NATIONAL QUALITY FORUM
Driving measurable health improvements together

Summary

Opioids and Behavioral Health Committee Web Meeting 5

The National Quality Forum (NQF) convened a web meeting for the Opioids and Behavioral Health Committee on May 6, 2021.

Welcome

Meredith Gerland, NQF Senior Director, welcomed participants to the web meeting and introduced herself as the new NQF project lead replacing Samuel Stolpe who left NQF to pursue a new opportunity. Committee Co-Chairs Dr. Caroline Carney and Ms. Laura Bartolomei-Hill made brief opening remarks to welcome meeting participants. Ms. Gerland reviewed the housekeeping reminders, introduced the NQF project team members in attendance, and reviewed the meeting agenda.

Attendance

Chris Dawson, NQF Manager, assessed attendance of the Committee members and Federal Liaisons, as well as recognized the members of the Centers for Medicare & Medicaid Services (CMS) in attendance.

Web Meeting 4 Recap and Project Updates

Dr. Robin Williams, NQF Consultant, provided a brief recap of Web Meeting 4, which was held on April 7, 2021. During Web Meeting 4, the NQF team set the background for the Committee to begin identifying measure gaps, best practices, and policies that could improve outcomes for the population of interest. Dr. Williams reminded the Committee of the Web Meeting 4 discussion that highlighted how individuals within the scope of this project do not often present themselves within traditional healthcare settings, which is unlike individuals with other common chronic conditions, such as diabetes and heart disease. Considering this, the Committee discussed opportunities to identify, diagnose, and engage patients experiencing opioid use disorder (OUD) and concomitant behavioral health conditions. During Web Meeting 4, the Committee discussed three common subgroups within the patient population: individuals with substance use disorders (SUD), which could include OUD in combination with other substance use or SUDs; individuals who occasionally or frequently use substances, drugs, alcohol, or misuse prescription medications but may not meet SUD criteria; and individuals at risk of being prescribed opioids due to chronic pain conditions. In addition to identifying measure gaps and proposing specified measure concepts, the Committee was also encouraged to consider other recommendations for larger structural changes such as regulations, financial disincentives, challenges to continuous insurance coverage, and barriers to accessing evidence-based care.

After the Web Meeting 4 recap, Mr. Dawson provided an update to the Committee on project activities that have occurred between Web Meetings 4 and 5, including posting of the final environmental scan report and Web Meeting 4 summary to the project webpage, completion of the measure gap prioritization survey and final report outline, and drafting the measurement framework domains and subdomains.

Measurement Gap Prioritization Exercise Results

Dr. Williams then presented the results of the measurement gap prioritization survey, which was shared with the Committee after Web Meeting 4. In the survey, Committee members rated a list of measure gaps and concepts based on five criteria:

- Anticipated impact on morbidity and mortality
- Feasibility to implement
- Contemporary gaps in performance (e.g., suggesting room for improvement)
- Person-centeredness (e.g., considering the values and motivations of those most impacted)
- Fairness and equity (e.g., broadly available, nondiscriminatory, sensitive to vulnerabilities)

Dr. Williams shared the ranking of all 60 measure concepts and gaps (which are included in slides 15-17 in the web meeting slides), with an emphasis on the first 20. Key themes within the first 20 measurement gaps included coordination of care, follow-up and linkages to evidence-based treatment, harm reduction strategies, recovery and person-centeredness, and vulnerable populations (e.g., youth, individuals engaged in criminal justice system). The top 20 measure gaps that were identified by the Committee members include the following:

1. Co-prescription of naloxone with every opioid prescription
2. Medications for opioid use disorder (MOUD) follow-up after emergency department (ED)/inpatient with OUD (7 day; 30 day)
3. Appropriate follow-up and treatment post-overdose
4. Percentage of high-risk patients with opioid prescriptions who are co-dispensed naloxone
5. Screening and initiation of MOUD in ED and inpatient for OUD
6. Outreach and follow-up after overdose event (7 day; 30 day)
7. State level access to appropriate MOUD
8. Initiation of buprenorphine/MOUD in the emergency room and inpatient hospital settings
9. MOUD follow-up after incarceration for OUD (7 day; 30 day)
10. Referral post-SUD sentinel event to appropriate clinical recovery program (not 12 step)
11. Ensuring health plan coverage in place immediately post-incarceration, with access and referral to SUD/OUD/mental health services
12. Screening and initiation of MOUD during incarceration
13. Measures of recovery and increased quality of life
14. Access to and quality of non-medication pain management (e.g., physical therapy)
15. Health plan level access to SUD/OUD and mental health treatment
16. Youth access to naloxone within educational settings
17. Post-incarceration support for other core needs (e.g., housing, food, etc.)
18. Role of telemedicine for consultations, coordinated care, and linking with specialists
19. Provision of fentanyl test strips to injection drug users
20. Receipt of non-traditional care services (e.g., peer navigation, care coordination, transportation, Wifi)

Draft Measurement Framework

Ms. Gerland informed Committee members that the final report will include a conceptual framework for addressing overdose and mortality resulting from polysubstance use involving synthetic and semi-synthetic (SSSO) opioids with an emphasis on persons with co-occurring behavioral health conditions. The conceptual framework is intended to facilitate systematic identification and prioritization of measure gaps and opportunities, and to help guide efforts to fill those gaps through measure development and endorsement. The framework will include measurement domains, with subdomains,

to organize measure concepts and gaps. Ms. Gerland gave an overview of the draft measurement framework domains and subdomains, and informed Committee members that the domains were selected from key themes that arose in the measure gap prioritizations survey and environmental scan. The three domains are Access, Clinical Interventions, and Integrated and Comprehensive Care for Comorbid Behavioral Health Conditions.

Dr. Caroline Carney then led a group discussion to obtain Committee feedback on the domains and subdomains. Committee members expressed agreement with the domains and raised the importance of only consolidating subdomains when it makes logical sense to do so based on the content of the subdomain. When discussing the subdomains, Committee members considered the appropriate domain for harm reduction services to be included given it could be incorporated into multiple domains. Dr. Williams shared the rationale for the placement of harm reduction in the Integrated and Comprehensive Care domain to highlight coordination with non-traditional services and how harm reduction can help contribute to increased patient engagement and improved patient outcomes.

The Committee also suggested adding equity as a new subdomain for Access, and reframing patient engagement, which was a subdomain for Integrated and Comprehensive Care, as person-centeredness. Committee members shared the importance of incorporating non-traditional settings, and Dr. Williams suggested adding non-traditional settings throughout the Integrated and Comprehensive Care domain or within the broader Discussion section of the report. Committee members also discussed how to best measure polysubstance use and described how optimal measurement would focus on linkages to care, shared data, and integration, rather than simply reducing co-prescribing. Committee members emphasized the potential unintended consequences of measuring polypharmacy, such as stigma and reducing access to needed prescriptions for individuals with complex medical conditions.

Co-chair Ms. Bartolomei-Hill then reviewed the top measure gap areas for each of the three domains, beginning with the Access domain. Based on the survey results, the NQF project team identified the following gap areas:

- Ensuring health plan coverage – with access and referral to SUD/OUD and mental health services – is in place immediately post-incarceration
- Post-incarceration support for other core needs (e.g., housing, food)
- Ensuring establishment of a primary care relationship for patients previously incarcerated
- Access to and quality of non-medication pain management (e.g., physical therapy)
- Receipt of non-traditional care services (e.g., peer navigation, transportation, Wi-Fi)
- Insurance reimbursement for social work related to SUD/OUD and behavioral health treatment
- Health plan level access to SUD/OUD and mental health treatment.

The Committee members suggested including access to harm reduction services, and MOUD in jails and prisons as measurement gap areas. Committee members also shared how stigma is an access issue and can prevent individuals from obtaining behavioral health and SUD/OUD treatment.

Ms. Bartolomei-Hill then reviewed the top measure gap areas within the Clinical Interventions domain, which included:

- Referral post-SUD sentinel event to appropriate clinical recovery program
- Co-prescription of naloxone with initial opioid prescription
- Percentage of high-risk patients with opioid prescriptions who are co-dispensed naloxone
- Screening and initiation of MOUD in ED and inpatient settings
- MOUD follow-up after ED/inpatient admission for OUD (at 7 and 30 days)
- Screening and initiation of MOUD during incarceration

- MOUD follow-up after incarceration for OUD (at 7 and 30 days)
- State level access to appropriate MOUD

The Committee suggested including buprenorphine in the co-prescription of naloxone with initial opioid prescription. Committee members also discussed prescribing MOUD in the ED and initiating MOUD during inpatient services prior to hospital discharge, as opposed to waiting seven or 30 days. Further discussion included Committee members suggesting adding patients with OUD who are prescribed MOUD as a gap area.

Lastly, Ms. Bartolomei-Hill reviewed the top measure gap areas within Integrated and Comprehensive Care for Co-morbid Behavioral Health Conditions domain. The top measure gaps that were identified include:

- The role of telemedicine for consultations, coordinated care, and linking with specialists
- Appropriate follow-up, and treatment after overdose event (at 7 and 30 days)
- Measures of recovery and increased quality of life
- Youth access to naloxone within educational settings
- Provision of fentanyl test strips to injection drug users

Committee members highlighted that care coordination and linkages to specialists is an important standalone gap area, without the incorporation of telemedicine. The Committee also suggested broadening the measure gap about fentanyl test strips to include all individuals who use substances, rather than just focusing on injection drug users.

Final Report Outline

Ms. Gerland briefly reviewed the sections of the final report, informing the Committee of content that will be included within each section. The Executive Summary will highlight the key findings and takeaways. The Introduction and Background section will highlight the fourth wave of the opioid crisis, the relationship between substance use and behavioral health conditions, and the role of mental health in worsening outcomes. In addition, this section will discuss characteristics of impacted populations, including high risks of subpopulations. The report will also highlight key elements that emerged from the 2019-2020 NQF Opioids Technical Expert Panel. Ms. Gerland then described how the Measurement Priorities in Polysubstance Use Involving Opioids and Behavioral Health Conditions, Measurement Framework for Opioids, Polysubstance Use, and Mental Health and Discussion sections will be the core of the report.

The Measurement Priorities in Polysubstance Use Involving Opioids section will highlight key measurement priorities, including measurement gaps, monitoring for unintended consequences, all-payer measures, care coordination and collaboration, and mortality from polysubstance use. The priorities in this section of the Report will reflect findings from the environmental scan, results from the measure gap prioritization survey, and Committee discussions.

Ms. Gerland then shared how the measurement framework section will include a discussion of the domains, descriptions of the subdomains, and key components to measure. The framework will also include examples of relevant measures and/or measure concepts, and information about high-risk populations and settings most relevant to the domain.

Ms. Gerland and Dr. Williams then described the Discussion portion of the report. This section will highlight how the measurement framework can support a coordinated measurement approach and overcome barriers that limit measurement, such as insurance coverage disruptions and regulations that

impede co-location of services. Dr. Williams asked Committee members to reflect on and share feedback about any notable barriers that the Report should address in this section.

Public Comment

Ms. Gerland then opened the discussion for public and member comments. No public comments were offered.

Upcoming Meetings and Next Steps

Mr. Dawson reviewed the project's upcoming dates and deliverables, which included Web Meeting 6, the 21-Day Public Comment Period for the Draft Report, and Web Meeting 7.

Adjourn

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