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Opioids and Behavioral Health Option Year (OY) Web Meeting 4

March 18, 2022

This project is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-2017-00060I –75FCMC20F0002

Welcome

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Housekeeping Remarks

- Please mute yourself when not speaking
- The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
- We encourage you to keep your video on throughout the event
- Please ensure your first and last name are listed correctly in your video
- Use the chat feature to communicate with NQF staff
- Please utilize the raise hand function to be called upon to speak
- We will conduct a Committee roll call once the meeting begins

If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at **OpioidBehavioralHealth@qualityforum.org**

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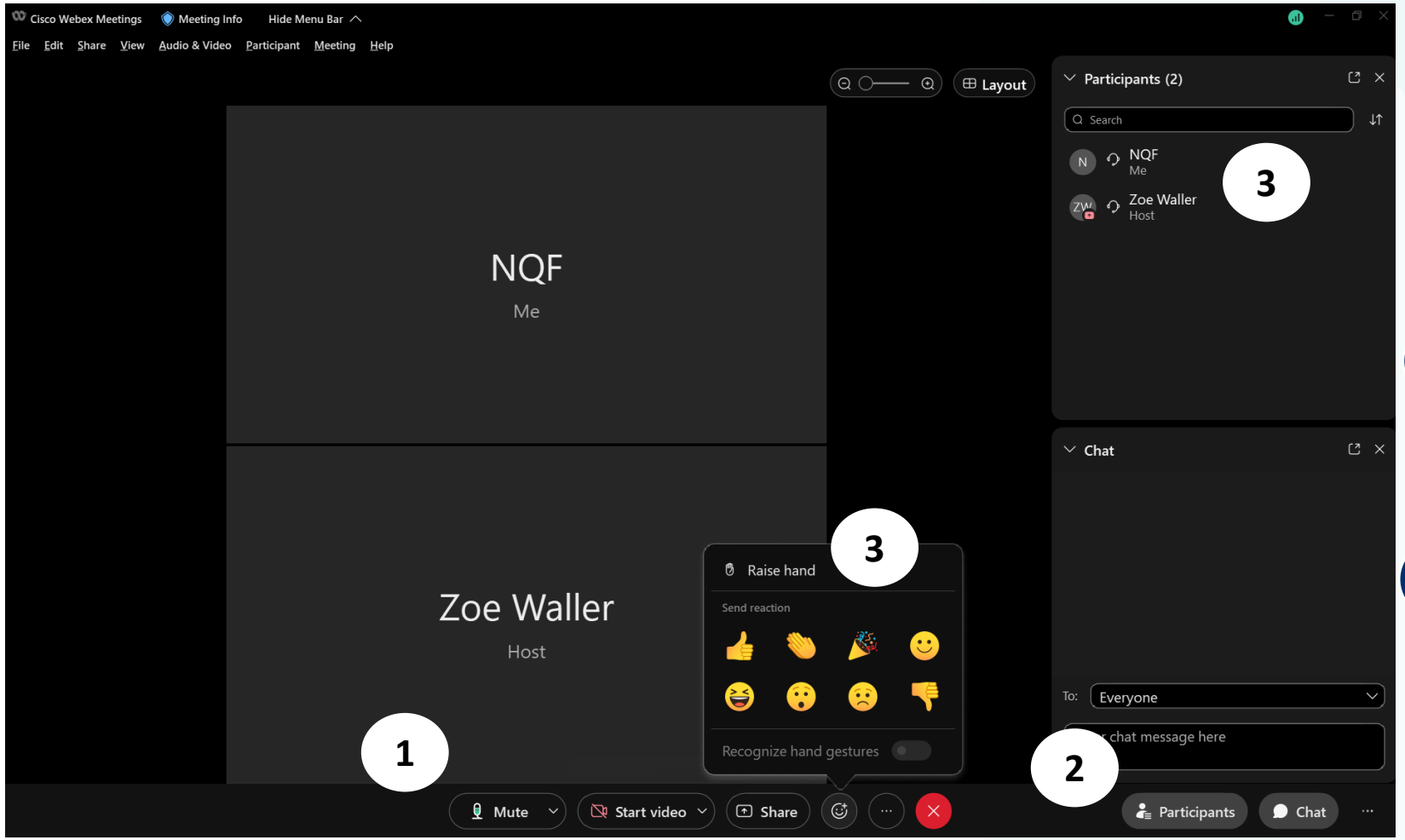
Using the WebEx Platform



1. Click the lower part of your screen to mute/unmute, start or pause video, and access reactions

2. Click on the participant or chat button to access the full participant list or the chat box

3. To raise your hand, select the raised hand function under the reactions tab or the raised hand next to your name in the participant's window

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Project Staff

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- **Zoe Waller,** Coordinator, Program Operations
- **Arthur Robin Williams,** MD, MBE, NQF Consultant

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Agenda

- Welcome and Attendance
- Overarching Use Case Barriers and Solutions Discussion
- Equitable Access Domain Case Exemplar Discussion
- Clinical Interventions Domain Case Exemplar Overview and Discussion
- Opportunity for Public Comment
- Next Steps

Attendance

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Committee Members

- Laura Bartolomei-Hill, LCSW-C (Co-Chair)
- Caroline Carney, MD, MSc, FAMP, CPHQ (Co-Chair)
- Jaclyn Brown
- Mary Ditri, DHA, MA, CHCC
- Carol Forster, MD
- Anita Gupta, DO, PharmD, MPP
- Barbara Hallisey, MSW, LCSW
- Brian Hurley, MD, MBA, DFASAM
- Margaret Jarvis, MD
- Sander Koyfman, MD
- Richard Logan, PharmD
- Perry Meadows, MD, JD, MBA
- Susan Merrill, MSW, LCSW
- Pete Nielsen, MA
- Rebecca Perez, MSN, RN, CCM
- Rhonda Robinson Beale, MD
- Eric Schmidt, PhD
- Richard Shaw, LMSW, CASAC
- Ben Shirley, CPHQ
- Sarah Shoemaker-Hunt, PhD, PharmD
- Eri Solomon
- Elizabeth Stanton, MD
- Steven Steinberg, MD
- Claire Wang, MD, ScD
- Sarah Wattenberg, MSW
- Jameela Yusuff, MD

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Federal Liaisons

- **Girma Alemu**, The Health Resources and Services Administration
- **Ellen Blackwell**, Centers for Medicare and Medicaid Services
- **Laura Jacobus-Kantor**, U.S. Department of Health & Human Services Office of the Assistant Secretary for Planning and Evaluation
- **Joseph Liberto,** United States Department of Veterans Affairs
- **Margaret O'Brien**, Substance Abuse and Mental Health Services Administration
- **Wesley Sargent,** The Centers for Disease Control and Prevention
- **John Snyder,** The Health Resources and Services Administration
- **Shawn Terrell,** The Administration for Community Living
- **Jodie Trafton,** United States Department of Veterans Affairs

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Centers for Medicare and Medicaid Services

- **Michael Paladino**, Opioids and Behavioral Health COR
- **Helen Dollar-Maples**, Deputy Director, DPMS
- **Gequincia Polk**, Health Systems Specialist, CCSQ/QMVIG/DPMS, IDIQ COR

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Ground Rules

- Be prepared for meetings and discussions by reviewing the materials beforehand
- Attend the Committee meetings
- Remain engaged in the discussion without distractions
- Keep comments concise and focused
- Allow others to contribute

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Scope of the Option Year

- The Option Year builds on the foundational work established in the Base Year by further refining the Final Report to help users implement the measurement framework.
- The updates will include:
  - Revisions to the measure inventory that reflect any new and relevant quality measures
  - A series of guiding principles for successful and equitable implementation of the three domains in the measurement framework
  - A detailed use case for how various stakeholders can apply and adapt the measurement framework

Overarching Use Case Barriers and Solutions Discussion

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Overarching Barrier: Stigma

Barrier	Stakeholders Impacted	Solution
Stigma and lack of person-centered care • Provider goals are not aligned with patient goals • Lack of awareness and access to community-based resources and services that improve social determinants of health	Patients, providers, and payers	• Use language that humanizes individuals with SUD • Promote person-centered care (e.g., use of goal attainment scales) • Educate providers to elicit patient-specific goals • Bring payers, providers, and patients together through advisory panels

Discussion Question:

- What additional solutions or strategies can be implemented to overcome this barrier?
- Who else is impacted by this barrier?

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Overarching Barrier: Limited Resources

Barrier	Stakeholders Impacted	Solution
Limited workforce and resources to implement evidence-based practices and non-medical services • Challenging patient panel can lead to perception of additional requirements and barriers	Providers	• Partner with community organizations to expand resources and knowledge

Discussion Question:

- What additional solutions or strategies can be implemented to overcome this barrier?
- Who else is impacted by this barrier?

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Overarching Barrier: Payment

Barrier	Stakeholders Impacted	Solution
Limited reimbursement structures for opioid use disorder (OUD)/substance use disorder (SUD) treatments and interventions • Limited or lack of insurance coverage for services and medications for individuals with SUD • Silos between physical and behavioral healthcare services and providers	Patients, providers, and payers	• Apply for Medicaid 1115 waivers to expand covered services • Healthcare organizations can seek and apply for local or state funds, or foundational grants, that cover the cost of providing medications for opioid use disorder (MOUD) • Establish a no-out-of-pocket-cost buprenorphine Bridge Clinic in the hospital

Discussion Question:

- What additional solutions or strategies can be implemented to overcome this barrier?
- Who else is impacted by this barrier?

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Overarching Barrier: Data Inconsistency and Limitations

Barrier	Stakeholders Impacted	Solution
Challenging data collection processes and poor data quality • Lack of available patient-level data on diagnosis, medications administered, and treatment • Reporting burden and uncertainty • Accuracy of information collected (e.g., taking more information than necessary, patient distrust impacting data accuracy, inconsistency between prescriber shown on data report and individuals making prescription decisions, incomplete data due to different payment methods used) • Privacy concerns hinder information sharing • Lack of accountability	Providers, payers, and measure developers	• Integrate electronic health record (EHR) systems across settings so that information is available to more providers • Include patients in the measure development process to ensure measures developed yield meaningful outcomes that can be used for accountability • Create accountability through regulatory measures • Identify how to use existing EHR infrastructure as a measurement tool instead of just using claims data

Discussion Question:

- What additional solutions or strategies can be implemented to overcome this barrier?
- Who else is impacted by this barrier?

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Overarching Barrier: Rapidly Evolving Measurement Landscape

Barrier	Stakeholders Impacted	Solution
Rapidly evolving measurement landscape • Multiple data sources needed for each measure (e.g., enrollment, medical claims, pharmacy claims) • Amendments to network contracts are required each time new measures are added • Lack of education related to measure development • Lack of validated, evidence-based patient-reported outcome scales	Providers, payers, and measure developers	• Improve existing training in residency to incorporate measures and measure development • Add medications dispensed during a hospitalization to inpatient claims files

Discussion Question:

- What additional solutions or strategies can be implemented to overcome this barrier?
- Who else is impacted by this barrier?

Opioid and Behavioral Health Equitable Access Case Exemplar Discussion

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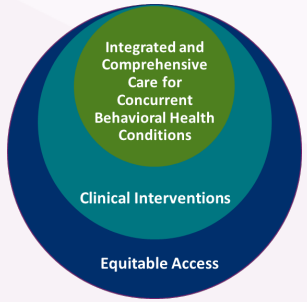

Subdomain of Equitable Access

- Equity and access to care are foundational components of addressing overdose and mortality resulting from polysubstance use among individuals with co-occurring behavioral health conditions
- **Subdomains:**
  - ***Existence of services*** highlights whether services that support individuals with polysubstance use and behavioral health conditions exist and are accessible
  - ***Financial coverage of services*** measures whether affordability is a barrier for individuals accessing needed services
  - ***Vulnerable populations*** focuses on whether populations are equitably able to access needed services, including treatment for SUDs/OUD, and whether affordability is a barrier to accessing care

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Approach for Case Exemplar Barriers and Solutions

Overarching case exemplar barrier	Overarching solutions to overcome case exemplar barrier	Solutions/updates specific to the case exemplar narrative
• *E.g., Limited resources and workforce for treatment interventions and follow-up*	• *E.g., Collaborate with local community organizations to support OUD/SUD treatment and interventions and care*	• *E.g., Provider contacts in-house social worker who arranges a warm handoff that same day with the local methadone center and places the patient in contact with the hospital's peer support group*

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Exemplar 1: Equitable Access Draft Narrative

- The patient is a 32-year-old white, ***visually impaired***, homeless male with a history of severe OUD, frequent methamphetamine use, and bipolar disorder. ***The patient's family also has a history of OUD/SUD.*** The patient was transferred to the local Emergency Department (ED), ***which he has frequented various times in the past few years,*** via Emergency Medical Services (EMS) with an abscess on his right forearm. The ED is exceptionally busy and crowded, with a long wait time for ED and inpatient beds. The ED is also short staffed and ***does not have a specific provider to care for individuals presenting with SUD.***
- The patient has erythematous streaks on his forearm and reports he feels lightheaded and nauseous. The patient is started on intravenous (IV) antibiotics after blood cultures are sent to the laboratory. Upon reviewing the patient's medical record, the Resident in the ED identifies that the patient was revived at the ED six months ago after an opioid overdose. After that visit, the patient was referred for OUD treatment but states he was never able to be seen by the treatment center ***and couldn't afford the transportation to visit the center frequently***. ***He does not have any family support to assist him with transportation.*** The patient reports also going to another hospital within the last year, but the Resident is unable to access any records or data from that visit.

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Exemplar 1: Equitable Access Draft Narrative (Cont.)

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

Discussion Question:

- Are the updated changes reflective of the Committee's feedback?
- Are there any major gaps still missing in the narrative that demonstrate challenges related to equitable access for this population?

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Case Exemplar 1: Measurement Barriers and Solutions

- Lack of interoperability, data, and data collection infrastructure
- Limited workforce, resources, and education
- Cost, or perceived cost, and limited access to treatment services
- Stigma

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Solutions for Lack of Interoperability, Data, and Data Collection Infrastructure

- Increase the use of measures that rely on EHR or claims data, and establish quality assurance processes to integrate measures based on outcome-driven care
- Develop communication protocols and data pathways between ED providers, EMS, and payers and integrate case management systems
- Establish all-payer claims databases and registries with consistent and up-to-date information from EHRs and other data resources that can allow for more holistic measurement

Discussion Question:

- How can these solutions for lack of interoperability, data, and data collection infrastructure be operationalized within the case exemplar narrative?
- What stakeholders should take actions, and what specific actions should they take?

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Solutions for Limited Workforce, Resources, and Education

- Create structural investment in the workforce to allow sufficient time to deploy best practices, implement true person-centered care, gather documents, and discuss care goals
- Invest in reimbursement parity for SUD/OUD treatment activities and harm reduction strategies
  - Remove caps on billed services for screening, testing, and treatment, expand methadone maintenance coverage to commercial insurers, and ensure pharmacy coverage for all forms of MOUD
- Create a continuous education curriculum that includes training on measurement-based and outcome-driven care
- Increase funding for OUD/SUD professionals and ease of billing for payment

Discussion Question:

- How can these solutions for limited workforce and resources/education be operationalized within the case exemplar narrative?
- What stakeholders should take actions, and what specific actions should they take?

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Solutions for Cost, or Perceived Cost, and Limited Access to Treatment Services

- Partner with payers to promote full coverage of OUD/SUD treatment and interventions to eliminate and/or reduce patient copays
- Support and implement no-wrong door policies
- Expand reimbursement options for harm reduction services
- Improve coordination between health care OUD/SUD services and the criminal justice system

Discussion Question:

- How can these solutions for cost, or perceived cost, and limited access to treatment services be operationalized within the case exemplar narrative?
- What stakeholders should take actions, and what specific actions should they take?

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Solutions for Stigma

- Implement ongoing training and support for providers who treat people with OUD and co-occurring mental health conditions
  - Research provider stigma and offer education and training on the impact that healthcare organizations (i.e., both positive and negative) may have on individuals who use drugs and their communities
- Collaborate with community-based organizations to share best practices for person-centered care and to assist in providing stigma reduction education for providers, community members, and family members
- Broaden expected outcomes of OUD/SUD treatment and interventions beyond abstinence
- Integrate patient and peer-led advisory councils into provider service models

Discussion Question:

- How can these solutions for stigma be operationalized within the case exemplar narrative?
- What stakeholders should take actions, and what specific actions should they take?

Clinical Interventions Domain Case Exemplar Overview and Discussion

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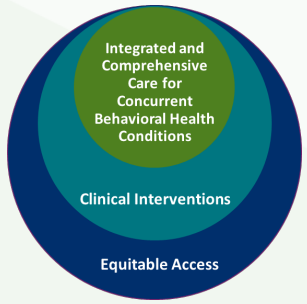

Subdomains of Clinical Interventions

- Clinical interventions build on a foundation of accessible, equitable care and refer to the use of appropriate, evidence-based clinical interventions to address overdose and mortality resulting from polysubstance use among individuals with co-occurring behavioral health conditions
- **Subdomains:**
  - ***Measurement-Based Care (MBC) for Mental Health and SUD Treatments*** focuses on measuring whether individuals with polysubstance use and co-occurring behavioral health conditions are receiving MBC for mental health and SUDs/OUD treatment services
  - ***Availability of Medications for Opioid Use Disorder (MOUD)*** addresses the availability of MOUD, including injectable forms of MOUD
  - ***Adequate Pain Management Care*** measures appropriate pain management practices to minimize risks of overdose and mortality resulting from polysubstance use involving SSSOs among individuals with behavioral health conditions, whether or not these individuals are actively being prescribed opioid analgesics

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Exemplar 2: Clinical Interventions Draft Narrative

- The patient is a 47-year-old non-Hispanic, African-American woman with unstable housing presented to the ED with shortness of breath, tachycardia, and altered mental status late at night. Her chest x-ray was sent to radiology and showed an enlarged heart. During her first night in the hospital the patient became increasingly irritable, diaphoretic, and nauseous. She had difficulty falling asleep and reported lower back and leg pain to the overnight nurses, asking for opioids for pain relief. By morning, her cardiopulmonary work up revealed a low left ventricular ejection fraction of 35% from an ultrasound overnight and during morning rounds her team found “track marks” on her arms.

- The patient reports she had become depressed after her mother’s death and began to occasionally use heroin with her new boyfriend, injecting 5-6 bags a day within a year. She also shared she has had a long history of depression since childhood and chronic back pain following injuries from a fall several years ago. She has never received any mental health services for her depression. The patient revealed that six months ago she entered a methadone treatment plan, but she stopped treatment due to a depressive episode. Despite being referred by the same ED system, there was limited information and only one Brief Addiction Monitoring (BAM) screening in the patient’s medical history. The results of the BAM were not acted on, and there was no mention of follow-up regarding her referral.

Exemplar 2: Clinical Interventions Draft Narrative (cont.)

- The patient now reports wanting to attempt another form of treatment. While her inpatient physician is considering prescribing her buprenorphine, he is worried that her heart condition is a contraindication. The physician also only believes she can afford a methadone maintenance program. The patient is monitored for another night and is sent home with an appointment in the cardiology clinic for next month, a list of nearby meetings for an abstience-only treatment program, and an intake number for the same local methadone clinic she was referred too during her last visit.

Case Exemplar Discussion Questions

- Does the clinical history and presentation represent a common situation of clinical interventions related to this population?
- Does the use case narrative reflect relevant measurement challenges and solutions of the Clinical Interventions domain?

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Case Exemplar 2: Measurement Barriers and Solutions

Top Barriers from Clinical Interventions Exemplar:

- Lack of measurement-based care and limited use of validated tools
- Inadequate or lack of timely initiation of evidence-based treatment
- Lack of or limited patient education

Case Exemplar Discussion Questions

- What other measurement barriers exist in this example?
- What solutions could be deployed in the example to support improved measurement?
- What specific actions can payers, providers, and/or measure developers take to support the solutions?

Opportunity for Public Comment

Next Steps

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Next Steps

- Complete the Web Meeting 4 survey
- Join Web Meeting 5 on April 13, 2022 from 12:00-2:00 pm ET
- Email OpioidBehavioralHealth@qualityforum.org if you did not receive any of the meeting invitations

THANK YOU.

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