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

FINAL 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—consuming more than one drug at once—involving synthetic or semi-synthetic opioids (SSSOs) among individuals with co-occurring behavioral health conditions. The environmental scan considers issues related to the use and misuse of opioids and other legal and illegal substances (e.g., psychostimulants, alcohol, cannabis, heroin, and tobacco), behavioral health, and where these areas intersect. This environmental scan also serves 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 crisis related to polysubstance use and the intersection between behavioral health needs and substance use disorders (SUDs). This effort and the previous Opioid TEP are both 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 and other legal and illegal drugs among individuals with co-occurring behavioral health conditions? (2) What are the major current and emerging concepts and trends regarding the commonly combined use of illegal and legal drugs of abuse that could inform future measurement? (3) What directions should quality measurement science take to advance the battle against the United States' (U.S.) opioid and SUD crisis to reduce overdose and mortality? For example, where are the apparent and important gaps?

This 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 and existing quality measure repositories, peer- and non-peer-reviewed literature, and 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 Opioid TEP, social determinants of health (SDOH), and measure concepts related to non-medical levers or medical-non-medical partnerships, such as between providers and criminal justice or social work. 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. Importantly, the scan also revealed some emerging best practices that could potentially inform measures to address polysubstance use involving opioids in persons with mental health conditions. By utilizing these results, the Opioids and Behavioral Health Committee (consisting of, but not limited to, physicians, social workers, pharmacists, patient/consumer/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 U.S.

Introduction and Background

Opioid-related overdose deaths and morbidity have emerged as complex and evolving challenges 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, nearly 47,000 U.S. deaths occurred that were attributable to opioid use, both prescription and illicit.[1] Moreover, a large proportion of those deaths are tied to heroin that is laced with illegally manufactured fentanyl, a substance also 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.[2,3] Quality measures related to opioid use are a key component to holding care providers, payers, and policymakers accountable as direct purveyors or indirect sponsors of the best possible care regarding pain management, SUD treatment and prevention, and behavioral health.[4] 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 and SUD crisis. The TEP was composed of 28 members, including physicians, nurses, patients, pharmacists, and others with expertise in both pain management and opioid use disorders (OUD) to address 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 overdose-related mortality and morbidity without undermining effective pain management.

In addition, the TEP made recommendations for appropriate opioid-related measures and measure concepts for five federal quality and performance programs administered by CMS.[5] 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 that was characterized by dramatic increases in synthetic opioid-related overdose and death. The TEP also recognized an emerging "fourth wave" of the opioid crisis related to polysubstance use.

Increasingly, individuals with OUD are more likely to use psychostimulants such as amphetamines, use opioids with other substances (e.g., alcohol, cannabis) during the same use period, and have concomitant mental disorders, such as anxiety, depression, and suicidal ideation.[6] In 63 percent of opioid overdose deaths, evidence of co-occurring prescription or illicit drug use was also present.[7] Because of the clear connection between concomitant behavioral health 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 OUD comorbidities with psychiatric conditions and SUD more broadly. The NQF Opioid TEP made a series of recommendations related to identifying and prioritizing gaps in quality measures that needed to be filled in order to reduce OUD and 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.[8]

In a study that compared 2013 and 2017 baseline characteristics among treatment-seeking patients who use opioids with co-occurring behavioral health conditions, researchers found that the 2017 cohort used less prescription opioids than those from 2013, although the 2017 cohort was more likely to use psychostimulants concurrently with opioids than the 2013 cohort.[9] These individuals in 2017 were also

more likely to have anxiety, depression, and suicidal thoughts.[10] The research suggests that these at-risk individuals underscore a responsibility of the healthcare community to deploy approaches that can be tailored to address multiple substances at once.

The ongoing opioid and SUD crisis has been compounded by the COVID-19 public health emergency, with research indicating increases in opioid-associated and other substance use morbidity and mortality.[11] People with SUD have found themselves increasingly isolated and with fewer distractions from behaviors associated with SUD due to COVID-19 social restrictions, placing them at increased risk for setbacks.[12] Like many others, they are also subject to social isolation and loneliness, both of which can increase substance use. COVID-19 has also resulted in decreased access to treatment for SUD, including OUD. With the increasing use of telemedicine, clinicians may be challenged to ensure appropriate urine screening is conducted during routine appointments.[13]

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 SUD and polysubstance use for people 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 to best 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, consumers, 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 SUDs, assessed the connection between behavioral health and polysubstance use, and developed recommendations to guide performance measurement. In subsequent work following this report, the Committee will both 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, 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 incorporate results from a quality measure gap identification and prioritization exercise. The prioritization of measure gaps is intended to inform decisions on measures that should be developed to address challenges with co-occurring opioid use, polysubstance use, and behavioral health.

Although the search to identify healthcare quality measures for the scan has an all-inclusive scope, the Committee's 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 of those with social risk factors (SRS) that may have an effect on their 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 nonmedical professionals with common goals of addressing behavioral health issues, opioid use disorders, and polysubstance abuse, such as criminal justice, public health, and social work.[14]

Methodology and Approach

To inform the work of the Opioids and Behavioral Health Committee, NQF staff drew from the approach and results from the previous Opioid TEP to conduct an environmental scan to assess the current state of quality measures that surround polysubstance use involving synthetic or semi-synthetic opioids (SSSO) among individuals with co-occurring behavioral health conditions. NQF staff reviewed a series of databases, repositories, and websites 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, because 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 three domains: (1) opioid use and misuse, (2) other substance use and misuse, and (3) 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.

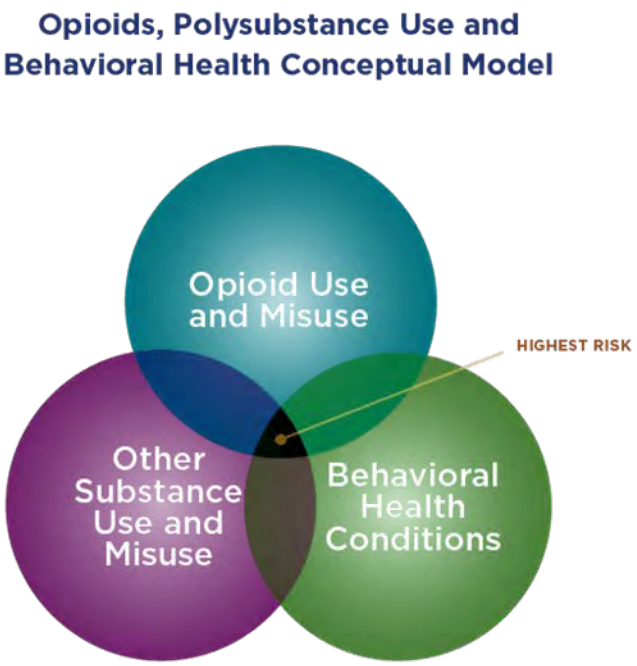

Figure 1 Opioids, Polysubstance Use and Behavioral Health Conceptual Model

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 of 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. As a result, this model was 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 and substance use
    - Measure or provide measure concepts related to nonmedical levers or medical-non-medical partnerships (i.e., social work, criminal justice, and 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 SUD and opioid use that can be used to advance associated quality measurement?
- What directions should quality measurement science take to advance efforts to address the opioid overdose and SUD crisis? 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 and SUD crisis. Appendix B offers more information on the methodology of the environmental scan. Before this document was finalized, members of the Opioids and Behavioral Health Committee, Committee federal liaisons, CMS staff (see Appendix A), and the general public were given opportunities to provide factual and subjective feedback. Accordingly, the finalized document is 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 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. Although NQF staff found no measures, recognition of the challenges associated with opioids and polysubstance use with other behavioral health conditions was clear in the literature as well as the state law and regulatory search results. For example, 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 of polysubstance use in 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…[15]

The Committee considers the scan results that produced no specific quality measures related to polysubstance use involving opioids as 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 in which individuals are using illegal and legal opioids and other substances. Furthermore, NQF's February 2020 Opioid TEP Final Report on opioids and OUDs included searches of components of the topic at hand. No relevant measures specific to the focus of this scan could be found in that environmental scan as well. It was noted in the report that the TEP considered the 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 to be specific to SSSO polysubstance use in patients with comorbid behavioral health conditions, NQF staff found 117 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

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.

Table 1. Peer-Reviewed Literature

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

PMID	Title	Journal
28815789	Cost-effectiveness of emergency department-initiated treatment for opioid dependence	Society for the Study of Addition
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

NQF staff scanned a series of web material and grey literature from government sources and other health advocacy groups to find potential measure concepts. Although no concepts were found, 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.

Table 2. Non-Peer Reviewed Literature

Item Number	Title	Summary
GAO-18-205	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.

Item Number	Title	Summary
GAO-18-44	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 time frames for its evaluation of its efforts to expand access to MAT. HHS concurred with both recommendations.
GAO-19-628	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. 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, although 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 comply 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 used 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").[16]

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 behavioral health 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 behavioral health program for beneficiaries with identified multiple behavioral health conditions.[17] Seminal events, such as emergency department (ED) visits due to overdose or new behavioral health 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 behavioral health 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 also discussed several other measurement gaps areas relevant to this topic. Given that the risk of overdose associated with polysubstance use may involve prescription medications and substances (legal and illegal) in addition to opioids, the Committee suggested that the *Co-Prescribing of Opioids and Benzodiazepines* measure could serve as an example for other measures of polypharmacy, such as concomitant use of amphetamines (especially for patients over 50) or gabapentin. Moreover, the Committee noted an NCQA measure that is currently open for public comment for inclusion within the HEDIS measure set associated with deprescribing benzodiazepines for older adults. The Committee suggested that this measure could also be useful for recognizing best practices in deprescribing that lead to reduced risk of overdose and death associated with concomitant opioid use.

Additionally, the Committee explored concepts related to organizational level process and structural measures, such as incorporating peer specialists, care support, and recovery specialists into patient engagement and the establishment of case review committees.

The Committee considered measurement ideas associated with randomized policy evaluation paired with implementation tracking by noting patients estimated at high risk of overdose or suicide. The Committee deemed ideas such as this to be important elements for care coordination. Another idea related to care coordination that was proffered by the Committee was associated with appropriate follow-up, such as following up on an overdose or a suicide attempt.

The Committee further suggested measures associated with other screening tools, such as the PHQ-9 as well as screening, brief intervention, and referral to therapy (SBIRT).

The Committee also raised aspirational concepts, such as partnerships between health plans and educational systems or employers. Furthermore, the Committee suggested partnering with criminal justice systems to provide training on naloxone use and ensuring that law enforcement officers regularly carry naloxone rescue kits. 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 crisis. The Committee noted that research has suggested that the opioid and SUD crisis is fundamentally fueled by economic and social influences and that its etiology is closely linked to the role of opioids and other substances as a refuge from physical and psychological trauma, concentrated disadvantage, isolation, and hopelessness. Each of these challenges is directly connected with poverty and other social risks.

Mortality associated with polysubstance use with SSSOs in persons with behavioral health 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 behavioral health 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.[18] The Committee also noted a recent observational study showing that substantial disparities exist in the use of medications to treat OUD. 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, sexual and domestic abuse, and many others. However, the Committee emphasized the important role that homelessness, unsafe housing, and criminal justice involvement play in fueling the opioid crisis and SUDs 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 opioids and other SUDs, as well as opioid overdose.[19] 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).[20] In addition, one recent study found that homeless persons with an SUD who entered housing intervention programs had greatly reduced (by 53 percent) financial needs for temporary housing, jail, and treatment services compared with those who were wait-listed controls for the same housing program.[21] 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, 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 themselves 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 the 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 behavioral health 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 (e.g., Department of Justice data collection) is very limited and only addresses federal settings.

The Committee further emphasized that measures for incarceration settings and re-entry would be likely to make significant contributions to abating opioid and other SUD misuse and relapse, but they 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 and SUD 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 sustain recovery. Studies have suggested that use of MAT treatment initiation while incarcerated is effective in promoting long-term recovery from OUD.[22]

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 waivered provider.[23] Furthermore, this research demonstrated that almost one-third (29.8 percent) of rural Americans live in a county without a buprenorphine provider compared to 2.2 percent of urban Americans.[24] Additionally, the U.S. Department of Health and Human Services (HHS) 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 waivered providers is not distributed evenly across the U.S.[25] More specifically, this OIG report found that 40 percent of counties in the nation did not have a single waivered provider in 2018 and that waivered 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 waivered providers.[26] In continued efforts to expand access to MAT, HHS released new practice guidelines in January 2021, allowing any physician licensed by the DEA to prescribe

buprenorphine to up to 30 patients, without requiring the previously standard eight-hour training to gain authorization. While only physicians qualify for this exemption, the 30-patient cap does not apply to hospital-based physicians, such as those employed in EDs.[27]

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 behavioral health 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 specifically identified this area 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 117 unique healthcare quality metrics and 71 measure concepts related to separate distinctions of opioids, SUDs, 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, a review of the articles identified returned some valuable results to guide the Committee's consideration of measure concepts and gaps. An 11-item screening instrument, the Current Opioid Misuse Measure (COMM), was identified.[28] 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 similar to it, could potentially be used as a patient-reported outcome measure to screen for OUD risk and tailor care for patients with behavioral health conditions. Moreover, it was noted in the study that COMM was significantly associated with key substance use characteristics, such as unmet pain needs or anxiety, 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-reported questionnaire that assesses four well-validated personality risk factors for substance misuse (impulsivity, sensation seeking, anxiety sensitivity, and hopelessness).[29] 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 have a tobacco use disorder.[30] 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 behavioral health conditions to address risks associated with OUD and polysubstance use, or to potentially identify patients not suitable for opioid or other therapy or identify people 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.[31]

Additional articles focused on the concept of measuring retention and recovery. One article extended a quality measurement concept found in the treatment of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) to OUD.[32] 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 (e.g., 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 behavioral health 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 themselves to the ED. The study describes results from a randomized trial in which patients with OUD received a brief intervention, an ED-initiated buprenorphine, and an ongoing follow-up in primary care with buprenorphine. Patients receiving this intervention 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.[33] Moreover, evaluation of the relative cost-effectiveness of these services for treating OUDs 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 themselves to the ED with OUD could potentially lessen the risk of overdose-associated mortality, especially for those patients with concomitant behavioral health conditions. Access to buprenorphine remains a challenge. According to a May 2020 data brief published by OIG, of all the Medicare Part D beneficiaries in 2017 who were diagnosed with OUD, only 7 percent received MAT through Part D. Any quality measure would need to ensure that providers operating under existing limitations are not inappropriately penalized.[34]

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, NQF staff identified opioid-related GAO reports that were informative to the Committee's objectives but were 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, prevention and treatment approaches, and 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.[35] 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 among 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 for which people need

treatment. The Committee recognized that further emphasis of SUD including OUD as mental disorders, with other behavioral health aspects, creates challenges and opportunities for healthcare providers to collaborate with the criminal justice system. Addressing inmates' SUD 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.[36]

This GAO report also recognized that the Government Performance and Results Act (GPRA) 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 that share 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 the 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.[37]

While this recommendation 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 the National Heroin Initiative. Data from these efforts could be used in performance indicators within state-level dashboards to hot-spot 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 and SUD 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.[38]

Another GAO report urged 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, MAT structure measures could also be used for health plans and pharmacy benefit managers (PBMs), particularly for patients with known concomitant behavioral health conditions.[39] The Committee acknowledged that additional Medicaid expansions have improved access to MAT since 2017, but they specifically recognized the difficulties associated with access to buprenorphine.

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 directly contributory to the focus of the measurement scan.

Where there are no laws identified specifically addressing the care of individuals, the Committee recognized that there are a variety of legal approaches within the states that address opioid use and substance use. The Committee noted that many states utilize statutory and regulatory language to require the use of prescription drug monitoring program (PDMPs), which the Committee suggested could potentially augment other data sources for quality measurement purposes for prescription drugs. The Committee also noted that many states have laws and regulations that limit the prescribing of opioids as well as other controlled substances, including drug time and dosage limits, physical examination requirements for prescription writing, doctor shopping laws, tamper resistant prescription form requirements, state prescription drug identification laws, pain management clinic regulation, drug overdose related laws, and laws associated with prescription-only pseudoephedrine.[40] Some states, such as Washington, have developed opioid-prescribing guidelines that are not dictated by regulation.[41] Washington state has also developed state-level metrics for population-level monitoring of opioid indicators.[42] The Committee additionally recognized that Oregon has developed a series of voluntary, internal quality improvement measures for primary care settings aiming to improve opioid prescribing and chronic pain management.[43]

The Committee further recognized that many states have laws, regulations and state-based initiatives related to harm reduction, which include a spectrum of strategies from safer use, to managed use, to abstinence. The Committee noted that laws authorizing harm reduction strategies are increasingly being adopted in the U.S. For example, in 2017, 49 states and the District of Columbia (D.C.) had a naloxone access law compared to only 11 in 2013.[44] As of 2018, 39 states, in addition to Puerto Rico and D.C., authorize syringe exchange programs compared to 16 before 2015.[45,46] In 2018, 45 states and D.C. have an overdose immunity law compared to 12 in 2013.[47,48]

The recent decriminalization of all illicit drug possession and use in Oregon was noted as an emerging legal feature that may influence the stigmatization associated with SUD. In November 2020, Oregon became the first U.S. state to decriminalize the personal possession of illegal drugs, including cocaine, heroin, oxycodone, and methamphetamine.[49] This is a significant paradigm shift from previous policy approaches, which have viewed the use of illicit substance as serious criminal activity to be primarily

addressed by the judicial system. Use 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.[50] 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 use of illicit substances is that data sources for measurement connection of healthcare to criminal justice may be fewer in the future. This is also reflected by increasing statutory acceptance of marijuana for both medical and recreational use across the states.

The Committee recognized that Oregon is not unique in decriminalization efforts, noting a New Mexico law that was passed in March 2019. The Plan of Safe Care Bill dictates that a notification be sent to the state any time an infant tests positive for addictive substances so that the state can assess the family's or individual's strengths and needs without requiring opening a formal abuse or neglect case.[51]

The Committee, likewise, drew attention to diversion programs, such as the Washington State Law Enforcement Assisted Diversion (LEAD) arrest diversion program. LEAD is a collaborative community safety effort that offers law enforcement an alternative to jailing individuals for criminal activity that stems from unmet behavioral health needs or poverty. LEAD diverts individuals who are engaged in low-level drug crime, prostitution, and crimes of poverty away from the criminal legal system—bypassing prosecution and jail time—and connects them with intensive case managers who can provide crisis response, immediate psychosocial assessment, and long-term wrap-around services, including SUD treatment and housing.[52] Forty-eight states and D.C. had statutory pretrial diversion programs in place in 2017.[53]

While not dictated by governmental bodies, the Committee noted state-level non-profit organizations that support harm reduction, such as the Texas Harm Reduction Alliance, which aims to provide overdose prevention education, naloxone, and linkage to same-day medicine-based treatment for opioid use disorders.[54]

The Committee further recognized that there are some federal regulations that introduce challenges associated with quality management of polysubstance use involving opioids in the presence of other mental health conditions, specifically citing 42 CFR Part 2, which is related to the confidentiality of patient records for SUD. The 42 CFR Part 2 regulations serve to protect patient records created by federally assisted programs for the treatment of SUD, generally requiring a patient's written consent before making a disclosure of protected records. Committee members suggested that while the provisions of 42 CRF Part 2 are well-intentioned, they make information sharing associated with patient care challenging, including with non-traditional healthcare partners.[55]

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 both the misuse and abuse of illegal and legal opioids and polysubstance use in U.S. healthcare, which have contributed to the opioid and SUD 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 the 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. Although 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 NQF-convened Committee will use this environmental scan as a tool moving forward in its deliberations regarding the 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 polysubstance use involving opioids in the U.S., 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 that 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 crisis? 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 (e.g., 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 the following sources:

1) PubMed (National Library of Medicine)
2) Internet searches at the following sites:
    a) United States Department of Health and Human Services
        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 & Medicaid Services
        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) National Quality Forum
    f) General Accountability Office

The following measure repositories, tools, and programs 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) Veterans Health Affairs (VHA) Program
7) Accreditation Programs
    a) National Committee on Quality Assurance (NCQA)
    b) URAC
8) Measure Developer Reports and Websites
    a) Minnesota Community Measurement (MNCM)
    b) Pharmacy Quality Alliance (PQA)

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 Medical Subject Headings (MeSH) terms. The NQF team refined the search parameters when appropriate as additional information was gathered.

Table 3. Search Parameters

Included	Excluded
Published/passed on or after January 1, 2013	Published before 2013 and not current
AND	Not available in English
Contains the strings: “opioid” OR “opiate” OR “substance use disorder” OR “addict*” OR “polysubstance”	Case studies
AND Contains the strings: “metric” OR “measure” OR “indicator” OR “survey”	Publications focusing exclusively pharmacology or other molecular-level research

Literature Review CONSORT Diagram

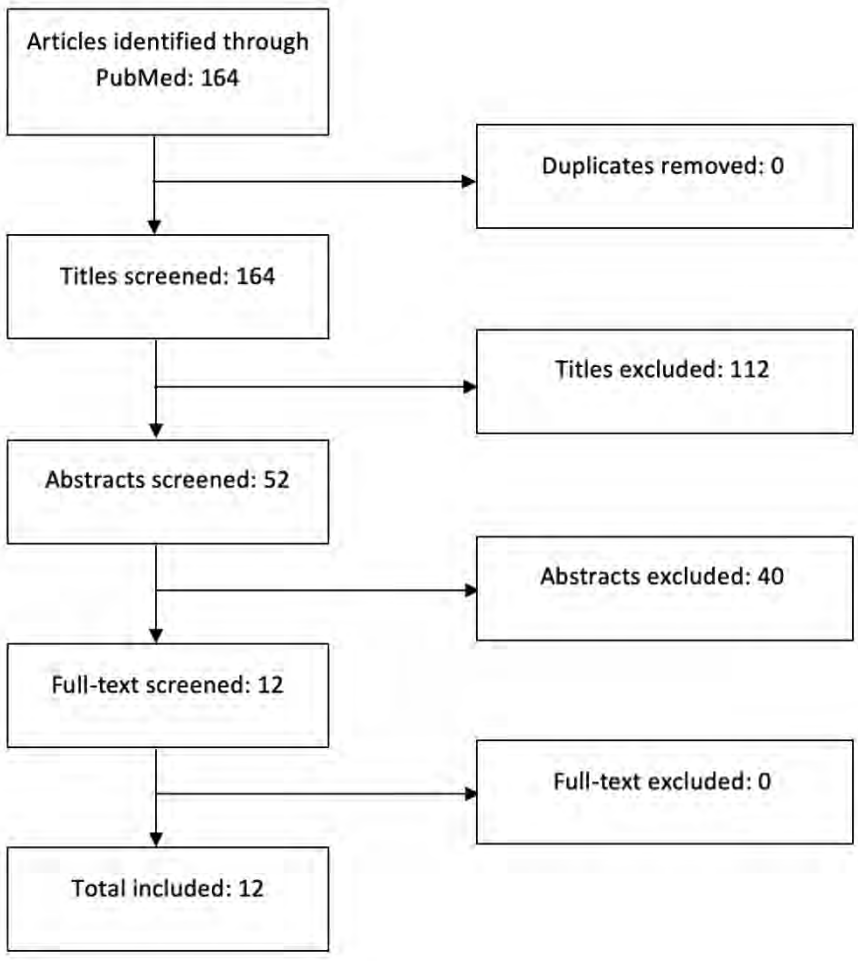

Figure 2. Literature Review CONSORT Diagram

Measure Repository CONSORT Diagram

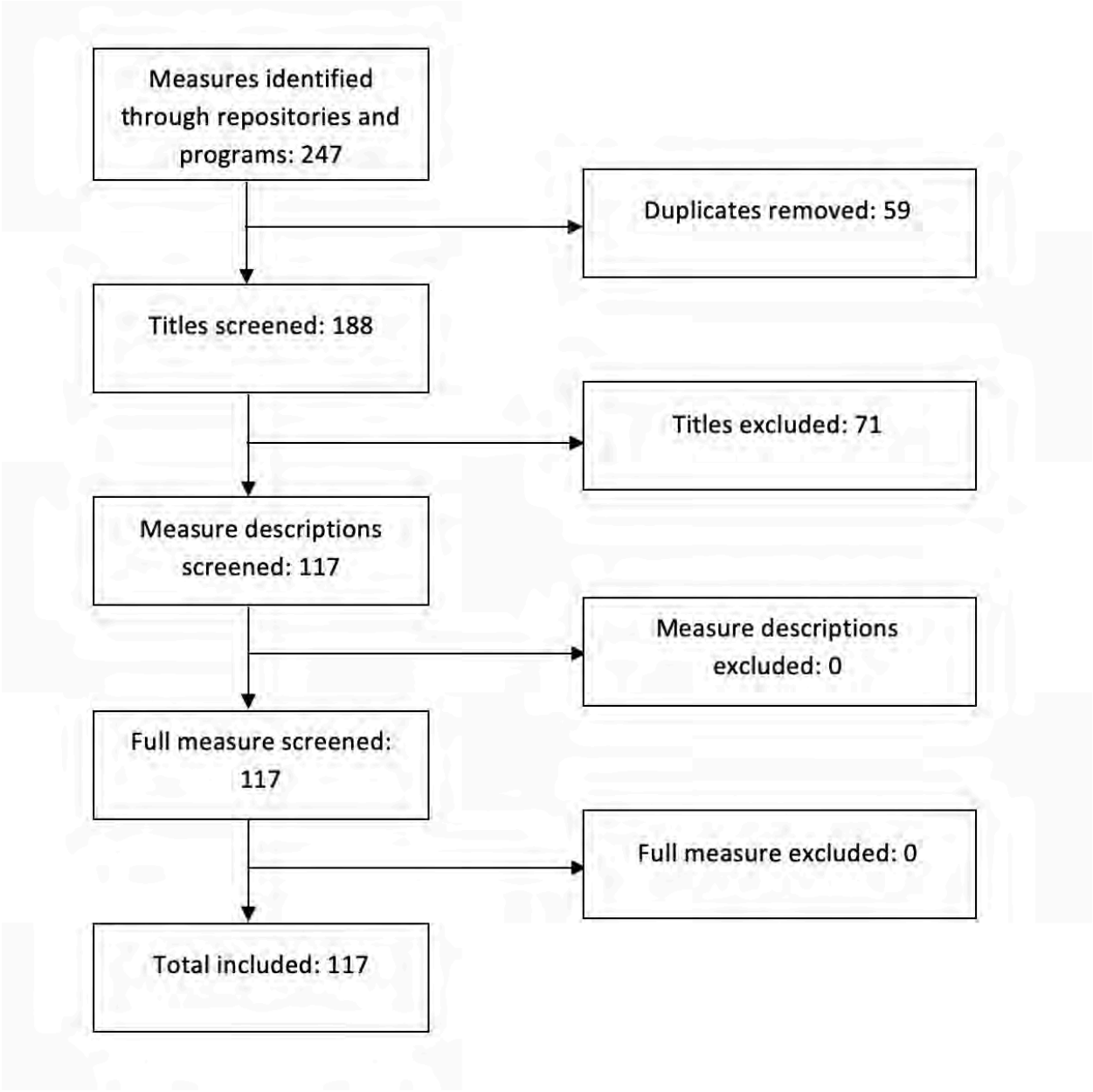

Figure 3. Measure Repository CONSORT Diagram

Operational Definitions

- **Access**: the timely use of personal health services to achieve the best possible outcomes.
- **Behavioral health condition**: Behavioral health describes the connection between behaviors and the health and well-being of the body and mind. Behavioral health conditions, therefore, include mental disorders, which include substance use disorders, among others.
- **Instrument**: an assessment tool such as a survey, scale, questions, etc.
- **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.

- **Substance use disorder**: a problematic pattern of substance use leading to clinically significant impairment or distress.
- **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.
- **Outcomes measure**: a measure that assesses a health state (e.g., death, lab results, illness remission).
- **Pain management**: the active treatment of acute or chronic pain under medical (e.g., surgical, dental, and/or 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.
- **Polysubstance use**: polysubstance use is the use of one or more substances that have misuse potential.
- **Process measure**: a measure that assesses an action that is presumed to be connected to quality of care (e.g., a treatment, screening, and scheduling).
- **Structural measure**: a measure that assesses resources available for care (e.g., supplies of naloxone, equipment, facilities, personnel, and procedures).
- **Substance misuse**: the use of a pharmaceutical or alcohol in a way that is risky (i.e., contraindicated, excessive, underage, and otherwise illicit).
- **Substance use disorders**: Substance use disorder encompasses varying degrees of excessive use of a substance, including alcohol; tobacco; opioids; caffeine; cannabis; hallucinogens; inhalants; sedative, hypnotics, or anxiolytics; stimulants (e.g., amphetamine, cocaine); and more. Various mental health conditions, such as depression, may co-occur along with substance use disorder.

Appendix C: Measure Inventory

Overview

This appendix lists 117 existing measures found by NQF staff that will be used by the Committee to develop a framework for this project.

Measures preceded by an asterisk (*) were also previously identified in the 2019 NQF Opioids and Opioid Use Disorder Final Environmental Scan and drawn from measure repositories such as the CMS Measure Inventory Tool, NQF Quality Positioning System (QPS), Qualified Clinical Data Registries, as well as measures identified by Committee members and NQF staff through the review of articles, grey-literature, and measure developer websites.

List of Measures

**(SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge*

NQF #: 1664
NQF Endorsement Status: Endorsement Removed
Measure Description: 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 the close of the measurement period are used to identify readmissions. Data from 12 months prior to the start of the measurement period through the measurement period are used to identify risk factors.
Measure Type: Process

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)

NQF #: 1879
NQF Endorsement Status: Endorsed
Measure Description: 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).
Measure Type: Intermediate Outcome

Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eCQM)

NQF #: 0104e
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

Adolescent Mental Health and/or Depression Screening

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of patients ages 12-17 who were screened for mental health and/or depression at a well-child visit using a specified tool. Note: Adolescents diagnosed with depression are excluded from this measure.
Measure Type: Process

Adult PHQ-9 Utilization

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of patients with a diagnosis of Major Depression or Dysthymia who also have a completed PHQ-9 tool during the measurement period.
Measure Type: Process

Adult Depression: PHQ-9 Follow-Up at 6 Months

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of patients with depression who have a completed PHQ-9 tool within six months after the index event (+/- 30 days)
Measure Type: Process

Adult Depression: 6-Month Response

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of patients with depression who demonstrated a response to treatment (at least 50 percent improvement) six months after the index event (+/- 30 days)
Measure Type: Outcome

Adult Depression: 6-Month Remission

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of patients with depression who reached remission (PHQ-9 score less than five) six months after the index event (+/- 30 days)
Measure Type: Outcome

Adult Depression: PHQ-9 Follow-Up at 12 Months

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of patients with depression who have a completed PHQ-9 tool within 12 months after the index event (+/- 30 days)
Measure Type: Process

Adult Depression: 12-Month Response

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of patients with depression who demonstrated a response to treatment (at least 50 percent improvement) 12 months after the index event (+/- 30 days)
Measure Type: Outcome

Adult Depression: 12-Month Remission

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of patients with depression who reached remission (PHQ-9 score less than five) 12 months after the index event (+/- 30 days)
Measure Type: Outcome

**Alcohol Problem Use Assessment & Brief Intervention for Home Based Primary Care and Palliative Care Patients*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

ALC: Alcohol Use Disorder: Alcohol Pharmacotherapy Use Not Including Topiramate

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Type: Process
Measure Description: VHA patients with an alcohol use disorder receiving alcohol use disorder pharmacotherapy

ALC_Top: Alcohol Use Disorder: Alcohol Pharmacotherapy Use

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients with an alcohol use disorder receiving alcohol use disorder pharmacotherapy
Measure Type: Process

SUB 2 - Alcohol Use Brief Intervention Provided or Offered

NQF #: 1663
NQF Endorsement Status: Endorsement Removed

Measure Description: 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 (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 [temporarily suspended]).
Measure Type: Process

Alcohol Use Disorder Outcome Response

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Patient Reported Outcome (PRO)

Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

NQF #: 0354
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

Antidepressant Medication Management (AMM)

NQF #: 0105
NQF Endorsement Status: Endorsed
Measure Description: The percentage of members 18 years of age and older who were treated antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported.

a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).
b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

Measure Type: Process

Anxiety Response at 6 Months

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Patient Reported Outcome (PRO)

Anxiety Screening

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

Avoidance of Co-Prescribing of Opioid Analgesic and Benzodiazepine

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percentage of Patients Who Were Not Concurrently Prescribed Opioid Analgesic and Benzodiazepine Medications.
Measure Type: Process

**Avoidance of Long-Acting (LA) or Extended-Release (ER) Opiate Prescriptions and Opiate Prescriptions for Greater Than 3 Days Duration for Acute Pain*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percentage of Adult Patients Who Were Prescribed an Opiate Who Were Not Prescribed a Long-Acting (LA) or Extended-Release (ER) Formulation.
Measure Type: Process

**Avoidance of Opiates for Low Back Pain or Migraines*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percentage of Patients with Low Back Pain and/or Migraines Who Were Not Prescribed an Opiate.
Measure Type: Process

Avoidance of Opioid Prescriptions for Reconstruction After Skin Cancer Resection

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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).
Measure Type: Process

BENZO_noMHnoMED_new: Benzodiazepine (active): No Recent Encounter for a Psychiatric Dx or Medical Indication

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients who had at least one outpatient prescription of a benzodiazepine and did not have a psychiatric diagnosis in the same time period or at least one medical indication within specified ICD codes
Measure Type: Process

BENZO_Opioid_OP: Opioid and Benzodiazepine: Concurrent Active Prescriptions

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients with active benzodiazepine and opioid prescriptions
Measure Type: Process

BENZO_PTSD_OP: PTSD: Benzodiazepine Use

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients diagnosed with PTSD with an active benzodiazepine prescription
Measure Type: Process

BENZO_SUD_OP: SUD: Benzodiazepine Use

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients with AUD, OUD, or sedative-hypnotic use disorder and an active outpatient benzodiazepine prescription
Measure Type: Process

**Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use*

NQF #: 0110
NQF Endorsement Status: Endorsement Removed
Measure Description: Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.
Measure Type: Process

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

NQF #: 1933
NQF Endorsement Status: Endorsed
Measure Description: The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.
Measure Type: Process

Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk-Assessment (eCQM)

NQF #: 1365e
NQF Endorsement Status: Endorsed
Measure Description: Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.
Measure Type: Process

Clinical Depression Screening and Follow-Up

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

CLO: Schizophrenia: Clozapine Use

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients with schizophrenia with one or more fills for an antipsychotic receiving one or more fills of Clozapine
Measure Type: Process

**Concurrent Use of Opioids and Benzodiazepines (COB)*

NQF #: 3389
NQF Endorsement Status: Endorsed
Measure Description: "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."
Measure Type: Process

**Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)*

NQF #: 3453
NQF Endorsement Status: Endorsed
Measure Description: 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 7 and 14 days after discharge.
Measure Type: Process

Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

NQF #: 3312
NQF Endorsement Status: Endorsed
Measure Description: 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 7 or 14 days after discharge.
Measure Type: Process

Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

NQF #: 3590
NQF Endorsement Status: Under Consideration
Measure Description: Percentage of Medicaid discharges, ages 18 to 64, being treated for a substance use disorder (SUD) from an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD follow-up treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within 7 and 30 days after discharge.
Measure Type: Process

**Continuity of Pharmacotherapy for Opioid Use Disorder*

NQF #: 3175
NQF Endorsement Status: Endorsed
Measure Description: Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.
Measure Type: Process

DEPOT_new: Schizophrenia: Antipsychotic Depot Use in Outpatient Setting

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients with a confirmed diagnosis of schizophrenia, at least 1 outpatient encounter and received one or more outpatient fill, clinic order or CPT code for an antipsychotic who received one or more fill for a depot antipsychotic
Measure Type: Process

Depression Remission at 12 Months (eCQM)

NQF #: 0710e
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Outcome

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

NQF #: 1934
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

NQF #: 1932
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

**Discharge Prescription of Naloxone After Opioid Poisoning or Overdose*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percentage of Opioid Poisoning or Overdose Patients Presenting to An Acute Care Facility Who Were Prescribed Naloxone at Discharge.
Measure Type: Process

Discharged to the Community With Behavioral Problems

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percentage of home health quality episodes of care at the end of which the patient was discharged, with no assistance available, demonstrating behavior problems.
Measure Type: Outcome

**Documentation of Signed Opioid Treatment Agreement*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

Elimination of Narcotic Medication Use Following Spinal Fusion Surgery

NQF #: N/A

NQF Endorsement Status: Not Endorsed
Measure Description: 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).
Measure Type: Patient Reported Outcome (PRO)

Evaluation or Interview for Risk of Opioid Misuse

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

NQF #: 3488
NQF Endorsement Status: Endorsed
Measure Description: 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:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Measure Type: Process

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

NQF #: 3489
NQF Endorsement Status: Endorsed
Measure Description: The percentage of emergency department (ED) visits for members 6 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:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Measure Type: Process

Follow-Up After High Intensity Care for Substance Use Disorder (FUI)

NQF #: N/A
NQF Endorsement Status: Endorsed

Measure Description: 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 7 and 14 days after discharge.
Measure Type: Process

Follow-Up After Hospitalization for Mental Illness (FUH)

NQF #: 0576
NQF Endorsement Status: Endorsed
Measure Description: The percentage of discharges for patients 6 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:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge
- The percentage of discharges for which the patient received follow-up within 7 days of discharge

Measure Type: Process

Follow-Up Care for Adult Medicaid Beneficiaries Who Are Newly Prescribed an Antipsychotic Medication

NQF #: 3313
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

Gains in Patient Activation (PAM) Scores at 12 Months

NQF #: 2483
NQF Endorsement Status: Endorsed
Measure Description: "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 health care. 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."
Measure Type: Outcome: PRO-PM

GE3CLASS_dep: Depression: 60+ Day Overlap of 3+ Classes of Psychotropics

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients with depression receiving medication from 3 or more of 4 psychotropic classes concurrently for 60 or more continuous days.
Measure Type: Process

GE3CLASS_PTSD: PTSD: 60+ Day Overlap 3+ Classes Psychotropics

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients with PTSD receiving medication from 3 or more of 4 psychotropic classes concurrently for 60 or more continuous days.
Measure Type: Process

**HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey*

NQF #: 0166
NQF Endorsement Status: Endorsed
Measure Description: "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).
Measure Type: Outcome

**Hospice and Palliative Care Composite Process Measure Comprehensive Assessment at Admission (hereafter referred to as the HIS Comprehensive Assessment Measure)*

NQF #: 3235
NQF Endorsement Status: Endorsed
Measure Description: For patients 18 years and older, percentage of patient stays during which the patient received all care processes captured by quality measures NQF #1641 Hospice and Palliative Care Treatment Preferences; NQF #1647 (modified) Beliefs/Values Addressed (if desired by the patient); NQF #1634 Hospice and Palliative Care Pain Screening; NQF #1637 Hospice and Palliative Care Pain Assessment; NQF #1639 Hospice and Palliative Care Dyspnea Screening; NQF #1638 Hospice and Palliative Care Dyspnea Treatment; NQF #1617 Patients Treated with an Opioid Who Are Given a Bowel Regimen, as applicable.
Measure Type: Composite

Hours of Physical Restraint Use

NQF #: 0640
NQF Endorsement Status: Endorsed
Measure Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.
Measure Type: Process

Hours of Seclusion Use

NQF #: 0641
NQF Endorsement Status: Endorsed
Measure Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.
Measure Type: Process

**Improvement in Pain Interfering With Activity*

NQF #: 0177
NQF Endorsement Status: Endorsed
Measure Description: Percentage of home health episodes of care during which the patient's frequency of pain when moving around improved.
Measure Type: Outcome

**Improving or Maintaining Mental Health*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percent of all plan members whose mental health was the same or better than expected after two years.
Measure Type: Outcome

Initial Opioid Prescribing at High Dosage (IOP-HD)

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions with an average daily morphine milligram equivalent (MME) of ≥50. A lower rate indicates better performance.
Measure Type: Process

Initial Opioid Prescribing for Long-Acting or Extended-Release Opioids (IOP-LA)

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for long-acting or extended-release opioids. A lower rate indicates better performance.
Measure Type: Process

Initial Opioid Prescribing for Long Duration (IOP-LD)

NQF #: 3558
NQF Endorsement Status: Endorsed
Measure Description: The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for >7 cumulative days' supply. A lower rate indicates better performance.
Measure Type: Process

**Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*

NQF #: 0004
NQF Endorsement Status: Endorsed
Measure Description: 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:

- 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.
- 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.

Measure Type: Process

loMPR: Antipsychotic (Active): Medication Possession Ratio <0.8

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA outpatients with schizophrenia or schizoaffective disorder who have a low antipsychotic medication possession ratio (less than .8)
Measure Type: Outcome

MED_Bipolar: Bipolar: Mood Stabilizers or Atypical Antipsychotic Use

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients with a confirmed diagnosis of bipolar disorder who received either mood stabilizers or atypical antipsychotic medications
Measure Type: Process

**Kidney Stones: Opioid Utilization After Ureteroscopy and Shockwave Lithotripsy*

NQF #: N/A
NQF Endorsement Status: Not Endorsed

Measure Description: 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.
Measure Type: Process

**Multimodal Pain Management*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percentage of patients, aged 18 years and older, undergoing selected surgical procedures that were managed with multimodal pain medicine.
Measure Type: Process

Non-Opioid Pain Management Following Mohs Micrographic Surgery

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

OAT: Opioid Use Disorder: Opioid Agonist Treatment

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Opioid dependent patients receiving Opioid Agonist Treatment in either a clinic (including fee-basis) or office-based setting
Measure Type: Process

**Oncology: Medical and Radiation – Plan of Care for Pain*

NQF #: 0383
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

**Opioid Therapy Follow-Up Evaluation*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

**Pain Interference Response Utilizing PROMIS*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Patient Reported Outcome (PRO)

Patients Discharged on Multiple Antipsychotic Medications With Appropriate Justification

NQF #: 0560
NQF Endorsement Status: Endorsed
Measure Description: 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: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission s accreditation process. Note that this is a paired measure with HBIPS-4 (Patients discharged on multiple antipsychotic medications).
Measure Type: Process

**Patients Treated With an Opioid Who Are Given a Bowel Regimen*

NQF #: 1617
NQF Endorsement Status: Endorsed
Measure Description: Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed.
Measure Type: Process

PDMP_Benzo: Benzodiazepine: Prescription Drug Monitoring Program (PDMP) Checks

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: VHA patients prescribed a benzodiazepine with a PDMP check documented in the past year
Measure Type: Process

Postoperative Opioid Management Following Ocular Surgery

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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 7 days or less post-operatively, or if

expected to require opioids for more than 7 days after the surgical procedure, having an opioid use management plan documented.
Measure Type: Process

Post-traumatic Stress Disorder (PTSD) Screening and Outcome Assessment

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.

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.
Measure Type: Patient Reported Outcome (PRO)

Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

NQF #: 3589
NQF Endorsement Status: Under Consideration
Measure Description: This measure reports the percentage of a provider's patients who were Medicaid beneficiaries ages 18 to 64 with an OUD diagnosis who filled a prescription for, or were administered or ordered, a FDA-approved medication to treat OUD within 30 days of the first attributable OUD treatment encounter with that provider.
Measure Type: Process

**Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)*

NQF #: 0418e
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

**Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling*

NQF #: 2152
NQF Endorsement Status: Endorsed
Measure Description: 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.

Measure Type: Process

Prostate Cancer: Opioid Utilization After Radical Prostatectomy

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percentage of patients who underwent radical prostatectomy and are discharged with ≤ 6 opioid pain pills (5mg oxycodone or equivalent) and do not get a prescription for opioids within 30 days of surgery.
Measure Type: Process

**Query of Prescription Drug Monitoring Program (PDMP)*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

Risk of Continued Opioid Use (COU)

NQF #: N/A
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

**Safe Opioid Prescribing Practices*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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:

1. Chemical dependency screening (includes laboratory testing and/or questionnaire) within the immediate 6 months prior to the encounter
2. Co-prescription of naloxone or documented discussion regarding offer of Naloxone co-prescription, if prescription is ≥50 MME/day
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.

Measure Type: Process

**Safe Use of Opioids – Concurrent Prescribing*

NQF #: 3316e

NQF Endorsement Status: Endorsed
Measure Description: 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).
Measure Type: Process

**Screening and Monitoring for Psychosocial Problems Among Children and Youth*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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 2 to 6 months after initial positive screen for externalizing and internalizing behavior problems.
Measure Type: Patient Reported Outcome (PRO)

SUD16: Opioid Use Disorder: Medication-Assisted Therapy

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Opioid dependent patients receiving Medication Assisted Therapy in either a clinic (including fee-basis) or office-based setting
Measure Type: Process

Shared Decision Making for Postoperative Management of Discomfort Following Rhinoplasty

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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 multi-modal post-operative management of discomfort. 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:
List 1) Non-opioid analgesics: Non-narcotic/Non-opioid, Acetaminophen/Tylenol, Cox-II inhibitor (Celecoxib), Local/Marcaine/Block, Anxiolytic, Tramadol, NSAID/ibuprofen
List 2) Non-systemic: Ice/Cooling, Elevation, Rest, Mindfulness, Meditation
Measure Type: Process

Sleep Quality Screening and Sleep Response at 3 Months

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Patient Reported Outcome (PRO)

Social Role Functioning Outcome Utilizing PROMIS

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Patient Reported Outcome (PRO)

Symptom Improvement in Adults With ADHD

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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%) on the Adult ADHD Self-Report Scale (ASRS-v1.1 - referred to as ASRS) 18 item self-report scale of ADHD symptoms within 2 to 6 months after initially reporting significant symptoms.
Measure Type: Patient Reported Outcome (PRO)

30-Day, All-Cause, Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)

NQF #: 2860
NQF Endorsement Status: Endorsed
Measure Description: "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."
Measure Type: Outcome

Use of a "PEG Test" to Manage Patients Receiving Opioids

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Percentage of patients in an outpatient setting, aged 18 and older, in whom a stable dose of opioids is prescribed for greater than 6 weeks for pain control, and the results of a "PEG Test" are correctly interpreted and applied to the management of their opioid prescriptions.
Measure Type: Process

**Use of Opioids at High Dosage in Persons Without Cancer*

NQF #: 2940
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

**Use of Opioids From Multiple Providers and at High Dosage in Persons Without Cancer*

NQF #: 2951
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

**Use of Opioids From Multiple Providers in Persons Without Cancer*

NQF #: 2950
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

**Use of Pharmacotherapy for Opioid Use Disorder (OUD)*

NQF #: 3400
NQF Endorsement Status: Endorsed
Measure Description: 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.
Measure Type: Process

**Verify Opioid Treatment Agreement*

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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 6-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.
Measure Type: Process

Assessed for SUD Treatment Needs Using a Standardized Screening Tool

NQF #: N/A
NQF Endorsement Status: Not Endorsed

Measure Description: Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period.
Measure Type: Process

Medicaid Beneficiaries With Newly Initiated SUD Treatment/Diagnosis

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period but not in the three months before the measurement period.
Measure Type: Process

Medicaid Beneficiaries With SUD Diagnosis (Monthly)

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 11 months before the measurement period.
Measure Type: Process

Medicaid Beneficiaries With SUD Diagnosis (annually)

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period.
Measure Type: Process

Medicaid Beneficiaries Treated in an IMD for SUD

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries with a claim for residential treatment for SUD in an IMD during the reporting year.
Measure Type: Process

Any SUD Treatment

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.
Measure Type: Process

Early Intervention

NQF #: N/A

NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.
Measure Type: Process

Outpatient Services

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

Intensive Outpatient and Partial Hospitalization Services

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

Residential and Inpatient Services

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.
Measure Type: Process

Withdrawal Management

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries who use withdrawal management services (such as inpatient, outpatient, or residential) during the measurement period.
Measure Type: Process

Medication-Assisted Treatment (MAT)

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: Number of beneficiaries who have a claim for MAT for SUD during the measurement period.
Measure Type: Process

Average Length of Stay in IMDs

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The average length of stay for beneficiaries discharged from IMD residential treatment for SUD.
Measure Type: Process

SUD Provider Availability

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.
Measure Type: Process

SUD Provider Availability – MAT

NQF #: N/A
NQF Endorsement Status: Not Endorsed
Measure Description: 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.
Measure Type: Process

Use and Adherence to Antipsychotics Among Members With Schizophrenia

NQF #: 0544
NQF Endorsement Status: Endorsement Removed
Measure Description: Assess the use of and the adherence of antipsychotics among members with schizophrenia during the measurement year.
Measure Type: Outcome

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

NQF #: 2801
NQF Endorsement Status: Endorsed
Measure Description: Percentage of children and adolescents 1-17 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.
Measure Type: 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.

Table 4. Measure Concept Inventory

#	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

#	Description	Measure Type
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
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% 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 7 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

#	Description	Measure Type
35	Percentage of patients prescribed opioid	Process
36	Percentage of patients prescribed opioid at discharge	Process
37	Percentage of patients prescribed opioid more than 3 month 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 3 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
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

#	Description	Measure Type
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 4 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
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

#	Description	Measure Type
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.

State-Level Laws

Table 5. State Level Laws

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 overdoes, opioid use disorder, and opioid overdose prevention.
State MAT Re-entry 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.
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.

Law Title	Law Number	State	Year Passed	Summary (Excerpt from Statute)
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.
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.

Law Title	Law Number	State	Year Passed	Summary (Excerpt from Statute)
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.

Law Title	Law Number	State	Year Passed	Summary (Excerpt from Statute)
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 to include all programs which are related to the prevention, treatment, and reduction of substance abuse use disorder. 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.
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.

State-Level Regulations

Table 6. State-Level Regulations

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 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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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 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

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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. The 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.
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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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 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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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;

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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. (b) The physician assistant shall document progress with achieving the tapering plan. (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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
OAC 4731-11-12, -33-01, -03, -04	OH 23050 2018	Ohio (OH)	2019	Repeals and establishes rules regarding office based opioid treatment, definitions, and medication-assisted treatment using naltrexone. (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.
Uncodified	RI 6343 2017	Rhode Island (RI)	2017	The Department is proposing rulemaking to adopt the amendments to incorporate substance use disorder discharge planning requirements. **9.6.5 Discharge Planning: Substance Use Disorder, Opioid Use Disorder, and Chronic Addiction** A. Evaluation 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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
Uncodified	RI 6344 2017	Rhode Island (RI)	2017	The department is proposing rulemaking to adopt the amendments to incorporate substance use disorder Discharge Planning requirements. D. Discharge Planning: Substance Use Disorder, Opioid Use Disorder, and Chronic Addiction 1. Evaluation 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.
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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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 Human Services, and certified by the Substance Abuse and Mental Health Services Administration in accordance with 42 C.F.R. 8.11;

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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 non-applicability. 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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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.
WAC 388-865, -877, -877A, -877B, -877C	WA 37377 2017	Washington (WA)	2018	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… (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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
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.
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.
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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
NMAC 8.321.2	NM 7084 2019	New Mexico (NM)	2019	Proposes some new services, as well as changes to some existing services. **(c)** 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.
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.

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
OAC 4731-33-01, -02	OH 24369 2020	Ohio (OH)	2020	Relates to definitions and standards and procedures for withdrawal management for drug or alcohol addiction. (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").

Regulation Citation	Regulation ID	State	Year Passed	Summary (Excerpt from Statute)
OAC 4730-4-01, -02	OH 24366 2020	Ohio (OH)	2020	Pertains to definitions and standards and procedures for withdrawal management for drug or alcohol addiction. (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: https://www.accessdata.fda.gov/scripts/cder/rems/index.cfm.
Title 69 Series 11	WV 6647 2016	West Virginia (WV)	2017	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.