NATIONAL QUALITY FORUM
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Meeting Summary

Opioids and Behavioral Health Committee Option Year Web Meeting 5

The National Quality Forum (NQF) convened a web meeting for the Opioids and Behavioral Health Committee on April 13, 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 provided an update on recent staff transitions: Alexandria Herr, NQF Managing Director, will take over for Maha Taylor, NQF Managing Director. Monica Harvey, NQF Project Manager, will take over the responsibilities of Katie Berryman, NQF Director of Project Management. Lastly, Chuck Amos, NQF Senior Director, will be taking over responsibilities for Ms. Gerland in late May. Ms. Gerland then gave a brief overview of the agenda. She informed the Committee that a survey would be disseminated at the end of the meeting to obtain the Committee's prioritization of barriers and corresponding solutions for the Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions 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 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.

Clinical Interventions Domain Use Case Exemplar Discussion

Carolee Lantigua, NQF Manager, introduced the next section of the agenda to obtain feedback on the Clinical Interventions narrative, barriers, and solutions. Ms. Lantigua explained that the Committee should identify actionable solutions relevant to the barriers in the case narrative and the three subdomains under the Clinical Interventions domain. These subdomains include measurement-based care for mental health and substance use disorders (SUD) treatments, availability of medications for opioid use disorder (MOUD), and adequate pain management care.

Ms. Lantigua transitioned to Ms. Laura Bartolomei-Hill, Committee co-chair, to review and facilitate a discussion on the Clinical Interventions case narrative. Ms. Bartolomei-Hill reviewed the updates to the narrative. She solicited feedback on the updates to the narrative, which included:

contaminated with fentanyl, (3) updating the language that describes the local methadone treatment center to help destigmatize methadone treatment, and (5) simplifying the medical terminology in the narrative. A Committee member suggested highlighting that in addition to not requesting a pain consultation, the provider did not refer the patient to an addiction medicine consult. Another Committee member elaborated that there are not enough psychiatrists and other behavioral health providers on a national level. They explained that hospitals can overcome this barrier by utilizing telehealth services and/or collaborative care models.

Ms. Bartolomei-Hill then gave an overview of the use case measurement barriers and solutions. The top barriers included: (1) limited measurement-based care and validated assessment tools, (2) inadequate use of evidence-based treatment for opioid use disorder (OUD)/SUD and co-occurring behavioral health conditions, (3) lack of shared decision making and patient education, and (4) insufficient follow-up care processes and strategies. She went over the solutions specific to each barrier and solicited feedback on operationalizing the solutions.

Ms. Bartolomei-Hill started the discussion by seeking solutions for the limited measurement-based care and validated assessment tools barrier. Ms. Bartolomei-Hill provided an example of universal referral programs where any hospital or mobile treatment team can use the same referral form and disseminate it to multiple programs efficiently. The health department can help administer these referrals, which has helped limit duplication amongst different hospitals. A Committee member proposed implementing a mechanism that capitalizes on this critical time when a patient wants to address their health concerns, ensure timely assessments are conducted to identify other diagnoses, provides a referral for further treatment, and promote accountability. Another Committee member shared that the proposed measure development should be supported by the Centers for Medicare & Medicaid Services (CMS) or other funding streams. This Committee member recommended that hospitals obtain funding to support patient-generated surveys, which will help identify and improve the gaps in care. A Committee member suggested including a metric that addresses readmissions, as it would allow health systems to measure if care plans were successful and where gaps continue to exist related to implementing measurement-based care and assessment tools.

Ms. Bartolomei-Hill transitioned the conversation to the next barrier: inadequate use of evidence-based treatment for OUD/SUD and co-occurring behavioral health conditions. A Committee member mentioned that accountable care organizations (ACO) are usually highly motivated to manage patients and provide treatments to prevent higher costs and unnecessary hospitalizations. However, non-ACO systems often have fragmented specialties and processes (e.g., hospitals, post-discharge providers, health plans, case management, and others) making care coordination challenging. The Committee member proposed that by creating a collaborative approach, healthcare systems can identify the gaps in core functions necessary to promote better care plans. A Committee member suggested having an "anchor provider" take responsibility for a population with a specific diagnosis to establish accountability for ensuring the patients' needs are met. The Committee agreed that using a hub and spoke model would benefit fragmented provider systems. Committee members also discussed approaches to establishing a coordinated follow-up system. A Committee member noted that some payers (e.g., Medicare Advantage, Managed Care Medicaid) offer case management services that allow for better transitions. Similarly, Committee members discussed having providers (e.g., nurses, emergency department staff) in the post-acute setting share resources and help motivate patients to go to follow-up appointments. Lastly, there was a brief discussion on when screening should occur and when/if providers should use urine drug screening to inform treatment plans and approaches.

Ms. Bartolomei-Hill transitioned the conversation to the next barrier: lack of shared decision-making and patient education. A Committee member mentioned that the case narrative highlighted how the provider made decisions without including the patient in their care plan. One solution to help resolve this issue and keep providers accountable is for health systems to implement patient-reported outcome measures to assess if patients feel engaged and report being heard. Multiple Committee members discussed the role of peer navigators, emphasizing that peer navigators are especially valuable because of the stigma patients with co-occurring behavioral health conditions may experience. Committee members also suggested leveraging reimbursable peer navigators to help address or create a follow-up plan for secondary or tertiary symptoms the patient may have. This would increase the patient's support network and help address workforce limitations within the healthcare setting. In addition, the Committee highlighted that behavioral health peer navigators are more successful in systems that have peer navigators for other clinical diagnoses since there is already a foundation and expectation for the use of these services. A Committee member also suggested broadening the definition of a support system, as a patient's family might not be able to help with a follow-up plan if they are experiencing the same social determinants of health as the patient. Committee members suggested expanding the term patient advocate to include family members or any individual identified by the patient. The Committee discussed adding broad solutions by educating providers on harm reduction strategies that go beyond handing out naloxone.

Ms. Bartolomei-Hill transitioned the conversation to the final barrier: insufficient follow-up processes and strategies. A Committee member supported the solutions around communication, emphasizing that they are essential to overcoming the barriers within the case exemplar. The Committee discussed the importance of community-level healthcare organizations being metric-driven and measuring safe prescription adherence and naloxone availability.

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

Ms. Lantigua then reviewed the subdomains of the Integrated and Comprehensive Care domain. The three subdomains include coordination of care pathways across clinical and community-based services, harm reduction services, and person-centered care. Dr. Robin Williams, NQF consultant, presented the draft narrative, which focuses on a patient taking a high-dose opioid who is later prescribed a benzodiazepine for anxiety. The patient has a general anxiety disorder that has worsened due to increased social isolation and experiences a lack of coordinated care. In the draft narrative, the connectivity issues (i.e., both telehealth and information sharing) resulted in no one recognizing the high-risk prescribing of both a benzodiazepine and an opioid. Dr. Williams facilitated the conversation, inquiring if the clinical history and presentation represent a typical situation related to individuals with co-occurring behavioral health conditions. A Committee member shared that they see the issues presented in the narrative happening in their integrated healthcare system. The Committee member further elaborated that they had success in developing tools to ensure that patients' outpatient providers engaged in the discharge planning upon initial patient admission. The Committee discussed using the prescription drug monitoring program (PDMP) as a solution to track controlled substance prescriptions. A Committee member posed that some providers may look at the PDMP and not communicate with other providers on the care team, or may hesitate to treat patients after reviewing the PDMP, which could result in patients dropping out of care. As a potential solution, a Committee member suggested using interdisciplinary team case reviews to standardize patient-specific treatment plans across different healthcare settings. Overall, Committee members felt the telehealth connectivity challenges within the narrative represented a common barrier. Specifically, internet connectivity issues

can be a barrier for many patients, leading to a gap in care because they do not have access to stable telehealth services.

The Committee discussion transitioned to how the narrative accurately portrayed communication and coordination challenges. A Committee member suggested clarifying if the oxycodone is long-acting or short-acting since it can alter the treatment approach. Committee members discussed the effects of prescribing opioids and ensuring the patient's safety is not compromised, even in complex patients with high-risk treatment regimens. Committee members emphasized the need for communication across providers and with the patients to help solidify a unique care plan for each patient. A Committee member mentioned that polypharmacy is a critical issue that needs to be addressed through education across different disciplines. Additional refinements to the case exemplar from Committee members included explicitly calling out the patient's use of unknown pain medications, her anxiety worsening due to prolonged periods of loneliness and lack of family support, and not receiving appropriate behavioral health interventions.

Dr. Carney discussed the top three barriers from the case exemplar: clinicians not addressing the unique patient needs, silos between mental health and physical healthcare, and limited or nonexistent interactions with the patient's family. A Committee member raised a solution to measure whether patients using opioids receive other treatments (e.g., behavioral interventions, anti-inflammatories). One solution proposed was to provide interventions such as linkages to support group systems that can address the unique patient's needs. In addition, implementing a collaborative care model could help address the behavioral health needs of the patient. A Committee member mentioned how the Veterans Health Administration is launching a "compassionate contact corps," which is a group of volunteers who are available and willing to engage with patients experiencing loneliness. In addition, the Committee discussed how the connectivity barriers in the narrative impact not only telehealth functionality and access but also prevent information sharing amongst providers. Committee members highlighted how specific limitations of virtual care (e.g., patients with limited access to a computer or who struggle with navigating a screen due to its readability) could be barriers to successful care.

Public Comment

Ms. Gerland opened the discussion to allow for public comments and member comments. There were no additional comments from the public.

Next Steps

The NQF team shared the link to the Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions 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 5 and the survey to inform the discussion for Web Meeting 6. Ms. Olawuyi emphasized the time change for Web Meeting 6, which will be held on May 9, 2022, from 1-3 pm ET.

Adjourn

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