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Opioids and Behavioral Health Option Year (OY) Web Meeting 5

April 13, 2022

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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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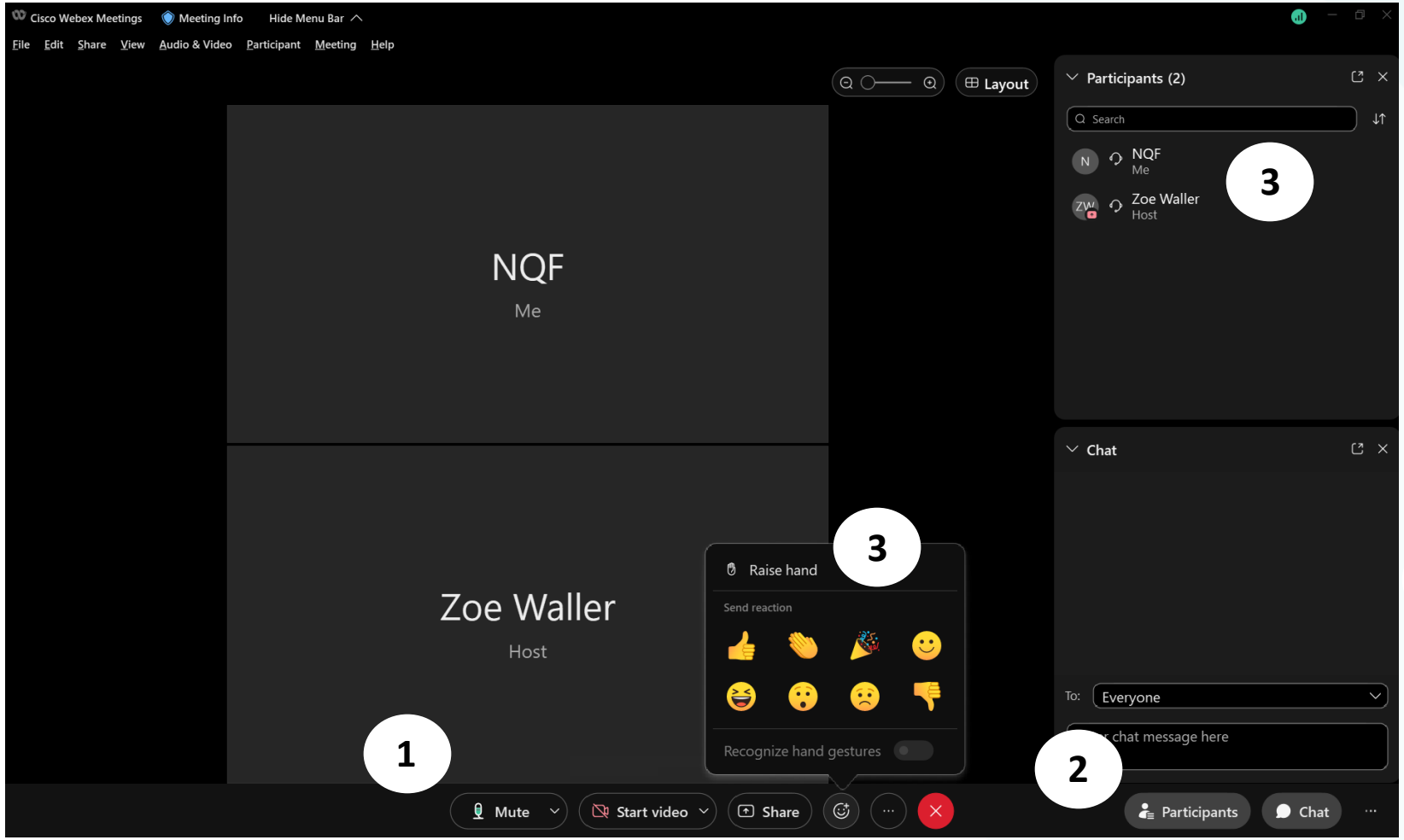
Using the WebEx Platform



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

- **Kathleen Giblin,** RN, Senior Vice President, Emerging Initiatives
- **Maha Taylor,** MHA, PMP, Managing Director, Emerging Initiatives
- **Meredith Gerland,** MPH, Senior Director, Emerging Initiatives
- **Chuck Amos**, MBA, Senior Director, Emerging Initiatives
- **Monika Harvey,** PMP, Project Manager, Program Operations
- **Carolee Lantigua,** MPA, Manager, Emerging Initiatives
- **Debbie Olawuyi,** MPH, Analyst, Emerging Initiatives
- **Zoe Waller,** Coordinator, Program Operations
- **Arthur Robin Williams,** MD, MBE, NQF Consultant

Agenda

- Welcome and Attendance
- Clinical Interventions Domain Case Exemplar Discussion
- Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions 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

Centers for Medicare and Medicaid Services

- **Michael Paladino**, Opioids and Behavioral Health COR
- **Helen Dollar-Maples**, 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

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

Clinical Interventions Domain Case Exemplar 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

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*

Exemplar 2: Clinical Interventions Draft Narrative

- The patient is a 47-year-old non-Hispanic, African-American woman with unstable housing presenting to the emergency department (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. ***While the patient is experiencing withdrawal, the care team does not accurately recognize the symptoms, nor do they request a pain consult for the patient. Instead, the team mistakenly believes she is stubborn and irritable.*** By morning, her cardiopulmonary work up revealed ***signs of congestive heart failure*** and during morning rounds her team found "track marks" on her arms. ***The nurse realizes the patient was likely in opioid withdrawal, but the patient went untreated.***

- The patient reports she became 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. ***The physician makes a mental note that the heroin was likely adulterated with fentanyl but does not mention this to the patient.*** The patient also shared she has had a long history of depression since childhood and chronic back pain following injuries from a fall several years ago. She has never received any mental health services for her depression. The patient revealed that six months ago she entered a methadone treatment plan ***which was initially successful***, but she stopped treatment due to 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 reports wanting to attempt another form of treatment. While the inpatient physician is considering prescribing her buprenorphine, he is worried that her heart condition is a contraindication. The physician also only believes she can afford a methadone maintenance program; ***however, the patient's treatment and payment options were not explored, nor were her goals discussed at any point***. The patient is monitored for another night and is sent home with an appointment in the cardiology clinic for next month and a list of nearby meetings for an abstinence-only treatment program. ***No additional follow-up was conducted.***

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 clinical interventions for this population?

Case Exemplar 2: Measurement Barriers and Solutions

- Limited measurement-based care and validated assessment tools
- Inadequate use of evidence-based treatment for OUD/SUD and co-occurring behavioral health conditions
- Lack of shared decision making and patient education
- Insufficient follow-up care processes and strategies

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Solutions for Limited Measurement-Based Care and Validated Assessment Tools

- Reimbursement mechanisms for healthcare organizations participating in measurement activities to reduce burden, decrease internal resource competition, and increase measurement
- Create measures that monitor the number of times a patient has been referred to a resource, number of times referrals have been made outside of normal business hours, and number of times patient fails to get connected to resources outside of normal business hours to identify gaps in care
- Create patient-generated surveys and leverage patient registries and hybrid measures using claims and clinical data that provide insights into unique challenges of this population

Discussion Question:

- How can these solutions for lack of measurement-based care and limited assessment tools be operationalized within the case exemplar narrative?
- What stakeholders should take actions, and what specific actions should they take?

Solutions for Inadequate Use of Evidence-based Treatment for OUD/SUD and Co-Occurring Behavioral Health Conditions

- Educate providers on differences between physical dependence and SUD
- Ensure adequate treatment of withdrawal through early screening (e.g., upon intake)
- Use EHR capabilities (e.g., flags, alerts to case management) to identify, manage, and ensure behavioral health concerns are recognized and addressed in follow-up and transition plans, especially for patients admitted with other complex medical needs
- Assess internal barriers for hiring staff with the necessary expertise (e.g., clinical social workers, addiction and treatment specialist, peer support specialist) and make the case for resources to executive leadership

Discussion Question:

- How can these solutions for the inadequate or lack of timely initiation of evidence-based treatment for OUD/SUD 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 Lack of Shared Decision Making and Patient Education

- Establish a norm of discussing and acting upon the patient's goals (e.g., interest in harm reduction, patient goals regarding substance use, personal health, and ideal outcomes of care)
- Leverage the use of peer navigators while an individual is in the inpatient setting

Discussion Question:

- How can these solutions for lack of shared-decision making and patient 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 Insufficient Follow-up Processes and Strategies

- Assist patient in ensuring they understand their follow-up plan and create warm handoffs for the next transition of care
  - Provide family members and caregivers with follow-up plan, facilitate and coordinate medication assistance and additional services to address social determinants of health (SDOH) factors, and assess the patient's ability to make and keep appointments
- Work with case managers and community health workers to address SDOH and coordinate follow-up care
  - Provide reimbursement for case management and social work services to support complex discharge planning
- Create measures that asses the effort of healthcare organizations to communicate with the next level of care

Discussion Question:

- How can these solutions for lack of follow-up processes and strategies be operationalized within the case exemplar narrative?
- What stakeholders should take actions, and what specific actions should they take?

Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions Case Exemplar Overview and Discussion

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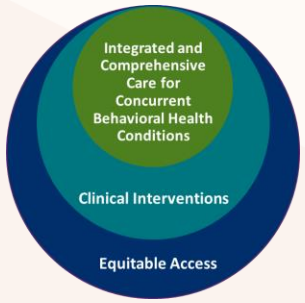

Subdomain of Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions

- Integrated and comprehensive care refers to the coordination, integration, collaboration, and comprehensiveness across care settings and providers – including both those within and outside the medical system
- **Subdomains:**
  - ***Coordination of Care Pathways Across Clinical and Community-Based Services*** highlights coordination across the care pathway, including prevention, screening, diagnosis, and treatment, and focuses on the extent to which care is coordinated and integrated to holistically care for an individual with polysubstance use and co-occurring behavioral health conditions
  - ***Harm Reduction Services*** focuses on opportunities to measure the use and implementation of harm reduction services to reduce overdose and mortality
  - ***Person-Centered Care*** includes assessment of individuals being at the center of their care, including their shared decision making, person-centered planning, and engagement to support informed, patient-centered decisions about the most appropriate treatment plan and path to recovery for each individual

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

- The patient is a 62-year-old married Hispanic woman originally from Puerto Rico, with three grown children and four grandchildren, who retired from working at a local preschool a decade ago and lives in a rural area. She has a history of rheumatoid arthritis, asthma, general anxiety disorder, and long-term opioid use. She is currently taking high-dose oxycodone three times a day with morphine. Despite being on a high dose, long-term opioid and her other risk factors, no one gives the patient a naloxone kit or discusses overdose prevention with her or her husband.
- She is regularly seen in the nearby Federally Qualified Health Center (FQHC) for her primary care, and meets with a rheumatologist, who is part of a separate healthcare system, every 6-12 months to review her pain regimen. There is a long wait to be seen by her rheumatologist and the patient often needs to fill her pain prescriptions early but cannot get through to the front desk on the phone. Her anxiety has worsened over the past year as two of her children, along with all her grandchildren, moved further away. Her husband and children are not actively engaged as partners in her care.

Exemplar 3: Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions Draft Narrative (cont.)

- Although she saw a psychiatrist in her late 40s for anxiety, she has not taken an anxiety medication regularly since her retirement and the FQHC no longer has a full-time mental health clinician on staff. She was referred to a psychiatric nurse practitioner (NP) over telehealth and had a virtual intake conducted, but her WiFi often cut out, she could not understand the clinician well, and she had unanswered questions about medication options. The NP does not have access to the medical records, and given the connectivity issues, the NP did not hear the patient report she is on oxycodone. The NP discussed prescribing a selective serotonin reuptake inhibitor (SSRI) or clonazepam. The patient chose clonazepam since the NP said it will help her feel better faster.
- Since the patient is receiving care at three separate, uncoordinated systems, no one recognizes that she is now on opioids and benzodiazepines. She also often uses all the morphine within the first week of picking up the refill, and as a result has been trying to augment it with other pain relief options from the corner store. The patient says she would like to take fewer medications but is scared the pain will get worse if she makes any changes.

Case Exemplar Discussion Questions

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

Case Exemplar 3: Measurement Barriers and Solutions

Top Barriers from Integrated and Comprehensive Care Exemplar:

- Care does not address unique patient needs
- Silos between mental health and primary care
- Limited or nonexistent interaction with patient's family

Case Exemplar Discussion Questions (Cont.)

- 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

Next Steps

- Complete the Web Meeting 5 survey
- Join Web Meeting 6 on May 9, 2022 from 1:00-3:00 pm ET
- Email OpioidBehavioralHealth@qualityforum.org if you did not receive any of the meeting invitations

THANK YOU.

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