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Opioids and Behavioral Health Committee Web Meeting 4

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Welcome

Housekeeping Reminders

- This is a Ring Central meeting with audio and video capabilities:
  - https://meetings.ringcentral.com/j/1491353769
- Optional: If unable to access the meeting using the link above, dial **(470) 869-2200** and enter passcode **1491353769#**.
- Please place yourself on mute when you are not speaking.
- We encourage you to use the following features:
  - Chat box: to message NQF staff or the group
  - Raise hand: 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 NQF project team at: opioidbehavioralhealth@qualityforum.org

Project Staff

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Agenda

- Attendance
- Web Meeting 3 Recap
- Project Updates
- Measurement Gap Discussion
- Measurement Gap Prioritization
- Upcoming Meetings and 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, PharmD
- Anita Gupta, DO, PharmD, MPP
- Barbara Hallisey, MSW, LCSW
- Lisa Hines, PharmD
- 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
- Tyler Sadwith
- Eric Schmidt, PhD
- Richard Shaw, LMSW, CASAC
- 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**, Health Resources and Services Administration
- **Ellen Blackwell**, Centers for Medicare & Medicaid Services
- **Jennifer Burden**, Department of Veterans Affairs
- **Laura Jacobus Kantor**, Office of the Assistant Secretary for Planning and Evaluation
- **Joseph Liberto**, Department of Veterans Affairs
- **Wesley Sargent**, Centers for Disease Control and Prevention
- **John Snyder**, Health Resources and Services Administration
- **Shawn Terrell**, Administration for Community Living
- **Jodie Trafton**, Department of Veterans Affairs

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Centers for Medicare & Medicaid Services

- **Charles Brewer**, NQF Opioids and Behavioral Health COR
- **Sophia Chan**, NQF Risk Adjustment COR
- **Helen Dollar-Maples**, CCSQ/QMVIG/DPMS Deputy Director
- **Maria Durham**, CCSQ/QMVIG/DPMS Director
- **Patrick Wynne**, NQF IDIQ COR

Web Meeting 3 Recap and Project Updates

Web Meeting 3 Recap

- Standing Committee adjudicated comments received from the public on the environmental scan
  - NQF staff have reached out to the commenters with additional questions to clarify intent
  - Responses from commenters were not received prior to publication deadline; prospectively included in Final Report
- Reviewed key areas of the Environmental Scan
  - Measure Repositories & Program Sources
  - Peer Reviewed Literature
  - Non-Peer Reviewed Literature
  - State Laws and Regulations
  - All-payer Measure Concepts
  - Social Risk Factors

Project Updates

- Final Environmental Scan published on NQF website on April 1, 2021.

Measure Gaps

Identification of Measure Gaps

- The Committee has noted that there are very few existing measures associated with polysubstance use involving opioids with concomitant mental health conditions.
- Many such individuals do not engage with the healthcare system in traditional ways.
- Proposed approach to identifying measures gaps:
  - Identify care gaps, best practices and policies that will lead to better care
  - First, identify engagement points (both within and outside of healthcare)
  - To do this, we must understand the population and key subpopulations.

Opioid Polysubstance Use with Mental Health Conditions

- NQF Staff have identified three Opioid Polysubstance Use Subgroups
  1. Common substance use disorder (SUD) Trajectories*
  2. Recreational Substance Users
  3. Acute/Long-term Pain Management Patients
- Note: these are not mutually exclusive, especially over time
- Review healthcare engagement points and gaps
  - When, where, and with whom do each of these subgroups interact?
  - What are engagement (e.g., screening and referral) best practices at the point of care?
  - What measures could capture this?
  - Are other structural changes needed to allow for successful measurement of these subgroups?
- Review and supplement gaps

1. Common SUD Trajectories: Characteristics

- Impaired psychological development and/or psychosocial functioning
  - Often young males with regular substance use, inception often at young ages (10-14 years)
    - (SAMHSA,2005) (Blanco,2014)
  - Risk factors: Family history of SUD, trauma, conduct disorder, and comorbid anxiety/depression
    - (SAMHSA,2005) (Blanco,2014)
  - Trauma history especially common among women with early or heavy substance use
    - (SAMHSA,2005) (Chilcoat,1998)
- If introduced to opioids, high risk for Opioid Use Disorder (OUD), especially with comorbid mental illness
  - Anxiety/depression, personality disorder, trauma disorders, etc. in addition to polysubstance use
- Greatest risk group for ongoing polysubstance use, criminal activity, overdose, death, infections, influencing others through social networks to use drugs.
- Can also be identified in alternate care settings/social services and shepherded through the OUD Treatment Cascade (emphasizing successful linkage with specialty services from non-traditional sites such as needle exchange, infectious disease clinics, etc.)

1. Common SUD Trajectories: Gap Questions

- What are critical milestones between initiation of any drug/alcohol, transition to opioid use (e.g., progression to heroin), and development of severe OUD (including injection drugs)?
  - What early interventions can disrupt this progression?
- How can we expand continuous insurance coverage for these populations?
- Which integrated care models*, in which settings**, are most effective for given subpopulations?
  - Women (Pregnant and parenting women)
  - Justice involved
  - Racial minorities
  - LGBTQ populations
- Can overdoses be considered reportable events (such as HIV or COVID)? Entered in prescription drug monitoring program or electronic health record as a flag (akin to allergies)

1. Common SUD Trajectories: Measure Gap Discussion

- What measure gaps should we include in our report associated with this subgroup (especially gaps for SDOH)?
- Example gaps identified thus far (with emphasis on equity):
  - Identification of child/adolescent BH risk factors and effective screening and intervention
    - » New York City has innovative model of joint health and education city agency to locate services in school settings
  - Insurance coverage lapses during/post-incarceration
    - » Post-incarceration treatment follow up, connection to specialty services
  - Management of multiple BH conditions within single coordinated care team
  - Receipt of non-traditional care services (e.g., peer navigation, care coordination, transportation, WiFi)
    - » What is the role of parole officers? Emergency room social work staff? Social services?
    - » “Referrals” are often to 12-step/group programs without medical care or evidence-based practice. Which AOD services should “count” to satisfy measures? For OUD specifically?

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2. Recreational Substance Use: Characteristics

- The great majority of active drug users are ~16-35 years
  - Only a subset ever develop a SUD, rates depend on the substance and mental health risks (Galanter,2015)
- Psychiatric comorbidity/trauma can both lead to and stem from drug use (Galanter,2015)
- Drug users may use opioids (e.g., prescribed or heroin) interspersed with other drugs: psychostimulants, alcohol or sedatives, etc.
  - Drug users preferentially using opioids to get high ("weekend warriors"), but not yet necessarily daily users, are at risk for overdose in part because low tolerance without daily use, unpredictability in products/strength, unknown supply
  - Daily illicit opioid users often develop severe OUD within 1-2 years
- Drug users primarily using other drugs with little/no opioid tolerance
  - Often polysubstance or could be predominantly psychostimulants (crystal meth or cocaine)
  - High risk of overdose death, especially with exposure to fentanyl
  - Most do not need or qualify for medications for OUD (MOUD) (although XR-naltrexone could aid treatment/overdose protection)

2. Recreational Substance Use: Gap Questions

- Which patient characteristics or risk factors predict episodes of recreational opioid use (and over what time span) becoming frequent opioid use/severe OUD?
- What percent of “fentanyl overdoses” are primarily among stimulant users who do not knowingly/preferentially use opioids (and how do interventions differ from MOUD)?
- Can social media be used to intervene with active users? To reduce drug consumption and/or risk of overdose?
- Potential measures for those with criminal justice involvement?
- What other intersections within healthcare or other systems could be engagement points for potential measurement?
  - Educational settings, criminal justice settings, pharmacies, nightlife and social venues

2. Recreational Substance Use: Measure Gap Discussion

- What measure gaps should we include in our report associated with this subgroup?
- Example gaps identified thus far:
  - Improving screening in primary care and mental health settings
  - Initiation of buprenorphine/MOUD in the emergency room and inpatient hospital settings
  - Appropriate follow-up and treatment post overdose
  - Smoking cessation among drug users/those with SUDs

3. Acute/Long-term Pain Management: Characteristics

- Opioid use for acute pain
  - Exposure to opioids for shorter periods (<1-12 weeks) due to injury, birth, or procedure
  - Most patients will not develop OUD, but many could have significant behavioral health risk factors (Galanter,2015)
    - Especially those from the prior two groups: recreational drug users and those with SUDs
- Long-term opioid use for pain syndromes
  - Exposure to higher volumes of opioids, likely at greater risk for OUD (e.g., 90 MEQs, >12 weeks)
    - (Dunn,2010) (Gaither,2016)
  - May have minimal to fair pain relief, but take greater and greater doses of opioids
    - (King,2015) (Health, 2011)
  - Great majority are unlikely to develop OUD, but those who do are more likely to have psychiatric comorbidity/SUDs, distress intolerance/poor coping skills, and multiple life stressors
  - This group more likely to have overdose and death associated with polypharmacy, alcohol use, and any medical conditions impairing circulatory/respiratory function

3. Acute/Long-term Pain Management: Gap Questions

- Persons with drug use and SUDs are likely to be over-represented among persons receiving opioid prescriptions. (Edlund,2010) Are there ways to identify these groups?
  - Screening/interventions/management as secondary prevention against opioid misuse/OUD?
- Would routine screening alongside initiating opioid prescriptions identify at risk patients?
  - USPSTF now recommending universal screening of adults for unhealthy drug use when referrals available
- How can risk factors for OUD (and SUD/polysubstance use) be better communicated across practice settings?
- Which characteristics contribute most to subsequent OUD and/or overdose risk?
- Can overdose events be effectively flagged as sentinel events that auto-populate into EHR systems in practice networks? At the state level? Into PDMPs?

3. Acute/Long-term Pain Management: Measure Gap Discussion

- What measure gaps should we include in our report associated with this subgroup?
- Example gaps identified thus far:
  - Screening across settings before prescribing opioids or opioid dose escalations
  - Communication across settings regarding OD events
  - Role of telemedicine for consultations and coordinated care, linking with specialists
  - Polypharmacy with opioid use
  - De-prescribing measures

Measurement Gap Prioritization

Gap Prioritization Exercise

- Based on this meeting, NQF staff will prepare a list of measure gaps/concepts, and then email a "ballot" with clear instructions so that the Committee can systematically:
  - Grade and rank a list of measure gaps/concepts
  - Point staff to specific citations/facts that support your ratings
  - Add any concepts/gaps, only if you believe a priority gap is yet unrepresented; these will be discussed during Web Meeting 5
- Voting timeline
  - Committee may submit gaps until Friday, April 9th, 2021
  - NQF staff will send voting instructions on Tuesday, April 13th
  - Voting open until Friday, April 16th
- Review of results and discussion to follow in Web Meeting 5

Gap Prioritization Criteria

- Anticipated impact on morbidity and mortality
- Feasibility to implement
- Contemporary gaps in performance (suggesting room for improvement)
- Person-centeredness (considers values and motivations of those most impacted, i.e., persons and families)
- Fairness and equity (broadly available, nondiscriminatory, sensitive to vulnerabilities)

Upcoming Meetings and Next Steps

Upcoming Meetings and Next Steps

Web Meeting #5 (Review Measure Gaps & Concepts)	**May 6, 2021** 2:00pm-4:00pm ET
Web Meeting #6 (Committee Feedback on Draft Final Report)	**June 2, 2021** 1:00pm-3:00pm ET
21-Day Public Comment Period on Draft Final Report	**July 9 – 30, 2021**
Web Meeting #7 (Review Public Comments on Draft Final Report)	**August 18, 2021** 2:00-4:00pm ET
Final Report	**September 17, 2021**

THANK YOU.

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