 and not current</li> <li>Not available in English</li> <li>Case studies</li> <li>Publications focusing exclusively pharmacology or other molecular-level research</li> </ul>

- AND Contains the strings: “metric” OR “measure” OR “indicator” OR “survey”

## Operational Definitions

- **Outcomes measure:** a measure that assesses a health state (e.g., death, lab results, illness remission)
- **Process measure:** a measure that assesses an action that is presumed to be connected to quality of care (e.g., a treatment, screening, scheduling)
- **Structural measure:** a measure that assesses resources available for care (e.g., supplies of naloxone, equipment, facilities, personnel, procedures)
- **Measure concept:** a quality measure that has not been fully specified and tested, such as one that draws on an existing or potential assessment tool or instrument that includes a planned target and population
- **Instrument:** an assessment tool such as a survey, scale, questions, etc.
- **Opioid:** This term encompasses the family of psychoactive pharmaceutical analgesics with a chemical structure similar to morphine, used primarily to treat pain and has high abuse and addiction potential.
- **Substance abuse or misuse:** the use of a pharmaceutical or alcohol in a way that is risky (i.e., contraindicated, excessive, underage, otherwise illicit)
- **Substance use disorder:** dependence on one or more legal or illegal drugs (including alcohol and tobacco) that is marked by increasing reliance on those substances, and negative behavioral change (e.g., frequent intoxication and lability).
- **Opioid use disorder:** a problematic pattern of opioid use leading to clinically significant impairment or distress.
- **Behavioral health condition:** Behavioral health describes the connection between behaviors and the health and wellbeing of the body and mind. Behavioral health conditions therefore include mental health conditions as well as substance use disorders, among others.
- **Polysubstance use:** Although polysubstance abuse often refers to abuse of multiple illicit drugs, it is also inclusive of prescription medications used in nonmedical circumstances.
- **Pain management:** the active treatment of acute or chronic pain under medical (surgical, dental, primary care) prescription or supervision, including the use of nonpharmaceutical interventions (e.g., occupational and/or physical therapy) and the use of interventions in the context of palliative care.
- **Access:** the timely use of personal health services to achieve the best possible outcomes.

## Appendix C: Measure Inventory

\*Measures that were also previously identified in the [2019 NQF Opioids and Opioid Use Disorder Final Environmental Scan](#).

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*(SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	1664	Endorsement Removed	This facility-level measure estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 24 months. Data from the start of the measurement period through 30 days after close are used to identify readmissions. Data from 12 months prior to the start of the measurement period through the end of the measurement period are used to identify risk factors.	Process
Adherence to Antipsychotic Medications For Individuals with Schizophrenia (SAA-AD)	1879	Endorsed	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	Intermediate Outcome
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eCQM)	0104e	Endorsed	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Process



Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*Alcohol Problem Use Assessment & Brief Intervention for Home-Based Primary Care and Palliative Care Patients	N/A	Not Endorsed	Percentage of newly enrolled and active home-based primary care and palliative care patients who were assessed for a problem with alcohol use at enrollment AND, if positive, have a brief intervention for problematic alcohol use documented on the date of the positive assessment.	Process
SUB 2 - Alcohol Use Brief Intervention Provided or Offered	1663	Endorsement Removed	Hospitalized patients 18 years of age and older who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use ( <i>SUB-1 Alcohol Use Screening; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge</i> [temporarily suspended]).	Process
Alcohol Use Disorder Outcome Response	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) who report problems with drinking alcohol AND with documentation of a standardized screening tool (e.g., AUDIT, AUDIT-C, DAST, TAPS) AND demonstrated a response to treatment at three months (+/- 60 days) after the index visit.	Patient Reported Outcome (PRO)
Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)	0354	Endorsed	The percentage of individuals 18 years of age and older who are on long-term opioid therapy and have not received a drug test at least once during the measurement year.	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Antidepressant Medication Management (AMM)	0105	Endorsed	<p>The percentage of members 18 years of age and older who were treated antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment. Two rates are reported.</p> <p>a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).</p> <p>b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).</p> <p>a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).</p> <p>b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).</p>	Process
Anxiety Response at 6-months	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) with an anxiety disorder (generalized anxiety disorder, social anxiety disorder, post-traumatic stress disorder, or panic disorder) who demonstrated a response to treatment at six months (+/- 60 days) after an index visit.	Patient Reported Outcome (PRO)

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Anxiety Screening	N/A	Not Endorsed	The percentage of adult patients (18 years and older) with an anxiety disorder diagnosis (generalized anxiety disorder, social anxiety disorder, post-traumatic stress disorder, or panic disorder) who have completed a standardized tool (e.g., GAD-7, GAD-2, BAI) during measurement period.	Process
Avoidance of Co-Prescribing of Opioid Analgesic and Benzodiazepine	N/A	Not Endorsed	Percentage of patients who were not concurrently prescribed opioid analgesic and benzodiazepine medications.	Process
*Avoidance of Long-Acting (LA) or Extended-Release (ER) Opiate Prescriptions and Opiate Prescriptions for Greater Than 3 Days Duration for Acute Pain	N/A	Not Endorsed	Percentage of adult patients who were prescribed an opiate who were not prescribed a long-acting (LA) or extended-release (ER) formulation.	Process
*Avoidance of Opiates for Low Back Pain or Migraines	N/A	Not Endorsed	Percentage of patients with low back pain and/or migraines who were not prescribed an opiate.	Process
Avoidance of Opioid Prescriptions for Reconstruction After Skin Cancer Resection	N/A	Not Endorsed	Percentage of patients aged 18 and older who underwent reconstruction after skin cancer resection who were prescribed opioid/narcotic therapy* as first line therapy (as defined by a prescription in anticipation of or at time of surgery) by the reconstructing surgeon for post-operative pain management. (Inverse measure).	Process
*Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	0110	Endorsement Removed	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Process
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1933	Endorsed	The percentage of patients 18-64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	Process
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk-Assessment (eCQM)	1365e	Endorsed	Percentage of patient visits for those patients aged six through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Clinical Depression Screening and Follow-Up	N/A	Not Endorsed	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the positive screen.	Process
*Concurrent Use of Opioids and Benzodiazepines (COB)	3389	Endorsed	The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year. A lower rate indicates better performance.	Process
*Continuity of Care after Inpatient or Residential Treatment for Substance Use Disorder (SUD)	3453	Endorsed	Percentage of discharges from inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18-64, which were followed by a treatment service for SUD. SUD treatment services include having an outpatient visit; intensive outpatient encounter or partial hospitalization; telehealth encounter; or filling a prescription, or being administered, or dispensed a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within seven and 14 days after discharge.	Process
Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs	3312	Endorsed	Percentage of discharges from a medically managed withdrawal episode for adult Medicaid beneficiaries, ages 18-64 that were followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder [pharmacotherapy]) within seven or 14 days after discharge.	Process
*Continuity of Pharmacotherapy for Opioid Use Disorder	3175	Endorsed	Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Depression Remission at Twelve Months (eCQM)	0710e	Endorsed	The percentage of patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 30 days) after an index visit.	Outcome
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	1934	Endorsed	The percentage of patients 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	Process
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1932	Endorsed	The percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Process
*Discharge Prescription of Naloxone after Opioid Poisoning or Overdose	N/A	Not Endorsed	Percentage of opioid poisoning or overdose patients presenting to an acute care facility who were prescribed naloxone at discharge.	Process
Discharged to the Community with Behavioral Problems	N/A	Not Endorsed	Percentage of home health quality episodes of care at the end of which the patient was discharged with no assistance available, demonstrating behavior problems.	Outcome
*Documentation of Signed Opioid Treatment Agreement	N/A	Not Endorsed	All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	Process
Elimination of narcotic medication use following spinal fusion surgery	N/A	Not Endorsed	Calculation of the percent of patients who report a reduction in narcotic medication intake from 'Daily use' or 'Occasional use' to 'No use' following a spine surgical intervention (cervical or lumbar).	Patient Reported Outcome (PRO)

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Evaluation or Interview for Risk of Opioid Misuse	N/A	Not Endorsed	All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during COT in the medical record.	Process
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	3488	Endorsed	<p>The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:</p> <ul style="list-style-type: none"> <li>- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).</li> <li>- The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).</li> </ul>	Process
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	3489	Endorsed	<p>The percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness. Two rates are reported:</p> <ul style="list-style-type: none"> <li>- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).</li> <li>- The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).</li> </ul>	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Follow-Up After High Intensity Care for Substance Use Disorder (FUI)	N/A	Endorsed	Percentage of discharges from inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18-64, which were followed by a treatment service for SUD. SUD treatment services include having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being administered or dispensed a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within seven and 14 days after discharge.	Process
Follow-Up After Hospitalization for Mental Illness (FUH)	0576	Endorsed	<p>The percentage of discharges for patients six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:</p> <ul style="list-style-type: none"> <li>- The percentage of discharges for which the patient received follow-up within 30 days of discharge</li> <li>- The percentage of discharges for which the patient received follow up within seven days of discharge</li> </ul>	Process
Follow-Up Care for Adult Medicaid Beneficiaries Who Are Newly Prescribed an Antipsychotic Medication	3313	Endorsed	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Gains in Patient Activation (PAM) Scores at 12 Months	2483	Endorsed	<p>"The Patient Activation Measure® (PAM®) is a 10 or 13 item questionnaire that assesses an individual's knowledge, skill and confidence for managing their health and healthcare. The measure assesses individuals on a 0-100 scale. There are 4 levels of activation, from low (1) to high (4). The measure is not disease specific but has been successfully used with a wide variety of chronic conditions, as well as with people with no conditions. The performance score would be the change in score from the baseline measurement to follow-up measurement, or the change in activation score over time for the eligible patients associated with the accountable unit. The outcome of interest is the patient's ability to self-manage. High quality care should result in gains in ability to self-manage for most chronic disease patients. The outcome measured is a change in activation over time. The change score would indicate a change in the patient's knowledge, skills, and confidence for self-management. A positive change would mean the patient is gaining in their ability to manage their health. A "passing" score for eligible patients would be to show an average net 3-point PAM score increase in a 6-12 month period. An "excellent" score for eligible patients would be to show an average net 6-point PAM score increase in a 6-12 month period."</p>	Outcome: PRO-PM



Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey	0166	Endorsed	"HCAHPS (NQF #0166) is a 29-item survey instrument that produces 10 publicly reported measures: 6 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, communication about medicines, discharge information and care transition); and 4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital)."	Outcome
*Hospice and Palliative Care Composite Process Measure Comprehensive Assessment at Admission (hereafter referred to as the HIS Comprehensive Assessment Measure)	3235	Endorsed	For patients 18 years and older, percentage of patient stays during which the patient received all care processes captured by quality measures NQF #1641 <i>Hospice and Palliative Care Treatment Preferences</i> ; NQF #1647 (modified) <i>Beliefs/Values Addressed</i> (if desired by the patient); NQF #1634 <i>Hospice and Palliative Care Pain Screening</i> ; NQF #1637 <i>Hospice and Palliative Care Pain Assessment</i> ; NQF #1639 <i>Hospice and Palliative Care Dyspnea Screening</i> ; NQF #1638 <i>Hospice and Palliative Care Dyspnea Treatment</i> ; NQF #1617 <i>Patients Treated with an Opioid Who Are Given a Bowel Regimen</i> , as applicable.	Composite
Hours of physical restraint use	0640	Endorsed	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.	Process
Hours of seclusion use	0641	Endorsed	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.	Process
*Improvement in Pain Interfering with Activity	0177	Endorsed	Percentage of home health episodes of care during which the patient's frequency of pain when moving around improved.	Outcome
*Improving or Maintaining Mental Health	N/A	Not Endorsed	Percent of all plan members whose mental health was the same or better than expected after two years.	Outcome

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	0004	Endorsed	<p>This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported:</p> <ul style="list-style-type: none"> <li>• Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of the diagnosis.</li> <li>• Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.</li> </ul>	Process
*Kidney Stones: Opioid utilization after ureteroscopy and shockwave lithotripsy	N/A	Not Endorsed	Percentage of patients who underwent ureteroscopy or shockwave lithotripsy and are discharged on NSAIDS, Acetaminophen, or "Other," and who were not prescribed opioids for pain control.	Process
*Multimodal Pain Management	N/A	Not Endorsed	Percentage of patients, aged 18 years and older, undergoing selected surgical procedures that were managed with multimodal pain medicine.	Process
Non-Opioid Pain Management Following Mohs micrographic surgery	N/A	Not Endorsed	Percentage of cases of Mohs surgery who received a prescription for opioid/narcotic pain medication (prescription prior to or at the time of surgical discharge from the Mohs surgeon) following Mohs micrographic surgery.	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*Oncology: Medical and Radiation - Plan of Care for Pain	0383	Endorsed	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.	Process
*Opioid Therapy Follow-up Evaluation	N/A	Not Endorsed	All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during opioid therapy documented in the medical record.	Process
*Pain Interference Response utilizing PROMIS	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) who report pain issues and demonstrated a response to treatment at one month from the index score.	Patient Reported Outcome (PRO)
Patients discharged on multiple antipsychotic medications with appropriate justification	0560	Endorsed	The proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: <i>Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed</i> , HBIPS-2: <i>Physical Restraint</i> , HBIPS3: <i>Seclusion</i> , HBIPS-4: <i>Multiple Antipsychotic Medications at Discharge</i> , HBIPS-6: <i>Post Discharge Continuing Care Plan</i> and HBIPS-7: <i>Post Discharge Continuing Care Plan Transmitted</i> ) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-4 <i>Patients discharged on multiple antipsychotic medications</i> .	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*Patients Treated with an Opioid who are Given a Bowel Regimen	1617	Endorsed	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed.	Process
Post-operative opioid management following ocular surgery	N/A	Not Endorsed	Percentage of patients aged 18 years and older who underwent ocular surgical procedures who were assessed for opioid use/requirements post-operatively, defined by either not receiving opioids post operatively, receiving opioids for pain for seven days or less post operatively, or if expected to require opioids for more than seven days after the surgical procedure, having an opioid use management plan documented.	Process
Posttraumatic Stress Disorder (PTSD) Screening and Outcome Assessment	N/A	Not Endorsed	<p>The percentage of patients with a history of a traumatic event (i.e., an experience that was unusually or especially frightening, horrible, or traumatic) who report symptoms consistent with PTSD for at least one month following the traumatic event AND with documentation of a standardized symptom monitor (PCL-5 for adults, CATS for child/adolescent) AND demonstrated a response to treatment at three months (+/- 60 days) after the index visit.</p> <p>This measure is a multi-strata measure, which addresses symptom monitoring for both child and adult patients being treated for post-traumatic stress symptoms. Assessment instruments monitoring severity of symptoms for PTSD are validated either for adult or child populations. Thus, while the measurement structure will be similar for both populations, the specified instruments for symptom monitoring will be different.</p>	Patient Reported Outcome (PRO)

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)	0418e	Endorsed	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Process
*Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2152	Endorsed	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Process
Prostate Cancer: Opioid utilization after radical prostatectomy	N/A	Not Endorsed	Percentage of patients who underwent radical prostatectomy and are discharged with $\leq$ six opioid pain pills (5mg oxycodone or equivalent) and do not get a prescription for opioids within 30 days of surgery.	Process
*Query of Prescription Drug Monitoring Program (PDMP)	N/A	Not Endorsed	For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.	Process
Risk of Continued Opioid Use (COU)	N/A	Endorsed	The percentage of individuals 18 years of age and older who are on long-term opioid therapy and have not received a drug test at least once during the measurement year.	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*Safe Opioid Prescribing Practices	N/A	Not Endorsed	<p>Percentage of patients, aged 18 years and older, prescribed opioid medications for longer than six weeks' duration for whom ALL of the following opioid prescribing best practices are followed:</p> <ol style="list-style-type: none"> <li>1. Chemical dependency screening (includes laboratory testing and/or questionnaire) within the immediate six months prior to the encounter</li> <li>2. Co-prescription of naloxone or documented discussion regarding offer of Naloxone co-prescription—if prescription is <math>\geq 50</math> MME/day</li> <li>3. Non co-prescription of benzodiazepine medications by prescribing pain physician and documentation of a discussion with patient regarding risks of concomitant use of benzodiazepine and opioid medications.</li> </ol>	Process
*Safe Use of Opioids – Concurrent Prescribing	3316e	Endorsed	Patients age 18 years and older prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge from a hospital-based encounter (inpatient or emergency department (ED), including observation stays).	Process
*Screening and monitoring for psychosocial problems among children and youth	N/A	Not Endorsed	Percentage of children from 3.00 to 17.99 years of age who are administered a parent-report, standardized and validated screening tool to assess broad-band psychosocial problems during an intake visit AND who demonstrated a reliable change in parent-reported problem behaviors two to six months after initial positive screen for externalizing and internalizing behavior problems.	Patient Reported Outcome (PRO)

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Shared-decision making for post-operative management of discomfort following Rhinoplasty	N/A	Not Endorsed	<p>Percentage of patients aged 15 years and older who had a rhinoplasty procedure who had documentation of a pre-operative shared-decision making strategy for multimodal post-operative management of discomfort.</p> <p>Definitions: Documentation of discussion of at least two mechanisms of pain management from the following terms or phrases (one term or phrase from each list) will meet the measure:</p> <p>List 1) Non-opioid analgesics: Non-narcotic/Non-opioid, Acetaminophen/Tylenol, Cox-II inhibitor (Celecoxib), Local/Maraine/Block, Anxiolytic, Tramadol, NSAID/ibuprofen</p> <p>List 2) Non-systemic: Ice/Cooling, Elevation, Rest, Mindfulness, Meditation</p>	Process
Sleep Quality Screening and Sleep Response at 3-months	N/A	Not Endorsed	Percentage of patients 18 years and older who reported sleep quality concerns (e.g., insomnia) with documentation of a standardized tool AND demonstrated a response to treatment at three months (+/- 60 days) after index visit.	Patient Reported Outcome (PRO)
Social Role Functioning Outcome utilizing PROMIS	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) with a mood or anxiety disorder who report concerns related to their psychosocial function and demonstrated a response to treatment two months (+/- 30 days) after the index visit.	Patient Reported Outcome (PRO)
Symptom Improvement in adults with ADHD	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) with a diagnosis of ADHD who show a reduction in symptoms of .25 (25 percent) on the Adult ADHD Self-Report Scale (ASRS-v1.1 - referred to as ASRS) 18-item self-report scale of ADHD symptoms within two to six months after initially reporting significant symptoms.	Patient Reported Outcome (PRO)

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	2860	Endorsed	"This facility-level measure estimates an all-cause, unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The performance period for the measure is 24 months."	Outcome
Use of a "PEG Test" to Manage Patients Receiving Opioids	N/A	Not Endorsed	Percentage of patients in an outpatient setting, aged 18 and older, in whom a stable dose of opioids are prescribed for greater than six weeks for pain control, and the results of a "PEG Test" are correctly interpreted and applied to the management of their opioid prescriptions.	Process
*Use of Opioids at High Dosage in Persons Without Cancer	2940	Endorsed	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	Process
*Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer	2951	Endorsed	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	Process
*Use of Opioids from Multiple Providers in Persons Without Cancer	2950	Endorsed	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	Process



Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
*Use of Pharmacotherapy for Opioid Use Disorder (OUD)	3400	Endorsed	The percentage of Medicaid beneficiaries ages 18-64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.	Process
*Verify Opioid Treatment Agreement	N/A	Not Endorsed	For at least one unique patient for whom a Schedule II opioid was electronically prescribed by the MIPS eligible clinician using CEHRT during the performance period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a six-month look-back period, the MIPS eligible clinician seeks to identify the existence of a signed opioid treatment agreement and incorporates it into the patient's electronic health record using CEHRT.	Process
Assessed for SUD Treatment Needs Using a Standardized Screening Tool	N/A	Not Endorsed	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period.	Process
Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	N/A	Not Endorsed	Number of beneficiaries with an SUD diagnosis and an SUD-related service during the measurement period but not in the three months before the measurement period.	Process
Medicaid beneficiaries with SUD Diagnosis (monthly)	N/A	Not Endorsed	Number of beneficiaries with an SUD diagnosis and an SUD-related service during the measurement period and/or in the 11 months before the measurement period.	Process
Medicaid Beneficiaries with SUD Diagnosis (annually)	N/A	Not Endorsed	Number of beneficiaries with an SUD diagnosis and an SUD-related service during the measurement period and/or in the 12 months before the measurement period.	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
Medicaid Beneficiaries Treated in an IMD for SUD	N/A	Not Endorsed	Number of beneficiaries with a claim for residential treatment for SUD in an IMD during the reporting year.	Process
Any SUD Treatment	N/A	Not Endorsed	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.	Process
Early Intervention	N/A	Not Endorsed	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.	Process
Outpatient Services	N/A	Not Endorsed	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step-down care, and monitoring for stable patients) during the measurement period.	Process
Intensive Outpatient and Partial Hospitalization Services	N/A	Not Endorsed	Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period.	Process
Residential and Inpatient Services	N/A	Not Endorsed	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.	Process
Withdrawal Management	N/A	Not Endorsed	Number of beneficiaries who use withdrawal management services (such as inpatient, outpatient, or residential) during the measurement period.	Process
Medication Assisted Treatment (MAT)	N/A	Not Endorsed	Number of beneficiaries who have a claim for MAT for SUD during the measurement period.	Process
Average Length of Stay in IMDs	N/A	Not Endorsed	The average length of stay for beneficiaries discharged from IMD residential treatment for SUD.	Process
SUD Provider Availability	N/A	Not Endorsed	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.	Process

Measure Title	NQF #	NQF Endorsement Status	Measure Description	Measure Type
SUD Provider Availability - MAT	N/A	Not Endorsed	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.	Process
Use and Adherence to Antipsychotics among members with Schizophrenia	0544	Endorsement Removed	Assesses the use of and the adherence of antipsychotics among members with schizophrenia during the measurement year.	Outcome
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	2801	Endorsed	Percentage of children and adolescents one to 17 years of age who had a new prescription for an antipsychotic medication, but no U.S. Food and Drug Administration primary indication for antipsychotics and had documentation of psychosocial care as first-line treatment.	Process

## Appendix D: Measure Concept Inventory

These measure concepts are a combination of those identified by the Opioids and Behavioral Health Committee and those previously published in the [2019 NQF Opioids and Opioid Use Disorder Final Environmental Scan](#).

#	Measure Description	Measure Type
1	Average inpatient daily MMEs administered during hospitalization	Process
2	Behavioral health integration in medical care instrument	Process
3	Clinical Opiate Withdrawal Scale	Process
4	Continuity of Pharmacotherapy for Opioid Use	Process
5	Current Opioid Misuse Measure is a 17-item survey useful in assessing prescription opioid use in SUD treatment settings	Process
6	Daily MMEs prescribed at discharge	Process
7	Days' supply of initial opioid prescription for acute pain.	Process
8	Discharges from opioid use	Process
9	Extended-release opioid prescriptions as a proportion of all initial opioid prescriptions for acute pain.	Process
10	Extended-release opioid prescriptions as a proportion of all initial opioid prescriptions for chronic pain.	Process
11	Hospital-level risk standardized opioid extended use following elective THA and/or TKA	Process
12	Hospital-level risk standardized opioid respiratory depression following elective THA and/or TKA	Outcome
13	Improvement or maintenance of functioning for all patients seen for mental health and substance use care	Outcome
14	Improvement or maintenance of symptoms for patients with opioid misuse	Outcome
15	Morphine milligram equivalent (MME) of initial opioid prescription for chronic pain.	Process
16	Neonatal Infant Pain Scale	Process
17	Neonatal Pain Agitation and sedation Scale	Process
18	Number of opioid prescribers for single patient	Process
19	Number of opioid prescriptions per 1,000 office visits	Process
20	Number of pills prescribed at discharge	Process
21	OD death synthetic opioids	Outcome
22	Opioid administration among the headache/migraine patients who visited ED	Process

#	Measure Description	Measure Type
23	Opioid burden	Outcome
24	Opioid-covered days prescribed to the patients who were discharged from ED	Process
25	Overdose deaths any opioid	Outcome
26	Pain measure for children in inpatient; pain reduction by 30 percent within 120 minutes of complaint	Outcome: PRO-PM
27	Patient experience of care for all patients seen with mental health and substance use care	Outcome: PRO-PM
28	Percentage of hospitalized patients with OUD on medication management	Process
29	Percentage of opioid prescriptions for acute pain with less than seven-day supply	Process
30	Percentage of opioid prescriptions with partial fill instructions	Process
31	Percentage of opioid-naïve patients prescribed C-II & C-III opioid on emergency department discharge	Process
32	Percentage of patients administered long-acting opioid during hospital stay	Process
33	Percentage of patients prescribed chronic opioid with risk and plan documented	Process
34	Percentage of patients prescribed long-acting opioid at hospital discharge	Process
35	Percentage of patients prescribed opioid	Process
36	Percentage of patients prescribed opioid at discharge	Process
37	Percentage of patients prescribed opioid more than three months after surgery	Process
38	Percentage of patients prescribed opioid with daily MME > 90 among those who were prescribed	Process
39	Percentage of patients that received more than 50 MME during at least one day of their hospitalization	Process
40	Percentage of patients treated for opioid overdose in emergency department	Process
41	Percentage of patients with documented Opioid Risk Tool assessment among those on chronic opioids	Process
42	Percentage of patients with Naloxone on medication list while they received opioid with daily MME > 90	Process
43	Percentage of patients with office visits within prior three months among chronic opioid users	Process
44	Percentage of patients with OUD discharged with naloxone	Process
45	Percentage of patients with urine drug toxicology among chronic opioid users	Process
46	Percentage of prescribers who have written for 1+ prescription of buprenorphine/nlx	Process

#	Measure Description	Measure Type
47	Percentage of prescribers with a suboxone waiver	Process
48	Proportion of patients who received a urine drug test within 30 days before initial opioid prescription (initial screening) and within 365 days after initial opioid prescription (annual screening) for chronic pain.	Process
49	Proportion of patients with a follow-up visit (based on E&M CPT codes) within 30 days after the initial opioid prescription for chronic pain.	Process
50	Quantity of opioid prescribed to the patients who were discharged from ED	Process
51	Rapid Recovery Progression Measure: 6-item	Intermediate Outcome
52	Rate of NY Office of Alcoholism and Substance Abuse Services (OUD treatment program) use	Process
53	Recovery Progression Measure: 36-item	Intermediate Outcome
54	Subjective Opiate Withdrawal Scale	Process
55	The percentage of patients on long-term opioid therapy the clinician counseled on the risks and benefits of opioids at least annually.	Process
56	The percentage of patients on long-term opioid therapy who had a follow-up visit at least quarterly.	Process
57	The percentage of patients on long-term opioid therapy who had at least quarterly pain and functional assessments.	Process
58	The percentage of patients on long-term opioid therapy who had documentation that a PDMP was checked at least quarterly.	Process
59	The percentage of patients on long-term opioid therapy who were counseled on the purpose and use of naloxone, and either prescribed or referred to obtain naloxone	Process
60	The percentage of patients on long-term opioid therapy with documentation that a urine drug test was performed at least annually.	Process
61	The percentage of patients with a follow-up visit within four weeks of starting an opioid for chronic pain.	Process
62	The percentage of patients with a new opioid prescription for acute pain for a three days' supply or less	Process
63	The percentage of patients with a new opioid prescription for an immediate-release opioid.	Process
64	The percentage of patients with a new opioid prescription for chronic pain with documentation that a PDMP was checked prior to prescribing.	Process

#	Measure Description	Measure Type
65	The percentage of patients with a new opioid prescription for chronic pain with documentation that a urine drug test was performed prior to prescribing.	Process
66	The percentage of patients with chronic pain who had at least one referral or visit to nonpharmacologic therapy as a treatment for pain.	Process
67	PROMIS Pain Interference instruments	Outcome: PRO-PM
68	PROMIS Physical Function - Short Form	Outcome: PRO-PM
69	PROMIS Pain Intensity Scale	Outcome: PRO-PM
70	PROMIS Emotional Distress-Depression Short Form	Outcome: PRO-PM
71	PROMIS Emotional Distress-Anxiety Short Form	Outcome: PRO-PM

Appendix E: State Laws & Regulations

State-level laws and regulations identified in this search are described in the below tables.

Law Title	Law Number	State	Year Passed	Summary (Excerpt From Statute)
Opioid Prescription Drugs: Prescribers	CA A 714	California (CA)	2019	Makes provisions to offer a patient a prescription for the complete or partial reversal of opioid depression applicable only to a patient receiving a prescription for an opioid or benzodiazepine medication and makes the provisions specific to opioid-induced respiratory depression, opioid overdoses, opioid use disorder, and opioid overdose prevention.



Law Title	Law Number	State	Year Passed	Summary (Excerpt From Statute)
State MAT Reentry Incentive Program	CA A 1304	California (CA)	2020	Establishes the State Medically Assisted Treatment (MAT) Reentry Incentive Program which would make a person released from prison on parole, with specified exceptions, who has been enrolled in or successfully completed an institutional substance abuse program, eligible for a reduction in the period of parole if the person successfully participates in a substance abuse treatment program that employs a multifaceted approach to treatment.
Criminal Justice and Substance Use Disorder Treatment	CO H 1017	Colorado (CO)	2020	Concerns treatment of individuals with substance use disorders who come into contact with the criminal justice system; provides for opioid treatment for a person in custody; provides for safe stations where a person may turn in any controlled substances and request assistance in gaining access to treatment for a substance use disorder; provides for the continuity of care for persons released from jail.

Law Title	Law Number	State	Year Passed	Summary (Excerpt From Statute)
Alcohol Dependency Coverage	DE H 220	Delaware (DE)	2019	Adds coverage for Medication-Assisted Treatment for drug and alcohol dependencies to the Mental Health Parity Laws for health insurance; requires health insurance carriers to provide coverage for prescription medications approved by the US Food and Drug Administration for MAT at no greater financial burden than for prescription medication for other illness or disease, without step therapy requirements, and at the lowest tier of the drug formulary.
Commitment to Ending the Opioid Epidemic	IL 2 2020	Illinois (IL)	2020	Executive Order: Strengthens the state's commitment to ending the opioid epidemic. I. Establish local recovery-oriented systems of care (ROSC) councils in communities that have been disproportionately impacted by the opioid crisis in order to reach out to and engage individuals in all stages of recovery.

Law Title	Law Number	State	Year Passed	Summary (Excerpt From Statute)
Prior Authorizations	ME S 218	Maine (ME)	2019	Amends the prior authorization process for health insurance carriers; reduces the time frame for a carrier's response to a prior authorization request; exempts medication assisted treatment for opioid use disorder from prior authorization requirements; requires a health insurance carrier to develop an electronic transmission system for prior authorization of prescription drug orders.
Accountability of Opioid Manufacturers	ME S 237	Maine (ME)	2020	Prohibits opioid medication manufacturers and distributors from falsely advertising that an opioid medication does not have abuse liability or has a lower abuse liability than another opioid medication, distributing a quantity of opioid medications that is not medically reasonable, or failing to report orders that are not medically reasonable; establishes a civil violation and authorizes the Attorney General to investigate violations.
Prior Authorization for Medication	ME H 1378	Maine (ME)	2020	Prohibits the Department of Health and Human Services from requiring, under the MaineCare program, prior authorization for medication-assisted treatment for opioid use disorder, the prescription of at least one drug for each type of medication used in medication assisted treatment, except that the department may not require prior authorization for medication-assisted treatment for opioid use disorder for a pregnant woman.

Law Title	Law Number	State	Year Passed	Summary (Excerpt From Statute)
Opioid Addiction Advisory Council	MN H 400	Minnesota (MN)	2019	Establishes the Opioid Addiction Advisory Council and the Opioid Stewardship Fund; establishes an opiate product registration fee; modifies provisions related to opioid addiction prevention, education, intervention, treatment, and recovery; appropriates money.
Health and Human Services	MN S 12 a	Minnesota (MN)	2019	Relates to health and human services; modifies provisions relating to children and families, operations, direct care and treatment, continuing care for older adults, disability services, chemical and mental health, healthcare, health coverage, prescription drugs, health related licensing boards, Health Department, and additional miscellaneous provisions; modifies provisions governing childcare providers and medical assistance; establishes the Child Welfare Training Academy.
Opioid Use Disorder Treatment	WA S 5380	Washington (WA)	2019	Revises provisions relating to opioid use disorder treatment, prevention, and related services; expands the list of individuals that are immune from criminal and civil liability or disciplinary action to include the secretary who issues a standing order prescribing opioid overdose reversal medications to any person at risk of such; provides exemptions from the requirements for a refill authorization of controlled substances to be electronically submitted. The legislature declares that opioid use disorder is a public health crisis. State agencies must increase access to evidence-based opioid use disorder treatment services, promote coordination of services within the substance use disorder treatment and recovery support system, strengthen partnerships between opioid use disorder treatment providers and their allied community partners, expand the use of the Washington state prescription drug monitoring program, and support comprehensive school and community-based substance use prevention services.
Office of Drug Control Policy	WV H 4103	West Virginia (WV)	2020	Relates to the Office of Drug Control Policy; directs the office to create a state drug control policy in coordination with the bureaus of the Department of Health and Human Resources and other state agencies; requires the policy

Law Title	Law Number	State	Year Passed	Summary (Excerpt From Statute)
				<p>to include all programs which are related to the prevention, treatment, and reduction of substance abuse use disorder.</p> <p>The bill will also: Develop recommendations to improve communication between healthcare providers and their patients about the risks and benefits of opioid therapy for acute pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose.</p>
Health Treatment for Inmates	UT H 38	Utah (UT)	2020	Modifies and enacts provisions relating to substance use treatment, mental health treatment, and healthcare provided in a correctional facility; directs the Department of Health to apply for a waiver under the state Medicaid plan to offer a program to provide Medicaid coverage to inmates within a certain time period before the release from a correctional facility; requires a county to provide matching funds to the state for Medicaid coverage, and costs relating to the Medicaid coverage.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
7 AAC 33, 70, 135, 160	AK 4851 2016	Alaska (AK)	2017	Amends rules to modify requirements for providers, add opioid use disorder treatment services, create an obligation for providers of these opioid treatment services to meet department approval requirements, add a new section that lists the specific program requirements for these opioid use treatment services, adopt documents by reference related to substance abuse treatment, and remove outdated service requirements.
7 AAC 70.010 - 160.990 (non seq)	AK 5204 2019	Alaska (AK)	2020	Amends rules regarding Medicaid coverage for behavioral health services dealing with behavioral health provider requirements. The department will approve an organization to provide behavioral health services in this state only if that organization meets the requirements for a community

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
				behavioral health services provider under 7 AAC 70.100 or 7 AAC 70.130 and provides one or more of the following:...
7 AAC 136.010 - 160.990 (non seq)	AK 5220 2019	Alaska (AK)	2019	Establishes rules to add two new chapters, Behavioral Health 1115 Demonstration Waiver and Substance Use Disorder Waiver Services.
540-X-21	AL 10125 2015	Alabama (AL)	2015	Adds a new chapter of rules regulating the treatment of opioid addiction in the medical office. The use of buprenorphine for the treatment of opioid addiction is governed by the federal Drug Addiction Treatment Act of 2000, commonly referred to as "DATA 2000" (Public Law 106-310, Title XXXV, Sections 3501 and 3502). This legislation allows physicians to treat opioid addiction with FDA-approved controlled drugs in office-based settings. Specifically, DATA 2000 allows physicians to use buprenorphine and other controlled substances in the federal Controlled Substances Act (21 U.S.C. §§ 801, et. seq.) (CSA) Schedules III, IV, and V, which have been approved by the FDA for the treatment of opioid dependence, to treat patients in office-based settings, provided certain conditions are met.
410-2-2-.01,-.02, -.03, -.04, -.05, -.06, -.07, -.08	AL 13337 2019	Alabama (AL)	2019	Repeals the 2014-2017 Plan and adopts the 2020-2023 Plan... (6) The State should encourage and promote a variety of treatments for SUD. Traditional treatments for SUD include abstinence-based systems such as 12-step programs. Methadone has been used successfully in recent years, especially for severe cases. SAMHSA has recently reported significant success with Medication-Assisted Treatment (MAT) which uses medications (primarily buprenorphine), in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery.
IAC 441-78.1 thru .4, .6, .7, .9, .10, .14, .26, .28; -79.1	IA 4763 2019	Iowa (IA)	2020	Updates and clarifies language to reflect existing prescribed outpatient drug policies for qualified prescribers, reasons for non-payments of drugs, covered nonprescription drugs, quantity prescribed, drug reimbursement methodology (including dispensing fee limitation) and credits for returned unit dose drugs not consumed. This rulemaking also adds language regarding initiation of refill requirements with the prohibition of automatic refills without the members consent and

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
				includes legislatively required prior authorization (PA) limitations on medication-assisted treatment (MAT), including opioid overdose treatment, under the pharmacy and medical benefits.
908 KAR 1:370	KY 23121 2019	Kentucky (KY)	2019	This administrative regulation establishes licensing procedures, fees, responsibilities of the governing authority, quality assurance and utilization review, policies and procedures, staff qualifications and training, client rights, client records, assessment, treatment planning, and adverse action procedures for outpatient and residential alcohol and other drug treatment entities.
908 KAR 1:374	KY 23132 2019	Kentucky (KY)	2019	This administrative regulation establishes standards for nonhospital based alcohol and other drug treatment entities that provide ambulatory withdrawal management, outpatient treatment services, intensive outpatient services, partial hospitalization, or office based opiate treatment services.
LAC 50:XXII.Chapters 61-69	LA 15435 2018	Louisiana (LA)	2019	Adopts rules governing the CMS-approved Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Waiver
LAC 50:XXXIII.14101, 14301, 14303 and 14501	LA 15437 2018	Louisiana (LA)	2018	Amends rules governing substance use disorders services in order to align these provisions with the CMS-approved Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Waiver.
LAC 50:XXXIII.Chapters 151-157	LA 15719 2019	Louisiana (LA)	2020	Amends rule concerning Opioid Use Disorder in Opioid Treatment Programs. AThe Medicaid Program hereby adopts provisions to provide coverage for medication-assisted treatment provided in Opioid Treatment Programs, including but not limited to methadone treatment, to all Medicaid-eligible adults and children with opioid use disorder (OUD).
105 CMR 164	MA 10601 2015	Massachusetts (MA)	2016	Amends rule as an emergency to address the ongoing opioid abuse epidemic by removing specific prohibitions in order to allow providers to offer treatment in an appropriate setting for individuals committed to treatment.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
130 CMR 450, 508	MA 11183 2018	Massachusetts (MA)	2018	Allows disabled individuals enrolled in One Care who turn 65 and are eligible for CommonHealth to remain enrolled in One Care pursuant to authority received by MassHealth in the November 2016, 1115 waiver amendment. Previously, this option was available only to members who were eligible for MassHealth Standard. Updates language related to terminology for the Duals Demonstration, ICOs, and One Care to reflect that ICOs are now referred to as "One Care plans." Additionally, the referral requirement for medication-assisted treatment (MAT) for opioid use disorder is being removed for MAT services delivered to members enrolled in the PCC Plan or in a Primary Care Accountable Care Organization.
10-144-101, Ch II Section 80	ME 11184 2017	Maine (ME)	2017	Amends rules regarding prescribing opioids for pain management, buprenorphine and buprenorphine combination products for substance use disorder, and the CMS outpatient drug rule.
10-144-101, Ch. II and III, Section 93	ME 11562 2018	Maine (ME)	2019	Sets forth emergency rule to ensure that a continuum of evidence-based treatment and recovery support services for opioid use disorder is accessible to the people of Maine.
02-373-12; -380-12; -383-12	ME 11794 2019	Maine (ME)	2020	Establishes rules to ensure safe and adequate treatment of opioid use disorder with approved medications in an outpatient medical setting. The Board is obligated under the laws of the State of Maine to protect the public health and safety. The Board recognizes that medical and advanced nursing practice dictate that the people of the State of Maine have access to appropriate, empathetic and effective treatment of opioid use disorder (OUD). This rule establishes minimum requirements for qualified Office Based Opioid Treatment (OBOT) clinicians to prescribe, and in limited circumstances, dispense approved medications to individuals requiring and seeking treatment for OUD.
02-373-21; -380-21; -383-21; -396-21	ME 11793 2019	Maine (ME)	2020	Amends a joint rule regarding the use of controlled substances for the treatment of pain.
NDAC 75-9.1-10-1 thru -15	ND 4660 2013	North Dakota (ND)	2014	Establishes the licensing rules for opioid treatment programs...  [c. An opioid treatment program shall work with a patient to develop a plan of continuing care that includes discharge and recovery planning. An opioid treatment program shall ensure the discharge



Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
				planning process includes procedures that address the patient's physical and mental health problems following detoxification treatment. The opioid treatment program shall include in the discharge plan, a plan for continuing care following the last dose of medication, including making a referral for continuing outpatient care as needed, and planning for reentry to maintenance treatment if relapse occurs and resumption of care continues to be appropriate.
He-A 304	NH 9305 2017	New Hampshire (NH)	2018	Sets forth the operational requirements necessary to establish, maintain, and operate a certified opioid treatment program in New Hampshire in a manner that protects the safety and welfare of its clients.
He-W 513	NH 9538 2018	New Hampshire (NH)	2018	These rule amendments are proposed to provide better clarity, reflect current best practices, align with recent state legislation, adjust expectations with the practical application of the outlined services, and comply with federal requirements. (n) "Opioid treatment services" means treatment for opioid use disorders using a combination of approved medications, limited to methadone and buprenorphine, and behavioral health services which is delivered by an agency certified as an opioid treatment program in accordance with He-A 304.03.
OAC 4723-9-13	OH 23030 2018	Ohio (OH)	2019	Establishes rule regarding medication-assisted treatment.  (a) Prior to treating a patient with naltrexone, the advanced practice registered nurse shall inform the patient about the risk of opioid overdose if the patient ceases naltrexone and then uses opioids. The advanced practice registered nurse shall take measures to ensure that the patient is adequately detoxified from opioids and is no longer physically dependent prior to treatment with naltrexone;
OAC 4730-4-01, -03, -04	OH 23048 2018	Ohio (OH)	2019	Establishes rules regarding definitions, office-based treatment for opioid addiction, and medication-assisted treatment using naltrexone.  (a) The physician assistant shall verify the diagnosis for which the patient is receiving the other drug and coordinate care with the prescriber for the other drug, including whether it is possible to taper the drug to discontinuation. If the physician assistant prescribing buprenorphine is the prescriber of the other drug, the physician assistant shall taper the other drug to discontinuation, if it is safe to do so. The physician assistant shall educate the patient about the serious risks of the combined use.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
				<p>(b) The physician assistant shall document progress with achieving the tapering plan.</p> <p>(4) During the induction phase the physician assistant shall not prescribe a dosage that exceeds the recommendation in the United States food and drug administration approved labeling, except for medically indicated circumstances as documented in the medical record. The physician assistant shall see the patient at least once a week during this phase.</p>
OAC 4731-11-12, -33-01, -03, -04	OH 23050 2018	Ohio (OH)	2019	<p>Repeals and establishes rules regarding office based opioid treatment, definitions, and medication-assisted treatment using naltrexone.</p> <p>(1) Prior to treating a patient with naltrexone the physician shall inform the patient about the risk of opioid overdose if the patient ceases naltrexone and then uses opioids. The physician shall take measures to ensure that the patient is adequately detoxified from opioids and is no longer physically dependent prior to treatment with naltrexone.</p>
Uncodified	RI 6343 2017	Rhode Island (RI)	2017	<p>The Department is proposing rulemaking to adopt the amendments to incorporate substance use disorder discharge planning requirements.</p> <p><b>9.6.5 Discharge Planning: Substance Use Disorder, Opioid Use Disorder, and Chronic Addiction</b></p> <p>A. Evaluation</p> <p>1. The FECF must administer a standardized evaluation to all patients with an indication of substance use disorder, opioid use disorder, or chronic addiction. If the patient declines evaluation this must be documented in the medical record. If the patient is determined after an evaluation to have a substance use disorder or opioid use disorder then appropriate medical services will be offered to the patient. Services offered to the patient shall include, but are not limited to clinically appropriate inpatient and outpatient services.</p>
Uncodified	RI 6344 2017	Rhode Island (RI)	2017	<p>The department is proposing rulemaking to adopt the amendments to incorporate substance use disorder Discharge Planning requirements.</p>

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
				<p>D. Discharge Planning: Substance Use Disorder, Opioid Use Disorder, and Chronic Addiction</p> <p>1. Evaluation</p> <p>a. The hospital must administer a standardized evaluation to all patients with an indication of substance use disorder, opioid use disorder, or chronic addiction. If the patient declines evaluation this must be documented in the medical record. If the patient is determined after an evaluation to have a substance use disorder or opioid use disorder then appropriate medical services will be offered to the patient. Services offered to the patient shall include, but are not limited, to clinically appropriate inpatient and outpatient services.</p>
Uncodified	RI 7036 2018	Rhode Island (RI)	2018	Requires ICD-10 codes to be entered and transmitted with a prescription for controlled substances, requires naloxone to be co-prescribed under certain conditions, removes superfluous language, revise to consistently use the term prescription drug monitoring program, and cites resources for patient education on RIDOH's website. These rules and regulations establish minimum requirements for pain management and opioid prescribing by a practitioner, and require registration of every person who manufactures, distributes, prescribes, administers, or dispenses any controlled substance within Rhode Island.
R523-4	UT 44005 2019	Utah (UT)	2019	Prescribes the minimum standards required for justice certification of mental health and substance use disorder providers serving adults participating in mandatory education and treatment programs designed to reduce criminogenic risk. [Standards for...] (c) Opioid Treatment Programs engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 U.S.C. Sec. 823(g), licensed by the Office of Licensing, within the Department of Human Services, and certified by the Substance Abuse and Mental Health Services Administration in accordance with 42 C.F.R. 8.11;
R523-4	UT 52826 2020	Utah (UT)	2020	Amends rule concerning certification requirements for the screening, assessment, prevention, treatment and recovery support programs for adults. [Standards for...] (c) Opioid Treatment Programs engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 U.S.C. Sec. 823(g), licensed by the Office of Licensing, within the Department of

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
				Human Services, and certified by the Substance Abuse and Mental Health Services Administration in accordance with 42 C.F.R. 8.11;
18 VAC 85-21-10 thru -170	VA 175033 2017	Virginia (VA)	2018	Establishes the practitioners to whom the rules apply and the exceptions or nonapplicability. Regulations for the management of acute pain include requirements for the evaluation of the patient, limitations on quantity and dosage, and medical recordkeeping. Regulations for management of chronic pain include requirements for evaluation and treatment, including a treatment plan, informed consent and agreement, consultation with other providers, and medical recordkeeping. Regulations for prescribing of buprenorphine include requirements for patient assessment and treatment planning, limitations on prescribing the buprenorphine mono-product, dosages, co-prescribing of other drugs, consultation, and medical records.
18 VAC 90-30-220; -40-10, -150 thru -290	VA 175096 2017	Virginia (VA)	2019	Addresses the opioid abuse crisis. Regulations for the management of acute pain include requirements for the evaluation of the patient, limitations on quantity and dosage, and medical recordkeeping. Regulations for the management of chronic pain include requirements for evaluation and treatment, including a treatment plan, informed consent and agreement, consultation with other providers, and medical recordkeeping. Regulations for prescribing of buprenorphine include requirements for patient assessment and treatment planning, limitations on prescribing the buprenorphine mono-product (without naloxone), dosages, co-prescribing of other drugs, consultation, and medical records for opioid addiction treatment.
Uncodified	VT 1770 2017	Vermont (VT)	2017	This rulemaking expands capacity for the treatment of opioid dependence by allowing advanced practice registered nurses and physician's assistants to prescribe buprenorphine to individuals requiring and seeking treatment for opioid dependence. The rule also increases the number of patients a physician may treat from 100 to 275.
WAC 296-20-03010 thru -06101 (non seq.)	WA 32629 2013	Washington (WA)	2013	The department of labor and industries and is considering adopting rules related to the use of medications to ensure safe, appropriate and effective drug therapy designed to improve health outcomes for injured workers.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
WAC 388-865, -877, -877A, -877B, -877C	WA 37377 2017	Washington (WA)	2018	<p>The department is proposing to repeal existing rules, amend existing rules, and create new rules in Title 388 WAC regarding mental health and substance use disorders in order to provide a single set of regulations for behavioral health agencies to follow...</p> <p>(1) Opioid treatment program services include the dispensing of an opioid treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opioid use disorder. These services include withdrawal management treatment and maintenance treatment.</p>
WAC 246-341-0100 thru -1158 (non seq.)	WA 38422 2018	Washington (WA)	2019	Establishes the licensure and certification of behavioral health agencies who provide mental health, substance use disorder, and problem and pathological gambling services transferred over from DSHS. These rules also add a new certification for assisted outpatient behavioral health services that were created by ESSB 6491 (chapter 291, Laws of 2018), effective April 1, 2018.
WAC 246-922	WA 37468 2017	Washington (WA)	2018	Clarifies the application of ESHB 1427. These rules will pertain to podiatric physicians. The board will also review its current pain management rules for possible revisions consistent with the new opioid prescribing rules. The five boards and commissions intend to coordinate their efforts as much as possible to promote consistency.
WAC 246-918	WA 37472 2017	Washington (WA)	2018	Clarifies application of ESHB 1427. These rules will pertain to allopathic physicians and physician assistants. The commission will also review its current pain management rules for possible revisions consistent with the new opioid prescribing rules. The five boards and commissions intend to coordinate their efforts as much as possible to promote consistency.
Title 69 Series 12	WV 6648 2016	West Virginia (WV)	2017	This rule applies to any publicly or privately owned medication-assisted treatment program in physician offices that treat individuals with substance use disorders through the prescription, administration or dispensing of medication-assisted treatment medication in the form of opioid agonist, partial opioid agonist or other medication-assisted treatment medication as defined in W. Va. Code Section 16-5Y-2 and further described in this rule.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
Title 69, Series 12	WV 6969 2018	West Virginia (WV)	2019	Amends rules relating to specific standards and procedures for the health, safety, and protection of the rights and dignity of patients utilizing office-based medication-assisted treatment programs.
NMAC 8.321.2	NM 7084 2019	New Mexico (NM)	2019	<p>Proposes some new services, as well as changes to some existing services.</p> <p><b>(c)</b> A healthcare provider who prescribes an opioid analgesic for a patient shall co-prescribe an opioid antagonist if the amount of opioid analgesic being prescribed is at least a five-day supply. The prescription for the opioid antagonist shall be accompanied by written information regarding the temporary effects of the opioid antagonist and techniques for administering the opioid antagonist. That written information shall contain a warning that a person administering the opioid antagonist should call 911 immediately after administering the opioid antagonist.</p>
12 VAC 30-60-181, -185; -70-418; -80-32; -130-5010 thru -5150	VA 200181 2020	Virginia (VA)	2020	Clarifies and updates the requirements for providers of Addiction and Recovery Treatment Services (ARTS) Program services to Medicaid members, including updating citations and terminology, clarifying roles for professionals who provide various addiction treatments, specifying that medical assisted treatment must be provided onsite or through referral in intensive outpatient, partial hospitalization, and residential levels of care pursuant to the Centers for Medicare and Medicaid Services requirements, including telemedicine in the definition of "face-to-face" for purposes of providing ARTS services, and clarifying that drug screening can be done by testing urine or blood serums.
OAC 4731-33-01, -02	OH 24369 2020	Ohio (OH)	2020	<p>Relates to definitions and standards and procedures for withdrawal management for drug or alcohol addiction.</p> <p>(3) Prior to providing ambulatory detoxification, the physician shall perform an assessment of the patient. The assessment shall include a thorough medical history and physical examination. The assessment must focus on signs and symptoms associated with opioid addiction and include assessment with a nationally recognized scale, such as one of the following:</p> <p>(a) Objective Opioid Withdrawal Scale ("OOWS");</p>

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt From Statute)
				<p>(b) Clinical Opioid Withdrawal Scale ("COWS"); or</p> <p>(c) Subjective Opioid Withdrawal Scale ("SOWS").</p>
OAC 4730-4-01, -02	OH 24366 2020	Ohio (OH)	2020	<p>Pertains to definitions and standards and procedures for withdrawal management for drug or alcohol addiction.</p> <p>(i) The physician assistant shall not initiate treatment with buprenorphine to manage withdrawal symptoms until between twelve and eighteen hours after the last dose of short-acting agonist such as heroin or oxycodone, and twenty-four to forty-eight hours after the last dose of long-acting agonist such as methadone. Treatment with a buprenorphine product must be in compliance with the United States food and drug administration approved "Risk Evaluation and Mitigation Strategy" for buprenorphine products, which can be found on the United States food and drug administration website at the following address: <a href="https://www.accessdata.fda.gov/scripts/cder/remis/index.cfm">https://www.accessdata.fda.gov/scripts/cder/remis/index.cfm</a>.</p>
Title 69 Series 11	WV 6647 2016	West Virginia (WV)	2017	<p>This rule applies to any publicly or privately owned medication-assisted treatment opioid treatment program in clinics or facilities that treat individuals with substance use disorders through the prescription, administration or dispensing of medication-assisted treatment medication in the form of opioid agonist, partial opioid agonist or other medication-assisted treatment medication as defined in W. Va Code Section 16-5Y-2 and further described in this rule.</p>