NATIONAL QUALITY FORUM
Driving measurable health improvements together

# Meeting Summary

## Opioids and Behavioral Health Committee Web Meeting 4

The National Quality Forum (NQF) convened a web meeting for the Opioids and Behavioral Health Committee on April 7, 2021.

### Welcome, Introductions, and Review of Web Meeting Objectives

Samuel Stolpe, NQF Senior Director, welcomed participants to the web meeting and introduced the NQF project team as well as Robin Williams, the new NQF Consultant on the project. Co-Chairs Caroline Carney and Laura Bartolomei-Hill provided opening remarks by thanking the Committee members on their ongoing participation on the project. Chris Dawson, NQF Manager, conducted attendance of the Committee members and invited the federal liaisons and Centers for Medicare & Medicaid Services (CMS) representatives to introduce themselves.

### Web Meeting 3 Recap and Project Updates

Dr. Stolpe reviewed and discussed with the Committee members the current state of the environmental scan and provided an overview of Committee activities from Web Meeting 3 on February 17, 2021. During Web Meeting 3, the Committee members discussed and adjudicated comments received from the public on the Draft Environmental Scan Report and reviewed key areas of the environmental scan including the measure repositories & program sources, peer reviewed literature, non-peer reviewed literature, state laws and regulations, all-payer measure concepts and social risk factors. Dr. Stolpe also provided the Committee members with a project update since the previous Web Meeting 3 was held, noting that the Final Environmental Scan report was completed and posted to the project webpage.

### Measure Gaps Discussion

Dr. Stolpe began the discussion by informing the Committee members that Web Meetings 4 and 5 will be dedicated to gathering information for the draft of the final report. The report will include the identification and the prioritization of measure gaps related to polysubstance use involving opioids with concomitant behavioral health conditions and a measurement framework. The framework will include a set of organizing principles for the universe of measures that can be used to address the care needs associated with the population. Web Meeting 6 will be used to gather feedback from the Committee on the draft of the final report. This will be followed by a public comment period on the draft final report, and Web Meeting 7 will be used to adjudicate comments and provide suggestions prior to the publishing of the final report.

While drafting the Environmental Scan Report the project team noted there are very few existing measures specifically those associated with polysubstance use involving opioids with concomitant mental health conditions. Measures were found related to substance use disorder (SUD) specific to opioid use as well as measures related to mental health. A few measures existed that tied these categories together but not a significant amount. Dr. Stolpe noted that most individuals who engage in polysubstance use involving opioids and have mental health issues often do not engage in the healthcare system in a traditional way, which makes it difficult to establish quality measures specific to

healthcare providers to produce meaningful accountability. Due to this limitation, the NQF project team identified a proposed approach to identifying measure gaps which includes identifying care gaps, addressing best practices and policies that will lead to better care and, identifying engagement points (both within and outside of healthcare). To do this, the population, key subpopulations and engagement points must be understood.

Dr. Williams facilitated the discussion for the Opioid Polysubstance Use Subgroups. The three subgroups that were identified by the project staff included, common SUD trajectories, recreational substance users and acute/long-term pain management patients. Dr. Williams informed the Committee members that the individuals in each of the subpopulations are not mutually exclusive as people's habits change throughout their life course which ultimately may impact their subgroup classification.

## Common SUD Trajectories: Measure Gap Discussion

Dr. Stolpe introduced the measure gaps that have been identified thus far by the Committee members with an emphasis on equity. The measure gaps include: identification of child/adolescent behavioral health risk factors and effective screening and intervention, insurance coverage lapses during and post-incarceration, management of multiple behavioral health conditions within a single coordinated care team and receipt of non-traditional care services (e.g., peer navigation, care coordination, transportation, Wi-Fi).

Co-chair Dr. Carney led the discussion on measurement gaps that are associated with the common SUD trajectories sub-group. Committee member Eri Solomon emphasized that there needs to be more focus on youth and young people who are often under-served in research measures and developmentally appropriate services as engagement will look different for young people particularly those who still reside with their families as opposed to an older adult. Mx. Solomon also cautioned against use of twelve-step programs as they do not incorporate evidence-based care in their treatment and are often hostile to individuals who are receiving evidence-based care, specifically those receiving medication for addiction treatment. An example of this includes the prevention of individuals who attend Narcotics Anonymous meetings who are on medication for opioid use disorder (OUD) from claiming coins for abstinence periods and not allowing them to engage during meetings. Keeping this in mind, Mx. Solomon further emphasized that referrals for twelve-step programs are not often effective.

Dr. Carney followed up by asking Mx. Solomon if there are gaps that currently exist in abstinence only residential programs. Mx. Solomon agreed by stating that abstinence only programs tend to be based on the twelve-step program model.

Mx. Solomon pointed out that school nurses and other health interactions that young people have throughout schools are an underappreciated potential touchpoint and there is limited training in addiction medicine for primary care providers and a gap regarding pediatricians as the number of pediatricians who can identify and properly treat OUD is small. Mx. Solomon further stated that the healthcare clinicians that oversee the care of young people are often limited and undertrained. Though gaps exist everywhere for individuals with OUD it is particularly acute for young people because their providers are not as engaged and trained in identifying and treating opioid use.

Committee member Dr. Sander Koyfman stated that there needs to be a way to measure family involvement and familial engagement in treatment in families where early exposure, and high exposure are persistent and further focusing on opportunities that offer family-centric rather than individual-centric interventions capitalizing on strengths and addressing risks. Dr. Koyfman also stated that another population that needs to be addressed is healthcare providers that may be struggling with substance use and potentially addressing what causes provider burn-out. Addressing these issues allows the

opportunity to ensure that providers are appropriately addressing their patients' needs but also ensuring that those same providers are also being offered the services they need from the respective entities.

Committee member Dr. Claire Wang pointed out the importance of highlighting care quality for criminal justice involved individuals for this population across the continuum as this interacts with the measurements for crisis response systems. Many patients with co-occurring mental health conditions are often deferred to emergency response police, emergency room or inpatient care, or jail, despite these settings not necessarily being the most appropriate opportunity to connect a patient with the support needed. Dr. Wang also pointed out that treatment for formerly incarcerated individuals should begin during incarceration as opposed to post-incarceration. Dr. Wang also stated that though the systems are disjointed, a patient's data should follow them post-release. In response to Dr. Wang's statement, Dr. Carney discussed current metrics that exist for all the states that look at programs in Medicaid where managed care organizations are involved and what mandates are in place that allow managed care organizations to safely transition individuals from incarceration back to Medicaid and what metrics address lapse in coverage.

Co-Chair Laura Bartolomei-Hill discussed the connection between post-incarceration and a criminal record that is associated with substance use and distributing as these individuals are often excluded from housing and government assistance.

The Committee members mentioned further areas of measure gaps to explore including measures around more conservative controlled substance prescribing and unused medication retrieval count since they contribute to access to substances in youth.

Committee member Dr. Steven Steinberg raised the issue of youth being exposed to opioids due to the amount of early childhood trauma and other risk factors for SUD such as sports injuries which usually begins with a single longer duration/higher dose opioid prescription after injury.

## Recreational Substance Use: Measure Gap Discussion

Co-Chair Laura Bartolomei-Hill facilitated the recreational substance use measure gap discussion. The Committee members discussed education around fentanyl testing strips by addressing that this is usually targeted to people who use heroin. Getting fentanyl testing strips into the hands of those who are using heroin and stimulants will help them understand why it is important is a critical intervention.

Further Committee discussion included gathering data from syringe service programs, which are often less stigmatizing to patients when compared to more traditional settings, such as abstinence-only treatment programs. A Committee member indicated that fentanyl strips are illegal in the state of Arizona so disparities between states is another aspect that should be further addressed. Discussion from the Committee also included considering measures around polypharmacy, particularly around controlled substances, and psycho-pharmacy and often with the absence of engagement in behavioral and psychotherapy interventions, and typically across several providers.

The discussion was concluded with addressing patient-centeredness of care and having care decisions that are made in collaboration with the patients and decision making from their perspective. This is important as this limits conflicts between patients and providers which often leads to disengagement in care on both sides.

## Acute/Long-term Pain Management: Measure Gap Discussion

Dr. Carney led the Acute/Long-term Pain Management Measure Gap Discussion. Committee member Dr. Anita Gupta recommended that a screening measure should be implemented at point of care for individuals. She further stated that the challenge is not only opioid use but rather readily accessible medication including over the counter pills. Starting a universal screening should not be reserved for only opioid users but also for poly-pharmacy patients as well as for anyone who is high risk for a drug problem, adverse event, or a drug interaction.

Dr. Margaret Jarvis stated that a there will not be a universal screening that will be adequate enough to address all the current issues that exist. Rather, screening should look for several risk factors such as adverse childhood events, periodic drug toxicology, etc. as one perfect screening isn't going to be productive, but a number of things should be done that will be more realistic.

The Committee concluded their discussion by addressing suicide as a major concern in this population. Dr. Carney mentioned that non-clinicians often do not engage in suicide screenings due to associated perceived liability issues, however Dr. Koyfman expressed that not asking suicide screening questions does not prevent suicides from occurring so clinicians should begin to implement these questions especially with patients that are in crisis.

## Measurement Gap Prioritization

After Web Meeting 4, 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 their ratings
- Add any concepts/gaps, only if believed to be a priority gap that is unrepresented.

The measure gaps will be discussed during Web Meeting 5. The Committee may submit gaps until Friday, April 9th, 2021 and NQF staff will send voting instructions to the Committee members on Tuesday, April 13th. Voting will be open until Friday, April 16th.

The Committee will be asked to prioritize measurement gaps based on the following 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)
- Fairness and equity (broadly available, nondiscriminatory, sensitive to vulnerabilities)

## Member and Public Comment

Before the conclusion of the web meeting, Dr. Stolpe opened the floor to allow for public and member comment. No public comments were offered.

## Upcoming Meetings and Deliverables

Jhamiel Prince, NQF Analyst, discussed upcoming dates and deliverables for the Opioid and Behavioral Health Committee, which included the following:

**Web Meeting 5:** May 6, 2021 2:00-4:00pm ET

**Web Meeting 6:** June 2, 2021 1:00pm-3:00pm ET

**21-Day Comment Period (Report):** July 9-30, 2021

**Web Meeting #7**: August 18, 2021 2:00-4:00pm ET

**Final Report:** September 17, 2021

## Adjourn

Dr. Stolpe and the Committee Co-chairs concluded the meeting by thanking the Committee members, NQF staff, and CMS partners.