NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Opioids and Behavioral Health Committee Option Year Web Meeting 4

The National Quality Forum (NQF) convened a web meeting for the Opioids and Behavioral Health Committee on March 18, 2022.

Welcome, Introductions, and Review of Web Meeting Objectives

Meredith Gerland, NQF Senior Director, welcomed participants to the web meeting. Ms. Gerland reviewed the housekeeping reminders, provided an overview of the WebEx platform, introduced the NQF project team members, and reviewed the meeting agenda. In addition, Ms. Gerland informed participants that a survey would be disseminated at the end of the meeting to obtain the Committee's prioritization of barriers and corresponding solutions to the Clinical Interventions case exemplar.

Attendance and Scope of Option Year

Debbie Olawuyi, NQF Analyst, assessed the Committee member's and federal liaisons' attendance and recognized the Centers for Medicare & Medicaid Services (CMS) members in attendance. Next, Ms. Gerland reviewed the ground rules for the meeting. Ms. Gerland encouraged Committee members to be intentional in the language used during the meeting and to use person-first language, refraining from any stigmatizing language. She provided an overview of the scope of the Option Year (OY), which builds on the foundational work established in the Task Order Base Year by further refining the Final Report to help users implement the measurement framework. The goal of updating the Final Report is to ensure that the measurement framework remains timely and valuable to stakeholders and to support the implementation of the framework through the addition of guiding principles and a use case.

Overarching Use Case Barriers and Solutions Discussion

Ms. Gerland emphasized that Web Meeting 4 will focus on the solutions for the top overarching measurement framework barriers identified in the previous web meeting. The barriers include stigma, limited resources, payment, data inconsistency and limitations, and the rapidly evolving measurement landscape. Ms. Gerland transitioned to Ms. Laura Bartolomei-Hill, Committee co-chair, to review and facilitate a discussion on the barriers and solutions.

Ms. Bartolomei-Hill reviewed and solicited feedback on the solutions identified for the overarching barrier of stigma, which included using person-centered language, educating providers to elicit patient-specific goals, and bringing payers, providers, and patients together on advisory panels. A Committee member recommended including individuals with opioid use disorder (OUD) and/or substance use disorders (SUD) experience as part of the care team as peer support. Another Committee member mentioned that their organization uses educational videos that model appropriate ways to describe and talk to individuals with SUD/OUD. There was a larger Committee discussion on the utilization of public campaigns to reduce stigma, and Committee members discussed opportunities to leverage micro-influencers, who are trusted individuals in their respective communities, to change perceptions about individuals with SUD/OUD and co-occurring behavioral health conditions. Committee members also discussed examining existing hospital policies and practices that may unintentionally reinforce stigma and making systemic changes that remove stigma accordingly within the medical settings. A Committee

member shared solutions related to leveraging legislation as a tool to reduce the use of stigmatizing language, particularly for pregnant patients with OUD/SUD and behavioral health needs. Committee members discussed additional solutions related to incorporating specific language requirements (e.g., decreasing stigma and appropriate reading level language) in Medicare and Medicaid contracts.

Ms. Bartolomei-Hill transitioned the discussion to the next barrier, limited resources, and shared a solution for providers to partner with community organizations to expand resources and knowledge. A Committee member shared that implementing a service design like the hub-and-spoke model can increase a system's capacity to treat patients. Committee members discussed building opportunities to expand the workforce by engaging interns, house staff, medical and nursing students, and social workers to build capacity and expose them to individuals with SUD/OUD.

The Committee transitioned to discussing the next barrier, payment. Ms. Bartolomei-Hill highlighted solutions, including applying for Medicaid 1115 waivers, local or state funds, and foundational grants to cover the costs of medications for opioid use disorder (MOUD) and establishing a no-out-of-pocket cost buprenorphine Bridge Clinic in the hospital setting. There was a discussion on opportunities to improve the flexibility of service reimbursement through Medicaid. Committee members discussed including education on payment structures, benefits, and parity to help make it easier for both patients and providers to navigate complex payment systems. Committee members also discussed the need for flexibility in reimbursement mechanisms, as current reimbursement structures are not always aligned with the needs and clinical presentation of patients with OUD/SUD and co-occurring behavioral health conditions.

Ms. Bartolomei-Hill transitioned to discuss the barrier of data inconsistency and limitations, highlighting the solutions of integrating electronic health record (EHR) systems, including patients in the measure development process, creating accountability through regulatory measures, and using existing EHR infrastructure as a measurement tool. A Committee member agreed with the solutions listed and emphasized that there needs to be more incentives to encourage EHR vendors to work together in a cohesive and interoperable manner. Other Committee members acknowledged that sharing information across providers can be helpful for coordinating care but can also lead to stigmatization, discrimination, and denial of care for patients seeking to access healthcare services for other health concerns. The Committee proposed including patients in the discussions on how their information is shared amongst different healthcare providers as a potential solution to overcome this barrier.

Lastly, Ms. Bartolomei-Hill shared the final overarching barrier, rapidly evolving measurement landscape, and possible solutions, such as improving existing training in residency to incorporate measures and measure development and adding medications dispensed during hospitalizations to inpatient claims files. To help promote data continuity across payers, Committee members discussed the need to standardize systems and handoffs to allow claims history to follow a patient if they change payers. They explained that this would limit gaps in inpatient treatment, help identify at-risk individuals, increase the timely provision of services, and promote quality measurement efforts.

Equitable Access Domain Case Exemplar Discussion

Ms. Gerland introduced the next section of the agenda to obtain feedback on the Equitable Access narrative, barriers, and solutions. Ms. Gerland introduced Dr. Caroline Carney, Committee co-chair, to highlight the changes to the draft narrative based on the discussion from Web Meeting 3. There was agreement from the Committee members that this narrative is common and applies to many emergency departments (ED). Additional refinements from Committee members included explicitly adding

information to highlight the lack of discussion on harm reduction strategies and exploring if there is a way to incorporate law enforcement.

Dr. Carney then reviewed the barriers of the Equitable Access domain and facilitated a Committee discussion to identify specific solutions for those barriers. The Committee began discussing solutions for the lack of interoperability, data, and data collection infrastructure barrier. Committee members mentioned the interactions between law enforcement and individuals with SUD/OUD and suggested using law enforcement data to help health providers assess gaps in care.

Dr. Carney transitioned the conversation to address the limited workforce, resources, and education barrier. A Committee member suggested leveraging the use of telehealth services for patients who have existing transportation barriers. In addition, it was suggested to utilize online consultations with specialists who have a relationship with the ED to be a part of the care team. Dr. Carney transitioned the conversation to discuss the cost, or perceived cost, and limited access to treatment services barrier. Dr. Carney suggested creating a 24/7 network that provides care beyond regular business hours and includes specialists and case managers. In addition, Committee members discussed expanding telemedicine to include case management services that address housing and transportation. Lastly, when discussing the solutions for stigma, a Committee member mentioned the importance of using a broad harm reduction framework that incorporates access to services, resources, and education. Committee members discussed how intersectional anti-bias and anti-stigma training could help address the overlapping stigmas that exist for SUD, social determinants of health (SDOH), and vulnerable populations.

Clinical Interventions Domain Case Exemplar Overview and Discussion

Ms. Gerland transitioned to the next case exemplar by giving a brief overview of the subdomains of the Clinical Interventions domain. Dr. Robin Williams, NQF consultant, presented the draft case exemplar narrative, which focuses on an inpatient whose withdrawal, depression, and treatment goals go unaddressed. Mr. Williams and Dr. Bartolomei-Hill co-facilitated the conversation inquiring if the clinical history and presentation represent a typical situation related to this population. There was Committee agreement that this narrative presents a common scenario, especially when inpatient settings provide care for patients with complex health needs while also facing resource constraints. A Committee member proposed the narrative should provide more context on how the providers address the patient's pain management needs. Dr. Carney highlighted that the medical team in the narrative may have missed that the patient was experiencing withdrawal and the patient's comorbid depression alongside the opioid use.

Ms. Bartolomei-Hill transitioned the conversation to discuss the measurement challenges and solutions of the Clinical Interventions domain narrative. The top barriers included lack of measurement-based care, limited use of validated tools, lack of timely initiation of evidence-based treatment, and limited patient education. The Committee commented about the lack of measures that adequately address co-occurring conditions and how measures that focus solely on the primary diagnosis affect quality improvement and health outcomes. Ms. Bartolomei-Hill highlighted opportunities to enhance workforce support by providing reimbursement for case management services and social work to support complex discharge planning. One Committee member suggested establishing better discharge planning and ensuring the patient is connected to a SUD specialist and other non-medical specialists who can help address her other social needs, such as housing. Committee members discussed incorporating a solution revolving around patient-centered care to enable the provider to have a thoughtful conversation with the patient about her goals. Additional Committee suggestions to overcome these barriers included making follow-up appointments and booking transportation at the same time and following up with

related physical, mental, and substance use services within a specified period of time. In addition, Committee members suggested that those involved in discharge planning should have partnerships with health plans or community case managers.

Public Comment

Ms. Gerland opened the discussion to allow for public comments and member comments. A member of the public added a comment via the chatbox to recommend that hospitals partner with opioid treatment programs (OTP) in the area to ease provider burden and begin people on MOUD.

Next Steps

The NQF team shared the link to the Clinical Interventions case exemplar barriers and solutions survey. Ms. Olawuyi asked Committee members to complete the survey as soon as possible. The NQF team will use the information from Web Meeting 4 and the survey to inform the discussion for Web Meeting 5. Ms. Olawuyi reminded the Committee that Web Meeting 5 will be held on April 13, 2022, from 12-2 pm ET.

Adjourn

Ms. Gerland concluded the meeting by thanking the Committee members, CMS partners, and NQF staff.