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Opioids and Behavioral Health Option Year (OY) Web Meeting 6

May 9, 2022

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Welcome

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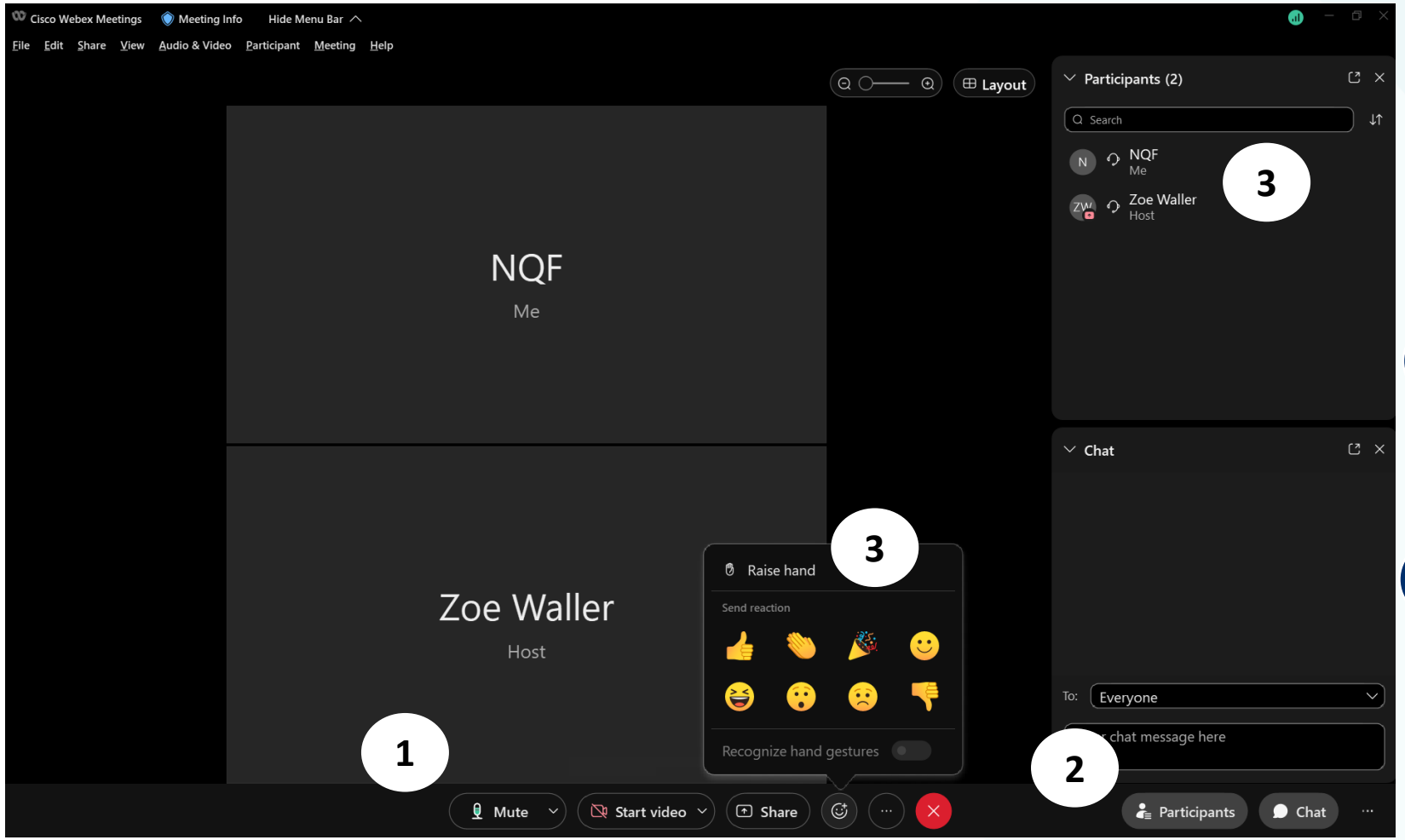
Using the WebEx Platform



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Project Staff

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Agenda

- Welcome and Attendance
- Measure Inventory Overview and Discussion
- Guiding Principles Overview and Discussion
- Overarching Measurement Framework Barriers and Solutions Overview and Discussion
- Use Case Exemplars 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
- 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

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**, Director, DPMS
- **Gequincia Polk**, Health Systems Specialist, CCSQ/QMVIG/DPMS, IDIQ COR

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

Measure Inventory Update

Measure Inventory Update

- NQF identified 16 new measures since the initial environmental scan conducted in the base year
- The new measures added to the final report include:
  - 3 measure related to equitable access and utilization of services
  - 6 measures related to opioid prescribing
  - 3 measures related to other clinical interventions
  - 3 measures related to integrated and comprehensive care for concurrent behavioral health conditions
  - 1 measure related to alcohol use disorder
- NQF also identified 8 measures related to tobacco use disorder; however, based on Committee discussion, they were not included in the final report

Discussion Question:

- Are there any questions or concerns adding these measures to the measure inventory?

Measurement Framework Guiding Principles

1. Promote Health Equity
2. Reduce Stigma
3. Emphasize Shared Decision Making and Person-Centered Care
4. Encourage Innovation
5. Intentionality in Measure Development and Implementation

Promote Health Equity

- Health equity is the attainment of the highest level of health for all people
- Promoting health equity includes raising awareness and creating systems to help account for and address population level factors
- Health equity is a foundational guiding principle as it recognizes that within this population, there is a subset of vulnerable populations who are at a higher risk for OUD/SUD and co-occurring conditions
- As a guiding principle, health equity becomes the lens through which healthcare systems and payers promote better care and reduce overdose and mortality

Reduce Stigma

- Stigma creates a fundamental barrier in the provision of quality care for individuals with OUD/SUD and co-occurring behavioral health condition
- Providers may have biases or assumptions based on a patient's payment method, medical history, or reported data which can impact their decision-making
- Patients and their support systems/families may also have their own stigma
- The framework aims to identify all points where stigma may be experienced including accessing care, receiving evidence-based interventions and harm-reduction services, or during care transitions
- Stigma is a complex area to measure, but may be assessed through patient reported outcomes or through potential stigma-related unintended consequences

Emphasize Shared Decision Making and Person-Centered Care

- Understanding an individual's informed decisions and desires regarding the provision of their care and OUD/SUD treatment choices is critical for achieving optimal health outcomes and reducing mortality
  - Shared decision making is an approach through which patient-centeredness can be achieved by promoting clear communication, tailoring evidence to individual patients, and placing value on a person's informed goals, preference, values, and concerns
  - Person centered care can help providers understand the drivers that lead a particular patient to use opiates and can help them identify harm reduction strategies that fit best fit the patient's risk profile
- This guiding principle aims to dismantle the idea that abstinence is the only outcome to measure
  - Measurement should focus a broad set of outcomes, measuring the actions that can lead to better health and a reduction in mortality
  - Centering care around a patient's goals is more valuable in achieving person-centered care and may lead to better outcomes

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Encourage Innovation

- The medical landscape around behavioral health and OUD/SUD is rapidly evolving, and measurement should aim be flexible enough to account for these changes
- Measurement efforts should consider new and innovative approaches to care, including evidence-based harm reduction strategies, treatments, interventions, telehealth and remote care platforms, and alternate payment models
- This principle recognizes that measure development requires years of testing, but seeks to encourage health systems and payers to be flexible and begin to implement quality improvement efforts
- Innovation should also be applied to data collection efforts to help inform approaches to treating people with OUD/SUD and co-occurring behavioral health conditions

Intentionality in Measure Development and Implementation

- Measure development and implementation must be purposeful and actionable
  - Future measures should be intentional in addressing health equity and promote person-centeredness and evidence-based care
- Measurement efforts should consider the:
  - Medical interventions being promoted
  - Data required
  - Accountability offered
  - Intended outcomes
  - Various healthcare settings a patient may encounter
  - Different levels of resources healthcare systems have
- Measure developers should account for the cost implications and reporting burden that new measures may have on providers, as they may dismay providers from wanting to care for patients with OUD/SUD and co-occurring behavioral health conditions

Discussion Questions

- Do the identified five guiding principles still make sense in the context of the measurement framework and Committee discussions to date?
- Do the key ideas related to each guiding principle encompass what the Committee wishes to convey?

Use Case Overview and Discussion

1. Critical Stakeholders
2. Overarching Barriers and Solutions
3. Equitable Access Case Exemplar
4. Clinical Interventions Case Exemplar
5. Integrated and Comprehensive Care for OUD/SUD and Concurrent Behavioral Health Conditions Case Exemplar

Critical Stakeholders

The Opioids and Behavioral Health Committee identified four critical stakeholders to engage in the implementation of the measurement framework and its guiding principles

- Providers
- Payers
- Measure developers
- Patients and their support systems

Discussion Question:

- Are there any critical groups missing from this list?

Overarching Barriers and Solutions

- Stigma
- Limited Resources
- Payment Challenges
- Data Inconsistency and Limitations
- Rapidly Evolving Measurement Landscape

Solutions to Overcome Stigma

- **Patient-Centered Care**
  - Offers solutions on how to align provider and patient goals to reduce stigma
- **Broaden Care**
  - Recognizes that stigma exist at the individual, organizational, and system wide level
  - Encourages expansion of organizational policies and approaches to care
- **Education**
  - Raises patient, provider, and public awareness of OUD/SUD treatment and harm reduction strategies

Discussion Question:

- In reviewing the solutions in the discussion guide, are there any gaps in the solutions or strategies to overcome stigma?
- Are these strategies a good mix of practical and aspirational strategies?

Solutions to Overcome Limited Resources

- **External Funding**
  - Identifies local, state, and federal funding sources that organizations can seek to help expand coverage for OUD/SUD treatments and/or increase organizational resources
- **Partnerships and Collaborations**
  - Proposes innovative partnerships or care models to overcome reductions in staffing or infrastructure which often limit individuals with OUD/SUD from accessing or receiving quality care
- **Structural Changes**
  - Creates efficiencies in care processes to prevent gaps in care/treatment and adverse events

Discussion Question:

- In reviewing the solutions in the discussion guide, are there any gaps in the solutions or strategies to overcome limited resources?
- Are these strategies a good mix of practical and aspirational strategies?

Solutions to Overcome Payment Challenges

- **Promote Parity in Reimbursement and Coverage**
  - Addresses opportunities to alter current reimbursement and coverage policies that inhibit patients from receiving care or providers from caring for patients
- **Expand Resources**
  - Identifies strategies beyond altering reimbursement structures to facilitate patients accessing care
- **Ensure Continuity of Care**
  - Minimizes payment challenges for patients who move between medical institutions or clinics

Discussion Question:

- In reviewing the solutions in the discussion guide, are there any gaps in the solutions or strategies to overcome payment challenges?
- Are these strategies a good mix of practical and aspirational strategies?

Solutions to Overcome Data Inconsistency and Limitations

- **Integration of Systems**
  - Offers solutions to integrate data elements or systems
- **Standardization**
  - Creates standardization of data collection and quality measurement methods to minimize inconsistencies
  - Offers guidance on critical stakeholders to consult with to make data collection meaningful and actionable

Discussion Question:

- In reviewing the solutions in the discussion guide, are there any gaps in the solutions or strategies to overcome data inconsistency and limitations?
- Are these strategies a good mix of practical and aspirational strategies?

Solutions to Overcome Rapidly Evolving Measurement Landscape

- **Education**
  - Highlights data and measurement education opportunities for patients and providers to make measurement use easier
- **Expansion of Data Collected**
  - Proposes potential sources for new data collection to inform future measure development

Discussion Question:

- In reviewing the solutions in the discussion guide, are there any gaps in the solutions or strategies to overcome a rapidly evolving measurement landscape?
- Are the barriers on data inconsistency and rapidly evolving measurement landscape distinct enough? If so, what are granular solutions to differentiate them?
- Are these strategies a good mix of practical and aspirational strategies?

Equitable Access Case Exemplar

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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

Equitable Access Exemplar Narrative Key Takeaways

- The patient is a 32-year-old white, homeless male with a history of severe OUD, frequent methamphetamine use, and bipolar disorder and a family history of OUD/SUD **who is admitted to the local ED 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**
- Based on medical records, the patient was revived at the ED six months ago after an opioid overdose and was referred for OUD treatment, but **patient reports he was never able to be seen by the treatment center and couldn't afford the transportation to visit the center frequently**
- The **ED cannot start the patient on buprenorphine** as they cannot keep the patient long enough to enter moderate withdrawal before induction due to limited beds
- The **patient is discharged with a printout list of nearby methadone programs, but without a discussion of his treatment goals**
- **Because the patient is unclear on treatment costs and cannot afford transportation, he ultimately decides not to purse further treatment after he is discharged**

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Key Barriers in the Exemplar

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

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

- Hospital implements a communication protocol and data sharing agreements between ED providers, EMS, and integrated case management system
- Hospital implements measure concepts that capture better data points to inform treatment approaches, such as:
  - Percentage of individuals with SUD/OUD and mental health conditions who have access to home and community-based services (e.g., peer support, care coordination, and nonmedical transportation)
  - Percentage of individuals with access to holistic pain management (e.g., physical therapy, occupational therapy, integrated care, and complementary care)
  - Percentage of individuals with SUD/OUD and mental health conditions who receive case management services that are covered

Solutions for Limited Workforce, Resources, and Provider Education

- Provider contacts in-house social worker who arranges a warm handoff that same day with the local methadone center
- Case worker connects the patient with a member of the hospital's peer support group
- Hospital contracts with a 24/7 network to provide access to specialists and/or providers with SUD expertise
- Hospital develops a program that supports buprenorphine induction in the ED prior to discharge

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

- Care team engages in shared decision making with the patient to discuss the patient's unique treatment goals prior to giving him information on specific treatment programs
- Social worker addresses the transportation limitations and provides options for virtual OUD treatment services
  - Case worker offers patient a list of community resources that are near his preferred location
- Hospital expands telemedicine offerings to include case management services that address housing, transportation, and other SDOH
- Hospital establishes a no-out-of-pocket-cost buprenorphine Bridge Clinic in the hospital

Solutions for Stigma

- Hospital implements anti-bias and anti-stigma training for ED staff and providers who may come across individuals with OUD/SUD and co-occurring behavioral health conditions to address the overlapping stigmas that exist for SUD, SDOH, and vulnerable populations

Discussion Question:

- Are there any narrative specific solutions or strategies missing?

Clinical Interventions Case Exemplar

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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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Clinical Interventions Exemplar Narrative Key Takeaways

- The patient is a 47-year-old non-Hispanic, African-American woman with unstable housing presenting to the ED with shortness of breath, tachycardia, and altered mental status
- The patient is experiencing withdrawal, but the **care team does not accurately recognize the withdrawal symptoms**; instead, the **team mistakenly believes she is stubborn and irritable**
  - The patient reports she has a long history of depression since childhood and has begun to occasionally use heroin with her new boyfriend, injecting 5-6 bags a day within a year
  - The care team does not request a pain management or addiction medicine consult
- 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**
- There was only one Brief Addiction Monitoring (BAM) screening in the record, and the **results of the BAM were not acted on**
- The physician considers prescribing buprenorphine, but is worried about her heart condition and believes she can only afford a methadone treatment program
- **The patient's treatment and payment options were not explored, nor were her goals discussed**
- The patient was sent home with an appointment in the cardiology clinic and a list of nearby meetings for an abstinence-only treatment program, and **no additional follow-up was conducted**

Key Barriers in the Exemplar (cont.)

- 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 processes and strategies

Solutions for Limited Measurement-Based Care and Validated Assessment Tools

- Provider administers the BAM every 1-3 months to monitor the patient's progress, and discusses which items the patient may be struggling with to tailor clinical interventions in real-time
- Hospital assesses measurement-based care using:
  - Existing quality measures, such as Adult Depression: PHQ-9 Follow-Up at Six Months and/or Assessed for SUD Treatment Needs Using a Standardized Screening Tool
  - Measure concepts, such as improvement or maintenance of functioning for dual-diagnosis populations (e.g., through use of BAM, Patient-Reported Outcomes Measurement Information System [PROMIS]) and/or percentage of individuals with SUD/OUD and a co-occurring mental health condition identified as having poor SDOH who have demonstrated improvement in clinical status within a given time frame

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

- Provider is notified via a flag in the EHR of patient's depression history, which the provider is then able to address through a referral and transition plan they give to the patient, her husband, and her peer support
- Provider conducts a screening early in the intake process which reveals patient is in withdrawal, subsequently triggering adequate treatment of her symptoms
- Hospital measures availability and use of MOUD using measure concepts, such as percentage of individuals with identified SUD/OUD and mental illness with MOUD initiated in the ED

Solutions for Lack of Shared Decision Making and Patient Education

- Provider discusses the patient's goals regarding harm reduction, substance use, personal health, and her ideal outcomes of care and creates a plan and interventions around those goals, which can be measured through measure concepts, such as patient-reported outcomes on whether the patient feels engaged and heard
- Hospital uses peer navigators to guide the patient through transitions of care and follow-up planning
- Provider educates patient on harm reduction strategies before discharge
  - Provider requests an addiction consult service to provide overdose education and distribute naloxone to the patient prior to discharge

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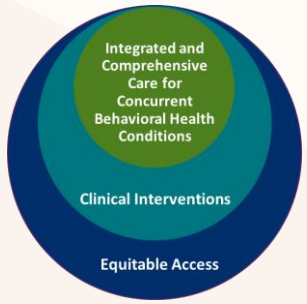
Solutions for Insufficient Follow-up Processes and Strategies

- Physician starts the patient on buprenorphine before she leaves the ED, and the social worker schedules her next treatment at a local treatment center
- A hospital case worker is assigned to the patient, along-side a peer navigator, who ensures patient understands the follow-up plan and is able to follow through with the follow-up plan
- The case worker connects the patient to community services to address her housing status
- Care team asks patient who they consider their support network, and then provides the identified individual(s) with the follow-up plan
- EHR alerts case worker to contact the patient within a week after discharge to confirm if the patient followed-up with referral and if any support is needed
- Hospital monitors and tracks follow-up processes and strategies using:
  - Existing quality measures, such as Discharged to the Community with Behavioral Problems
  - Measure concepts, such as number of times a patient has been referred to a resource, number of times patient fails to get connected to resources outside of normal business hours, and/or percentage of patients that return to the hospital within 30 days or less

Discussion Question:

- Are there any narrative specific solutions or strategies missing?

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



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, retired Hispanic woman with a history of rheumatoid arthritis, asthma, general anxiety disorder, and long-term opioid use
  - **Despite long-term use of a high-dose, extended-release opiate,** and 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 at separate healthcare system to review her pain regimen
- Her anxiety has worsened over the past year **and she found herself in prolonged periods of loneliness and with a lack of family support;** her husband and children are not actively engaged as in her care
- The FQHC no longer has a full-time mental health clinician and she was referred to a psychiatric nurse practitioner (NP) over telehealth; the **NP does not have access to the medical records, and due to connectivity issues, the NP did not hear the patient report she is on oxycodone**
- The patient was prescribed clonazepam and there **was no discussion of behavioral health interventions**
- 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 and as a result has been trying to augment it with **other unknown pain relief options she gets from a neighbor**

Key Barriers in the Exemplar (cont.2)

- Care is not tailored to individualized patient needs
- Siloes between physical and behavioral healthcare
- No engagement of patient's support system
- Lack of connectivity

Solutions for Care Not Tailored to Individualized Patient Needs

- Health systems (e.g., FQHC, other health system, and behavioral health provider) have processes in place to obtain feedback on patient experience and cultural competencies which can be measured through
  - Measure concepts, such as percentage of patients who reported that their mental health and SUDs/OUD treatment was coordinated or patient's experience of care for all patients seen for mental health and substance use care
- Provider conducts regular screening to help identify solutions for instances where medications are not being taken as prescribed, which can be measured through
  - Existing quality measures, such as Evaluation or Interview for Risk of Opioid Misuse
- Health systems actively measures high-risk prescriptions through
  - Existing quality measures, such as Avoidance of Co-Prescribing of Opioid Analgesic and Benzodiazepine and/or Co-occurring Use of Opioids and Benzodiazepines (COB)
- Provider raises and discuss patient's individual risks and circumstances, and discusses care decisions based on identified risks, which can be measured through
  - Existing quality measures, such as Risk of Continued Opioid Use (COU)

Solutions for Silos Between Physical and Behavioral Healthcare

- Health systems have an interdisciplinary team who conducts case reviews across specialists and disciplines (e.g., pain management, psychiatry, rheumatology, and pharmacy) for patients with OUD/SUD and co-occurring behavioral health conditions
- Health systems have dedicated administrative, infrastructure (e.g., EHRs and health information exchanges), funding, and reimbursement systems to improve coordination processes which can be measured through:
  - Measure concepts, such as system uses a measure such as percentage of providers who have a shared/integrated treatment plan between general health and behavioral health providers to track progress
- Health systems provides early career training and ongoing professional education to foster a culture of integrated care as a standard practice among its providers

Solutions for Silos Between Physical and Behavioral Healthcare (Cont.)

- FQHC appoints a case manager to help the patient communicate with her providers and establish options for virtual care
- Health systems use health plan data and PDMP to identify polypharmacy risks and/or high-risk medication regimens, and the system alerts and informs the telehealth provider
- Health systems maintains documentation of medication reconciliation and adverse drug reaction (ADRs) monitoring through:
  - Existing quality measures, such as PDMP_Benzo: Benzodiazepine: Prescription Drug Monitoring Program (PDMP) Checks or Safe Opioid-Prescribing Practices

Solutions for No Engagement of Patient's Support System

- Behavioral health provider appoints a patient advocate/peer navigator to assist the patient and her husband with appointment follow-up and interpretation of medical information
- Provider and peer navigator engage the patient's husband and other members of her chosen support network by answering their questions and providing them with relevant information (e.g., transition plan) to help the patient
- Health systems collects, disseminates, and routinely updates information on resources and services that can help patients with OUD/SUD and co-occurring behavioral health condition (e.g., support groups, faith-based organizations)
- FQHC and behavioral health provider have an established group of volunteers, including those with lived experiences, who are willing and able to talk with patients who are feeling lonely

Solutions for Lack of Connectivity

- Provider asks about patient's resources and telehealth limitations early to establish the best method of care (e.g., phone call, video call)
- Provider trains the patient when a new care method/platform is implemented (e.g., teaches her to use the video conferencing platform)

Discussion Question:

- Are there any narrative specific solutions or strategies missing from this list?

Opportunity for Public Comment

Next Steps

Next Steps

- Complete the Web Meeting 6 survey
- Share the Final Report when it is available for public comment from July 5 – 19
- Join Web Meeting 7 on August 10, 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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Appendix: Measure Inventory Update

Measures Related to Equitable Access and Utilization of Services

Measure Name	Measure Description
All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries in Need of Integrated Physical and Behavioral Health Care	Number of all-cause ED visits per 1,000 beneficiary months among adult Medicaid beneficiaries age 18 and older who meet the eligibility criteria for any of the four denominator groups: 1. Beneficiaries with co-occurring physical health and mental health conditions (PH+MH), 2. Beneficiaries with a co-occurring physical health condition and SUD (PH+SUD), 3. Beneficiaries with a co-occurring mental health condition and SUD (MH+SUD), and 4. Beneficiaries with SMI.
Mental Health Utilization	This measure summarizes the number and percentage of members receiving the following mental health services during the measurement year: Inpatient. Intensive outpatient or partial hospitalization. Outpatient. Emergency department (ED). Telehealth. Any service.
Acute Care Use Due to Opioid Overdose	This is a population measure that indicates the rate of emergency department visits for opioid overdose events in a specified geographic region using ICD-10 diagnosis codes from claims. The outcome is defined as the incidence of overdose events per 1,000 person-years among Medicare beneficiaries greater than 18 years of age residing in the specified

Measures Related to Opioid Prescribing

Measure Name	Measure Description
Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)	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.
Avoidance of Opioid Therapy for Migraine, Low Back Pain, Dental Pain	All ED encounters for patients aged 18 years and older with diagnosis of migraine or low back pain or dental pain who were prescribed or administered Opioids or Opiates.
Unsafe Opioid Prescriptions at the Prescriber Group Level	Percentage of all dialysis patients attributable to an opioid prescriber's group practice who had an opioid prescription written during the year that met one or more of the following criteria: duration >90 days, Morphine Milligram Equivalents (MME) >50, or overlapping prescription with a benzodiazepine. Please note that the opioid prescriber is the clinician

Measures Related to Opioid Prescribing (Cont.)

Measure Name	Measure Description
Unsafe Opioid Prescriptions at the Dialysis Practitioner Group Level	Percentage of all dialysis patients attributable to an opioid prescriber's group practice who had an opioid prescription written during the year that met one or more of the following criteria: duration >90 days, Morphine Milligram Equivalents (MME) >50, or overlapping prescription with a benzodiazepine. Please note that the opioid prescriber is the clinician
Overuse of Opioid Containing Medications for Primary Headache Disorders	Percentage of patients aged 12 years and older diagnosed with primary headache disorder, and taking an opioid containing medication who were assessed for opioid containing medication overuse within the 12-month measurement period, and treated or referred for treatment if identified as overusing opioid containing medication.
Risk-standardized Prolonged Opioid Prescribing Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Knee Arthroplasty	Informed by the Washington State Agency Medical Directors Group Guideline on Opioid Prescribing for Postoperative Pain, this electronic clinical quality measure will assess the risk-standardized rate of opioid-naive patients who are prescribed opioids for > 42 days (6 weeks) following their elective primary THA/TKA at the clinician group level. Because this is a Merit-based Incentivized Payment System (MIPS) measure, the target population is patients 18 years and older across all payers.

Measures Related to Other Clinical Interventions

Measure Name	Measure Description
Antidepressant Medication Management (AMM)	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).
Measurement-based Care Processes: Baseline Assessment, Monitoring And Treatment Adjustment AAM	Percentage of individuals 18 years of age and older with a diagnosis of mental and/or substance abuse disorder, who had a baseline assessment with ongoing monitoring, AND who had an adjustment to their care plan following assessment and monitoring
Hospital Harm – Opioid-related Adverse Events	This measure assesses the proportion of inpatient hospital encounters where patients ages 18 years of age or older have been administered an opioid medication, subsequently suffer the harm of an opioid-related adverse event and are administered an opioid antagonist (naloxone) within 12 hours. This measure excludes opioid antagonist (naloxone) administration occurring in the operating room setting.

Measures Related to Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions

Measure Name	Measure Description
Follow-up After High Intensity Care for Substance Use Disorder (FUI)	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.
Improvement or Maintenance of Functioning for All Individuals Seen for Mental Health and/or Substance Use Care	The percentage of individuals aged 18 and older with mental and/or substance use disorder who demonstrated an improvement in functioning (or maintained baseline level of functioning) based on results from the 12-item World Health Organization Disability Assessment Schedule (WHODAS 2.0) six months (+/- 30 days) after a baseline visit.
Follow-up After Psychiatric Hospitalization	The Follow-Up After Psychiatric Hospitalization (FAPH) measure assesses the percentage of inpatient discharges with principal diagnosis of mental illness or substance use disorder (SUD) for which the patient received a follow-up visit for treatment of mental illness or SUD at seven- and 30-days post-discharge.

Measures Related to Alcohol Use Disorder

Measure Name	Measure Description
Alcohol Screening and Follow-up for People With Serious Mental Illness	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.