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Addressing Opioid-Related Outcomes Among Individuals With Co-occurring Behavioral Health Conditions

FINAL REPORT – DRAFT 2

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Executive Summary

With estimates of over 284 individuals dying each day from a drug overdose in 2021, the United States (U.S.) continues to grapple with a devastating opioid and substance use disorder (SUD) crisis.[1,2] The first wave of the crisis began in the late 1990s and was led by overdose deaths involving prescription opioids. The U.S. then faced two additional waves centered on opioid-involved overdose deaths involving heroin, including a wave increasingly driven by synthetic opioids (e.g., fentanyl). The country is now facing a fourth wave, which is the result of rising polysubstance use (i.e., using more than one drug at once, such as the co-use of opioids and psychostimulants). Given the nature of the fourth wave of the opioid and SUD crisis, certain individuals are vulnerable to overdose and mortality resulting from polysubstance use, particularly those with SUDs/opioid use disorder (OUD) and co-occurring behavioral health conditions, such as depression and anxiety. The Centers for Medicare & Medicaid Services (CMS) has generally defined *behavioral health* as encompassing a person's whole emotional and mental well-being, which includes the prevention and treatment of mental disorders, including SUDs.[3] For the purposes of this report, *behavioral health condition* refers to mental disorders described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).[4]

Recognizing the evolution of the opioid crisis and the need for measures that address comorbidities, National Quality Forum (NQF), with funding from CMS, convened the Opioids and Behavioral Health Committee over a two-year period (a Base Year and an Option Year) to develop a quality measurement framework that addresses overdose and mortality resulting from polysubstance use involving synthetic and semi-synthetic opioids (SSSOs) among individuals with co-occurring behavioral health conditions. The goals of the framework are to guide measurements that will help improve the prevention and monitoring of SUDs/OUD, opioid-related overdoses, and opioid-related mortality among individuals with co-occurring behavioral health conditions who use SSSOs with other legal and/or illegal drugs; to apprise stakeholders of opportunities for coordination and partnerships across care settings to improve care; and to enable stakeholders to quickly adapt and improve their readiness to implement measures in a rapidly changing landscape.

Based on Committee discussions and prioritization exercises, NQF identified seven gap areas in which stakeholders need to prioritize new and better approaches to measuring polysubstance use and co-occurring behavioral health conditions. The gap areas include the following:

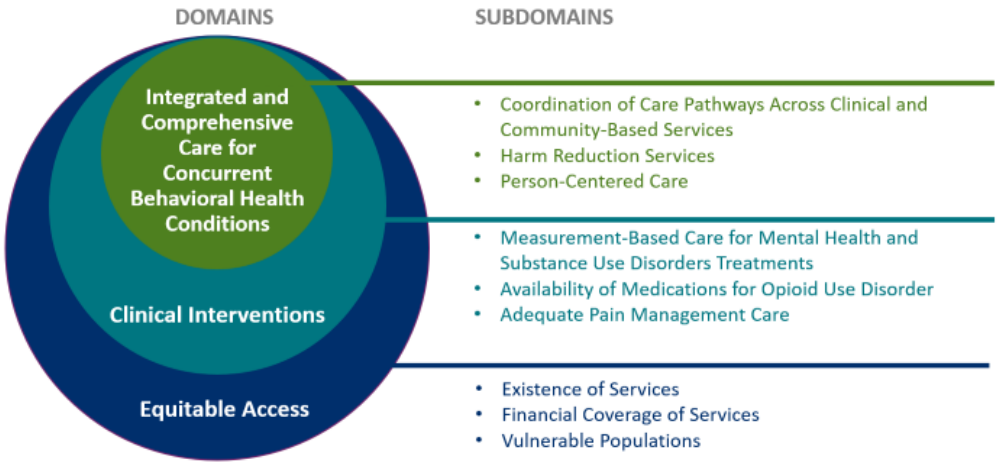
- All-payer measures
- Care coordination
- Person-centeredness and recovery
- Harm reduction
- Equity
- Vulnerable populations
- Linking individuals to evidence-based SUDs/OUD treatment

With these measurement priorities in place, the Committee identified five guiding principles for driving measurement and ultimately reducing overdose and mortality for individuals with SUDs/OUD and co-occurring behavioral health conditions:

- Promote health equity

- Reduce stigma
- Emphasize shared decision making and person-centered care
- Encourage innovation
- Ensure intentionality in measure development and implementation

The Opioids and Behavioral Health Measurement Framework identifies three essential domains (i.e., major categories for measurement), each of which addresses three subdomains (i.e., subcategories or measurement that is specific to each domain). This structure ensures comprehensive measurement of opioid-related outcomes among individuals with co-occurring behavioral health conditions. The three concentric circles found below represent the domains and their relationship to each other. Equitable Access is the outer layer and first domain, which is composed of three subdomains focused on the existence of services, financial coverage of services, and access for vulnerable populations, such as populations with risk factors related to social determinants of health (SDOH) (e.g., unstable housing, limited transportation, and food insecurity) or with criminal justice involvement. The middle layer and second domain is Clinical Interventions, which builds on the foundation of equitable and accessible services. The Clinical Intervention domain comprises three subdomains: measurement-based care (MBC) for mental health and SUDs/OUD treatment, availability of medications for opioid use disorder (MOUD), and adequate pain management care. While access to evidence-based clinical interventions may already exist, the importance of integrated and comprehensive care is essential for individuals with SUDs/OUD and co-occurring behavioral health conditions. Thus, the third and innermost layer of the framework is the Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions domain. This domain has three subdomains, which focus on coordination of the care pathway across clinical, community-based, and harm reduction services with an emphasis on person-centered care.



To guide how measurement should take place in these domains and subdomains, NQF worked with the Committee to identify and develop measure concepts for each of the measurement framework domains and subdomains. Measure concepts are ideas for new performance measures. To help overcome the challenges and barriers to measuring SUD/OUD and behavioral health conditions and as part of the option year of this work, the Committee created a detailed use case for applying the measurement framework. The use case is composed of barriers to measuring SUD/OUD and behavioral health conditions more broadly (including stigma, limited resources, payment, data inconsistencies and limitations, and a rapidly evolving measurement landscape) and corresponding solutions for

implementing the measurement framework. In addition, the Committee developed three specific case exemplars for implementing the framework, one for each of the framework domains, that illustrate common barriers and solutions for measuring care for individuals with SUD/OUD and co-occurring behavioral health conditions.

The Committee members also identified larger systematic opportunities to improve measurement and care, including overcoming structural barriers to coordinated care, improving integrated and continuous care for individuals in the criminal justice system, and addressing the unique challenges and opportunities in rural and frontier communities. The measurement framework and the guidance in this report provide a starting point for stakeholders to begin measuring, evaluating, and addressing overdose and mortality for individuals with SUD/OUD and co-occurring behavioral health conditions.

Introduction

The Fourth Wave of the Opioid and SUD Crisis

In 2021, drug overdose-related deaths reached an all-time high with an estimated 103,598 reported fatalities.[1,2] Of these deaths, 77,766 involved opioids.[1] These overdose deaths align with several distinct waves, beginning with expanded opioid-prescribing in the late 1990s,[5] followed by increased overdose deaths involving heroin beginning in 2010,[6] and a third wave emerging in 2013 related to synthetic opioids, specifically involving illegally produced fentanyl and related high-potency analogues. The U.S. is now facing a fourth wave of the opioid and SUD crisis,[7,8] which is the result of rising polysubstance use, such as the co-use of opioids and psychostimulants (e.g., methamphetamine or cocaine).[9]

The coronavirus disease 2019 (COVID-19) pandemic amplified the ongoing opioid and SUD crisis. The convergence of these two public health emergencies led to an acceleration in overdose deaths,[10] with a reported 46 percent increase in deaths from 2019 to 2021.[11] As information continues to emerge related to the long-term impacts of the pandemic, individuals with SUDs have been clearly and disproportionately affected by the disruption to daily life. Not only are individuals with a recent diagnosis of SUD—particularly OUD and tobacco use disorder—at a significantly increased risk for COVID-19, but individuals with both SUDs and COVID-19 had significantly worse outcomes than other individuals with COVID-19 only.[12,13] The mental health ramifications of social distancing and isolation also have far-reaching impacts, especially for individuals with SUDs.[14] In particular, younger adults and racial/ethnic minorities experienced disproportionally worse mental health outcomes during the pandemic, including increased substance use and suicidal ideation.[14]

Final Report Goals and Objectives

The Opioids and Behavioral Health initiative builds upon the results of the 2019-2020 NQF Opioid and Opioid Use Disorder Technical Expert Panel (TEP). The overall goals of this effort are to improve the prevention and monitoring of opioid-related overdoses and mortality among individuals with co-occurring behavioral health conditions who use SSSOs with other legal and/or illegal drugs; to apprise stakeholders of opportunities for care coordination and partnerships across settings and disciplines; and to create a framework that enables stakeholders to easily adapt and improve readiness, given the rapidly changing landscape.

Within the Final Report, the Committee identified measure concepts and recommendations to serve as a starting point for quality measurement for individuals with SUDs/OUD and co-occurring behavioral

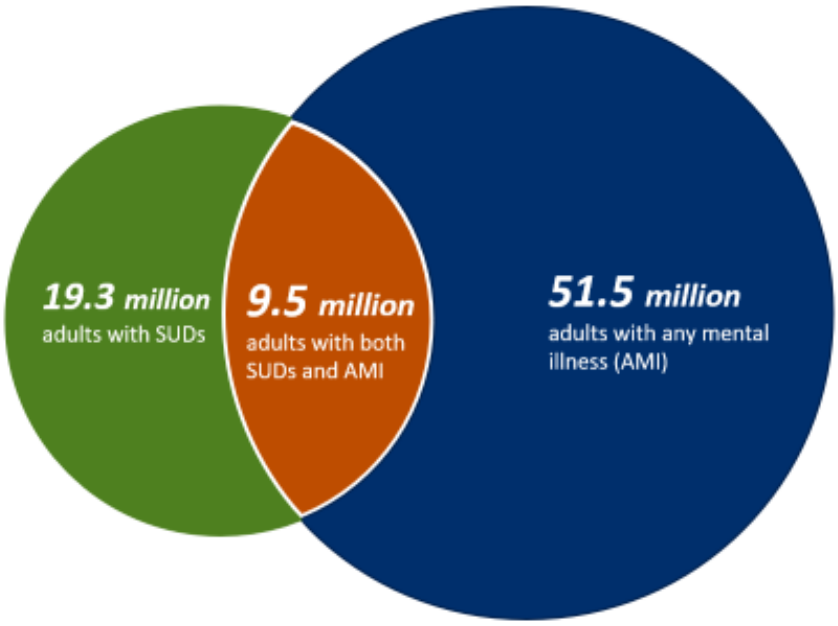
health conditions. Any measure concepts included in the framework should be fully specified, developed, and tested before implementation. Given the evolution of the opioid crisis, it is important to ensure measure concepts and recommendations evolve as the evidence base grows.

This report is an updated version of NQF's September 2021 publication under the same title. The initial version of the report presented a measurement framework to address overdose and mortality resulting from polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions, targeting an array of risk factors. The updated version adds guiding principles and a use case to support readers in implementing the framework.

In developing the measurement framework and associated measure concepts, one of the Committee's objectives was to incorporate all-payer measures or measure concepts whenever possible to maximize the usefulness of the framework. The Committee's objectives also included incorporating outcome measures and patient-reported outcome performance measures (PRO-PMs) to reflect all aspects of care and identifying electronic clinical quality measures (eCQMs) and claims-based measures to help reduce reporting burden for healthcare organizations. Given the population of interest, the Committee also sought to incorporate care coordination, SDOH, and disparities-sensitive measures to address the complex needs of individuals with polysubstance use and co-occurring behavioral health conditions in an equitable and meaningful manner.

As Figure 1 shows, the fourth wave of the opioid crisis has seen a growing overlap of individuals with SUDs, mental illness, and co-occurring SUDs. While 61.2 million adults had either an SUD or a mental illness in 2019, 9.5 million adults had both a mental illness and a co-occurring SUD.[15] Adults represented in the middle of the Venn diagram—those with both SUDs and mental illness—are especially high-risk populations and are the focus area of the measurement framework in this report. Notably, individuals may shift statuses (e.g., SUDs only, mental illness only, and co-occurring SUDs and mental illness) throughout their life span, so this report offers measures and measure concepts that relate to all three statuses reflected in Figure 1.

Figure 1. 9.5 Million Adults Have Co-occurring SUDs and Mental Illness



Adapted from McCance-Katz, E. Results from the 2019 National Survey on Drug Use and Health: Graphics from the Key Findings Report. Webinar. August 7, 2020.

Recommendations From the 2019 NQF Opioids Technical Expert Panel

Opportunities to Build Upon the 2019-2020 Opioids TEP

Prior to the efforts of this Opioids and Behavioral Health Committee, and as called for in the U.S. 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, NQF convened an Opioid and Opioid Use TEP from April 2019 to February 2020. The TEP's work culminated in the NQF report titled Opioids and Opioid Use Disorder: Quality Measurement Priorities.[16]

The 2019-2020 Opioid TEP conducted a thorough review of quality measures related to opioids and OUD, including those that were fully developed or under development. The TEP identified measurement gaps related to opioids and OUD and identified measure development priorities for the associated measure gaps. The results of the 2019-2020 Opioid TEP's work included the identification of the following top five measure gap priorities:

1. Opioid tapering and more general measures related to the treatment of acute and chronic pain
2. Measures for special populations (e.g., LGBTQI+, pregnant women, newborns, racial subgroups, and detained persons)
3. Short-term transitions between inpatient and outpatient settings and long-term follow-up of clients being treated for OUD across time and providers
4. Patient-centered pain management with proper tapering strategies for opioid analgesics
5. Physical (e.g., cardiovascular), psychiatric (i.e., mental health), and SUD comorbidities as part of OUD treatments

The 2019-2020 TEP also made recommendations to the U.S. Department of Health and Human Services (HHS) on related quality measures for improving care, prevention, diagnosis, health outcomes, and treatment. These included recommendations for measure revisions, new measure development, and inclusion of such measures in the Merit-Based Incentive Payment System (MIPS), alternative payment models (APMs), the Shared Savings Program (SSP), the quality reporting requirements for inpatient hospitals, and the Hospital Value-Based Purchasing (VBP) program.

To build on the work of the 2019-2020 Opioid and Opioid Use TEP, the current Committee focused on advancing the fifth measurement gap priority area, which highlights the importance of addressing physical, psychiatric, and SUD comorbidities as part of OUD treatment. This current report focuses specifically on the population that is affected by polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions. Furthermore, this priority area was identified by the previous Opioid and Opioid Use TEP as the fourth wave of the opioid crisis, which is related to polysubstance use and the intersection between behavioral health needs and SUDs. This current report seeks to identify measures and measure concepts that could be utilized by all payers and include concepts related to levers and/or collaboration between medical, clinical, and other community-based entities that care for the population of interest, such as between medical providers and criminal justice or social work. The current Committee also builds on the prior TEP's work by incorporating and addressing the role that SDOH play within this population. This report provides guiding principles, actionable strategies, solutions, and case exemplars to help health systems, providers, measure developers, and patients implement the measurement framework.

Background

The Relationship Between Substance Use and Behavioral Health Conditions

Despite a decline between 2018 and 2019, drug overdose deaths continue to dramatically rise as demonstrated by provisional data, which show overdose deaths increasing by nearly 46 percent from December 2019 to December 2021, with an average of 7,422 overdose deaths a month.[1,2] In May 2020, the U.S. experienced the largest one-month increase in drug overdose deaths ever documented since data estimates were first calculated, driven primarily by synthetic opioids.[2] During this time, the U.S. had also observed increased overdose death rates with co-involvement of synthetic opioids with prescription opioids, heroin, cocaine, and psychostimulants.[17] This increase was very likely driven by the overwhelming economic impact and disruptions of the COVID-19 pandemic in combination with the spread of SSSOs through the illicit psychostimulant market, especially in Western states.[18] Additional factors related to the pandemic, including social isolation, anxiety and depression, and disrupted access to SUDs/OUD support services and medications requiring in-person visits, likely contributed to these record overdose deaths driven by opioids and other substance use. Approximately 75 percent of all overdose deaths that occurred during the COVID-19 pandemic were attributed to opioids, with approximately 80 percent of those involving synthetic opioids.[19,20]

Another challenge within the current wave of increased polysubstance use is that many individuals who develop an SUD are also diagnosed with mental disorders and vice versa.[21] As of 2019, approximately 9.5 million adults have co-occurring mental disorders and SUDs, with nearly 50 percent of individuals with SUDs having a co-occurring mental health condition.[15] Mental disorders commonly associated with SUDs include depression, bipolar disorder, psychotic illness, antisocial personality disorder, borderline personality disorder, and attention deficit hyperactivity disorder (ADHD), as well as anxiety disorders, such as generalized anxiety disorder, panic disorder, and post-traumatic stress disorder (PTSD).[22–33] As shown by multiple national surveys, approximately half of those with mental illness will also experience an SUD, and research indicates similarly high rates with adolescent populations.[34] In 2019, approximately 3.6 million adults, or 27 percent of those with a *serious mental illness* (SMI), which is defined as a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities, also had an SUD.[15,35]

Some data suggest an increased risk for nonmedical use of prescription opioids by persons with mental health conditions and SUDs,[36] with 43 percent of individuals in SUD treatment for nonmedical use of prescription opioids demonstrating symptoms or a diagnosis of a mental health disorder.[37] Of the 9.5 million adults living with co-occurring mental health disorders and SUDs, more than half do not receive treatment for either diagnosis, and less than 8 percent receive treatment for both.[15] Although individuals engaging in SUD treatment may be prescribed MOUD quickly, substantial barriers exist when patients seek mental healthcare for bipolar disorder, psychosis, ADHD, and depression.[38] A lapse in treatment for mental health concerns can last from weeks to months, which often affects opioid and/or substance use, as people may not be stable enough to endure this waiting period.[38]

The Role of Mental Health Conditions in Worsening Health Outcomes

When individuals have SUDs with co-occurring mental health disorders, they experience worse clinical outcomes. The prevalence of opioid-related mortality is shown to be higher in individuals who are middle-aged and have substance misuse along with psychiatric comorbidities.[39] Specific risk factors for

overdose mortality related to medical and nonmedical opioid use include age, comorbid medical and mental disorders, a history of SUDs, and sources of social and psychological stress.[40–46] Comorbid mental illnesses are associated with increased functional impairments and mortality compared to individuals with physical illnesses without these comorbidities.[47] SUDs and social difficulties can further worsen and intensify the effects of comorbidities.[48] One study examining the likelihood of prescription opioid-related overdose or serious opioid-induced respiratory depression (OIRD) found that an SUD diagnosis at a healthcare encounter within the previous six months was strongly associated with OIRD in the study population, with bipolar disorder and schizophrenia also strongly associated with increased odds of OIRD.[45] When considering opioid-related mortality, common correlates of pain (e.g., stress; depression; substance misuse; and social issues, such as poverty and homelessness) increase the risk for deliberate overdose or suicide.[49–51]

Co-occurring SUDs and mental illness, including SMI, also affect inpatient hospital utilization.[52] One study found that individuals with SUDs and mental health disorders have significantly higher rates of inpatient utilization compared with individuals with only SUDs after adjusting for predictors such as older age, marital status, homelessness, suicide risk, pain diagnosis, other SUDs, and prior-year emergency department (ED)/inpatient utilization.[52]

Overview of Impacted Populations

Priority Populations With Elevated Rates of Mental Illness and Substance Use

To inform the identification of measurement gaps and priorities, the Committee first identified key subpopulations who engage with the healthcare and social service system in different ways and at different times. The Committee identified several high-risk populations with elevated rates of mental health disorders who face increased morbidity and mortality related to drug use. These priority subpopulations include individuals with SUDs, individuals who recreationally use substances but may not meet the criteria for SUDs, and individuals who are prescribed opioids for pain management. These three subpopulations overlap, and individuals may move into different subpopulations as their activities and diagnoses change over time.

There are numerous priority populations to consider more closely that are also reflected within the high-risk subpopulations, including justice-involved individuals, rural populations, Veterans, adolescents and young adults, and individuals who inject drugs.[53] For instance, over half of incarcerated adults meet the criteria for SUDs, and approximately a quarter of incarcerated adults meet the threshold for serious psychological distress (SPD), demonstrating mental health issues severe enough to cause moderate-to-serious impairment of their daily lives, thus placing them at great risk.[54,55] These trends are heightened for youth and young people, as approximately 50-75 percent of justice-involved youth meet the criteria for a mental health disorder.[56] Furthermore, the risk of death from overdose for adults in the two weeks following release from correctional settings is roughly 129 times that of the general population.[46] Disparities related to race and ethnicity, gender, and identification with the LGBTQI+ community also often result in poor mental health outcomes due to numerous factors, including lack of access to high quality and culturally competent behavioral health services, cultural stigma encompassing mental healthcare and treatment, discrimination, and overall unfamiliarity concerning mental health interventions.[57]

Individuals With SUDs

SUDs are complex conditions in which individuals have uncontrolled use of a substance despite negative or harmful consequences.[58] As defined in the DSM-5, SUDs involve a number of diagnostic criteria, which are related to impaired control, social impairment, risky use, and physiological indicators (i.e., tolerance and withdrawal).[4] Per the DSM-5, the diagnostic criteria for an SUD include 11 criteria: (1) using substances in larger amounts or for longer durations of time than intended; (2) wanting to reduce or stop the use of a substance but being unable to; (3) increasingly spending more time getting, using, or recovering from use of a substance; (4) having cravings or urges to use a substance; (5) continuing to use substances despite not managing work, school, and/or home responsibilities because of substance use; (6) continuing to use substances even in the face of relationship or interpersonal issues; (7) giving up important social, occupational, and/or recreational activities because of substance use; (8) using substances despite a substance putting the person at risk or in danger; (9) continuing to use substances despite an awareness that the use is causing or worsening physical and psychological problems; (10) developing a tolerance to a substance; (11) and experiencing withdrawal symptoms.[59] Per the DSM-5, SUDs can be classified as mild, moderate, or severe based on the number of diagnostic criteria met by a person. Individuals can develop an SUD related to alcohol, cannabis (i.e., marijuana), hallucinogens, inhalants, opioids, sedatives, stimulants, and tobacco/nicotine.[58]

OUD is often associated with a high risk for morbidity, mortality, and other adverse health and social conditions.[60,61] Adverse events include, but are not limited to, overdose, infection, injury, hospitalization, and suicide. Individuals with OUD and/or other SUDs may face challenges across multiple facets of their lives, such as unemployment or underemployment, fractured family structures, and involvement with the criminal justice system.

It is common for individuals with an SUD, such as OUD, to also use other substances. In particular, anxiety, depression, prior trauma, and other conditions may lead individuals to use varying combinations of drugs, irrespective of overdose risk. Among people who use drugs, individuals typically gravitate toward substances that provide reinforcing effects—whether to produce pleasure or escape physical or emotional pain. Some combinations of drugs are especially high risk for causing overdose events, such as the use of opioids with sedative-hypnotics and/or alcohol.

Unfortunately, risky drug use, mental health disorders, and trauma reinforce one another. Worsening mental health status and increasingly risky drug use can spiral into especially dangerous territory without effective clinical and psychosocial interventions. Individuals with OUD sometimes have interactions with healthcare and social service providers for reasons that may or may not have a direct relationship to their opioid use. However, traditional healthcare systems are often ill-prepared to effectively engage these high-risk individuals, as services for mental health and SUD treatment are often artificially separated and uncoordinated (e.g., located at different physical locations, unaligned care plans, and lack of medication management coordination or processes for communicating between sites). In further exacerbating problems from this siloed approach to care, providers in mental health settings do not always screen for unhealthy drug use or a co-occurring SUD.[62] Until treatment efforts acknowledge that both mental health disorders and SUDs/OUD need to be simultaneously screened for and addressed by providers and individuals, the cycle between behavioral health and SUDs will persist.[38]

Individuals Who Use Drugs Recreationally

While some individuals who use controlled substances (e.g., prescription drugs or illegal drugs) eventually develop an SUD, many individuals who regularly use drugs never develop an SUD. However, people who use illegal drugs are always at increased risk of overdose and/or other adverse events, given the greater lethality of the nation's illicit drug supply. While it is well known that drugs marketed as heroin may be adulterated with fentanyl and fentanyl analogues, this is also true of other powder-based drugs, such as methamphetamine and cocaine, as well as nonprescription pills, such as forged benzodiazepines and counterfeit painkillers. In addition to high-potency opioids, drugs are often contaminated with other substances, including, but not limited to, industrial compounds, veterinary medications, fungicides, antipsychotics, antidepressants, anxiolytics, antihistamines, anthelmintics, decongestants, anti-inflammatories, antipyretics, analgesics, antispasmodics, bronchodilators, and other impurities.[63] This tremendous array of substances can increase an individual's risk of overdose and other unintended effects, especially among people with compromised respiratory or neurologic functioning due to medical conditions or infection.

Due to the inherent risks and illegal nature of illicit drug use, individuals who use drugs recreationally have an increased likelihood of presenting to acute care settings, being hospitalized, and becoming involved with the criminal justice system.[64,65] Injuries related to intoxication and impairment, decreased impulse control and disinhibition, panic and anxiety from excessive drug use, and self-harming and suicidal behaviors all occur at higher rates with drug use.[64–67] These risks are magnified among individuals with psychiatric comorbidities, such as mood, anxiety, and psychotic disorders.[64–67] Additionally, there are elevated rates of drug use among chronically homeless and shelter-bound populations—groups known to have high rates of mental illness. Notably, individuals across these settings are often incentivized to conceal the extent of their drug use and may face prejudice and discrimination if they reveal illegal behavior (e.g., not allowed in the shelter overnight or unable to use vouchers for public housing). Rather than use these clinical, social service, and justice-related encounters as opportunities to engage people who use drugs, such windows of opportunity may be missed.

Individuals Prescribed Opioids for Pain Management

In the early stages of the opioid and SUD crisis, much of the emphasis regarding overdose risk was placed on patients who were prescribed opioids by healthcare providers. While overdose death rates from prescription opioids have been greatly overshadowed over the past decade by overdose deaths involving heroin, fentanyl, and psychostimulants, tens of millions of Americans continue to be prescribed opioids each year for acute or chronic pain. Pain treatment itself is a large public health challenge, as data from the Centers for Disease Control and Prevention (CDC) indicate more than 50 million adults in the U.S. experience chronic pain (i.e., pain for more than three months duration). Common conditions that include pain are low back pain, osteoarthritis, neck pain, fibromyalgia, and sickle cell anemia, amongst others. Balancing the needs of patients with chronic pain and addressing the opioid crisis require careful consideration of pain management strategies through shared decision making and appropriate, evidence-based opioid prescribing. Providers must partner together with their patients to identify the most appropriate treatment plan for a given patient. Screening for mental illness, SUDs, risk of suicidality, and risky drug use before the initiation of opioid use and over the course of treatment could help to identify individuals at risk for opioid dose escalations and adverse events.[68]

Risk Factors, Including Social Risk Factors, That Increase the Risk of Polysubstance Use Involving SSSOs Among Individuals With Co-occurring Behavioral Health Conditions

Poverty

Drug overdose-related deaths have risen and are associated with structural causes and risk factors, such as poverty, low socioeconomic status (SES), worse economic prospects, and high rates of unemployment.[69] Research examining the geographic association between measures of economic opportunity, substance use, and opioid prescribing found that areas with higher poverty and unemployment rates typically have increased rates of retail opioid sales, Medicare Part D opioid prescriptions, opioid-related hospitalizations, and drug overdose deaths.[69] Financial instability affects individuals in many ways that can contribute to unhealthy coping mechanisms, and stress brought on by worry of how to pay for food, rent, and other basic needs can be overwhelming.[70] In 2016, individuals who lived below the federal poverty line were over twice as likely to have an OUD compared with individuals who were living 200 percent above the federal poverty line.[69] Socioeconomic marginalization is an important but underexplored determinant of opioid overdose and SUDs, with important implications for health equity.[70]

Unstable Housing and Homelessness

Lack of safe and stable housing has been shown to negatively affect both physical and behavioral health.[71] Although substance use can cause and prolong homelessness, individuals experiencing homelessness rarely have SUDs alone.[71] Research has demonstrated that homeless individuals often have SUDs as well as mental health conditions.[70] A national study indicated that 75 percent of the people experiencing homelessness and an SUD within the past year also had a comorbid mental illness.[71]

Chronic pain is common among the homeless population.[72] Homeless individuals often sleep outdoors and spend much of their day walking, and the transient and chaotic nature of life often contributes to their experience.[72] Chronic pain in the homeless population is often compounded by injuries, poorly treated medical conditions, insufficient shelter, and repeated exposure to extreme weather elements.[72] Although substance use can cause homelessness, it can also occur as a result of individuals becoming homeless.[73] A lack of access to health insurance and specialty care also decreases the ability of homeless individuals to manage and cope with pain, which often results in increased risks.[72] The combination of these factors translates into homeless individuals having higher rates of SUDs, poorer health, and a great risk of mortality.[72,74,75]

Criminal Justice Involvement

There are high rates of substance use within the criminal justice system, with 65 percent of the prison population having an SUD.[76] Inmates with OUD are also at a higher risk for overdose following release from incarceration.[76] Based on the 2015–2016 National Survey on Drug Use and Health (NSDUH), the odds of being involved in the criminal justice system increase greatly for persons using opioids.[77] Approximately 35 percent of individuals with a heroin use disorder pass through American prisons annually, and an estimated 17 percent of state inmates and 19 percent of jail inmates report regularly using opioids.[77] Approximately 30–45 percent of these individuals report having withdrawal symptoms or an inability to control their use, which is indicative of OUD.[77] Untreated SUDs or OUD during incarceration can result in a fatal relapse post-release due to a loss of tolerance that would have occurred during incarceration.[76] To prevent relapse and continued misuse of opioids and other drugs,

treatment must begin during incarceration and be sustained upon release. However, only a small percentage of inmates receive treatment while incarcerated.[76]

A substantial and growing number of individuals in the justice system have SUDs/OUD and co-occurring mental disorders.[78] When mental illness is combined with SUDs or OUD, the likelihood of recidivism and failure in correctional rehabilitation is greatly increased.[78] Roughly 20 percent of incarcerated individuals and individuals on probation and/or parole suffer from a serious or persistent mental health disorder.[77] When SUDs and mental health disorders co-occur, the continued symptoms of one disorder are likely to precipitate relapse in the other.[77] For example, a person recovering from an SUD who continues to experience depression has an elevated risk for relapsing. Conversely, a person recovering from depression who continues to use substances is likely to experience a resurgence of depression.[77]

Despite demonstrated evidence-based benefits of OUD treatment, individuals in the criminal justice system often do not receive the care they need as a result of limited funding, resources, and stigma.[79] Rather than affording opportunities for screening, diagnosis, and referral to treatment, justice involvement often impedes rather than promotes improved clinical outcomes. Despite the effectiveness of MOUD, in 2018, only 14 states offered methadone or buprenorphine maintenance in any of their jail or prison facilities, 39 offered injectable naltrexone as a preventative measure prior to release, and only Rhode Island offered all three Food and Drug Administration (FDA)-approved medications for OUD.[77] Individuals transitioning from jail back to the community are also negatively affected by opioid use and a lack of evidence-based treatment, with approximately 75 percent of individuals relapsing during their first ninety days.[77] Efforts are rarely made to ensure that incarcerated individuals being integrated into society have access to evidence-based treatment plans, which ultimately only increases the vulnerability of this population.[80]

Intimate Partner Violence

Intimate partner violence (IPV) plays a critical role in the development and the exacerbation of mental health and SUDs; thus, the connection between IPV, substance use, and mental health is an essential area to address.[81] Research indicates that survivors of IPV are at a greater risk for depression, PTSD, and suicide.[81] Survivors of IPV often use substances to cope with emotional trauma, and they may also be coerced into using substances by an abusive partner, who might sabotage their recovery and use their substance use as a means of control.[81] According to a 2012 survey conducted by the National Domestic Violence Hotline, 15 percent of women reported that they tried to get help for SUD, and of those individuals, 60 percent reported that their current or previous partner tried to prevent or discourage them from getting that help.[81]

Together, OUD and IPV create a synergistic effect that leads to poor health and psychosocial outcomes in women in rural communities.[82] Women in rural areas often experience difficulties when trying to access safety and recovery programs, which complicates removing women from abusive situations.[82] A 2020 study that examined IPV and OUD in rural Vermont found substantial barriers to accessing needed services.[82] Geographic isolation, transportation difficulties, inaccessibility of existing services, lack of integrated SUD treatment and domestic violence services, social isolation, and amplification of stigma in small rural communities prevented women from receiving much-needed care for IPV and OUD.[82] To better support rural populations experiencing IPV and OUD concurrently, researchers recommend increasing access to care that encourages collaboration between IPV and substance use service providers.[83]

Measurement Priorities in Polysubstance Use Involving Opioids and Behavioral Health Conditions

Identifying Measurement Gaps and Priorities

To identify current measurement priorities for addressing overdose and mortality resulting from polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions, the Committee reviewed the existing measurement landscape, which is summarized in NQF's Environmental Scan Report. Committee members then identified care and measurement gaps to inform the measurement framework. To identify the gaps, Committee members categorized the key engagement points—both within and outside of health—for individuals with SUDs/OUD and co-occurring behavioral health conditions. Through a series of web meetings, Committee members identified these critical engagement points by identifying the population and key subpopulations most impacted by substance use and behavioral health conditions. The three subpopulations identified by the Committee included individuals with SUDs, individuals who use drugs for recreational use, and individuals who are prescribed opioids for pain management. Committee members had robust discussions about how each of these subgroups interact with the healthcare system, what the critical engagement points are at the point of care, and what measure concepts could best capture these aspects. Committee members also discussed notable structural changes needed to allow for successful measurement across the subgroups.

Building on the Committee's discussion, Committee members completed a measurement gap prioritization survey to prioritize a list of measure gap areas and potential concepts based on five criteria:

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

The results of the prioritization survey, which are included in Appendix D, are intended to inform decisions on measures and measure concepts that should be developed to address challenges with co-occurring opioid use, polysubstance use, and behavioral health conditions.

Measurement Priority Gap Areas for the Measurement of Polysubstance Use and Concurrent Behavioral Health Conditions

NQF identified the key priority gap areas to address polysubstance use and co-occurring behavioral health conditions through the results of the environmental scan, measurement prioritization survey, and Committee web meeting discussions. Key gap areas included all-payer measures; measure concepts about coordination across settings and providers; harm reduction strategies; person-centeredness and recovery; and linkages to appropriate, evidence-based treatment for SUDs/OUD. Committee members also highlighted gap areas relating to equity, SDOH, and priority populations, including youth and individuals involved in the criminal justice system.

All-Payer Measures That Address Opioid Use, Misuse, and Behavioral Health Conditions

While quality measures independently exist related to opioid use, misuse, and behavioral health, there is a dearth of all-payer quality measures related to the intersection between substance use, including SSSOs, and behavioral health conditions. Quality measures are needed to benefit individuals with SUDs/OUD and co-occurring behavioral health conditions, considering that comorbidity is the rule rather than the exception in behavioral healthcare. While patients with SUDs, comorbid mental illness, and an overdose history are disproportionately covered by Medicaid, the rates of these conditions are increasingly prevalent among individuals with commercial and Medicare plans.[84–88] A coordinated measurement framework is needed to address gaps in all-payer measures that address the overlap between substance use and behavioral health conditions.

Measures and Measure Concepts That Encourage Care Coordination and Collaboration Across Settings, Providers, and/or Nonmedical Professionals

Committee members highlighted the lack of measures and measure concepts that encourage care coordination and collaboration across settings, providers, and/or nonmedical professionals as a critical gap area. Individuals with polysubstance use involving SSSOs who have co-occurring behavioral health conditions may engage multiple medical and nonmedical professionals to support their care, and coordination across these groups is critical. Individuals who use drugs and/or have SUDs also utilize social, health, and community services in nonmedical settings. The ED is both an entry point for high-intensity medical care and a source of referrals for community-based programs. However, many people with SUDs are quickly discharged from the ED without comprehensive evaluations by behavioral health specialists and without being successfully linked to care in the community. Strengthening affiliations and referral networks between traditional healthcare settings and community-based services could improve the identification and engagement of high-risk persons through comprehensive care.

Recognizing that both nonmedical professionals and nontraditional settings play key roles, the Committee emphasized that quality measurement must go beyond the traditional scope of healthcare entities to support optimal care. For example, measurement must support coordination with community-based organizations, outreach programs, and the criminal justice system.

Measures and Measure Concepts That Support Harm Reduction Strategies

The Committee also prioritized measures and measure concepts that support harm reduction strategies. Current quality measures do not include harm reduction strategies, such as the distribution of naloxone, the use of fentanyl test strips, and/or syringe service programs. Committee members identified the co-prescription of naloxone as a critical gap area, especially for high-risk individuals. While harm reduction strategies have gained attention and momentum in recent years, some states or localities may have regulations that limit the use of these programs. Committee members discussed how these regulations present a challenge to the access, use, and measurement of harm reduction programs.

Measure and Measure Concepts That Link Individuals to Evidence-Based SUDs/OUD Treatment

The current quality measure landscape does not incorporate measures that assess linking individuals with polysubstance use and behavioral health conditions to evidence-based SUDs/OUD treatment and care. While some measures exist that focus on a subset of this population, measures that address the specific population of interest are lacking. The Committee highlighted how quality measures do not focus exclusively on linking individuals to evidence-based treatment (e.g., MOUD), and measurement

that is focused on follow-up after an overdose to link individuals with behavioral health conditions to MOUD is a notable gap area. This gap is further magnified when looking at priority populations, such as those involved in the criminal justice system.

Measures and Measure Concepts Recognizing High-Risk Populations

In identifying measurement priorities for individuals with polysubstance use and co-occurring behavioral health conditions, the Committee prioritized measures that encompass high-risk populations. Current quality measures do not explicitly address specific high-risk populations, including youth, individuals with SDOH factors (e.g., unstable housing, low income, unsafe neighborhoods, and substandard education), and individuals involved in the criminal justice system.[89] Committee members identified specific gap areas for these populations, such as measuring youth access to naloxone and referrals to specialized treatment. Multiple measurement priorities arose related to incarcerated individuals, particularly regarding timely access to MOUD, successful linkages to community providers post-release, and continuous insurance coverage.

Measures and Measure Concepts Focused on Person-Centeredness

Individuals with SUDs/OUD and co-occurring behavioral health conditions do not follow one central path to recovery, as each individual is on their own journey towards recovery and well-being. Committee members identified measures focused on person-centeredness and recovery as a critical gap area for this population. Developing measures that assess whether a patient is achieving recovery; improving their quality of life; and attaining their personal, functional, and other goals is a current gap area that, if addressed, would help stakeholders identify whether improvements are being made through the current plans of care. This is a challenging task, as recovery can look very different for each individual and often requires several years—if not an indefinite time period—of treatment. Opportunities exist for stakeholders to build on current initiatives focused on indicators for person-centered care plans.[90]

Monitoring for Potential Unintended Consequences, Impacts on Quality, and Outcomes

When discussing measurement priorities, Committee members highlighted the need to monitor for potential unintended consequences (e.g., increased stigma, reduced access to care and treatment services, and decreased access to necessary opioid therapy), impacts on quality, and health outcomes. As measurement efforts evolve, stakeholders who analyze measures must pay special attention to any unintended consequences that may arise. This is especially important for vulnerable populations, as population-based approaches can inadvertently exacerbate disparities in healthcare.[91] Monitoring for potential unintended consequences is critical for measurement regardless of a measure's use, as measures that are used for either quality improvement or accountability can have unintended consequences.

Committee members discussed how addressing polypharmacy is critical for individuals with polysubstance use involving SSSOs; however, there are risks for unintended consequences and outcomes related to measuring polypharmacy. Measurement for polypharmacy should focus on linkages to care, shared data, and data integration rather than the reduction of co-prescribing rates. If measurement takes a narrow lens to solely focus on reducing polypharmacy, individuals who require multiple medications for the management of complex medical and behavioral health conditions may experience stigma, decreased quality of care, and even harm from abrupt tapers or treatment abandonment if using prescription medications.[92] While some patients require the co-prescription of

several classes of medications, poorly monitored medication regimens, especially across multiple treatment settings without unified electronic health record (EHR) systems or with poor communication, can introduce increased risk of patient harm, particularly in situations in which medication dosing escalates over time. Efforts are needed to improve care coordination and communication across disparate treatment settings.

Given the lack of existing quality measures related to individuals with SUDs/OUD and co-occurring behavioral health conditions, the Committee prioritized focusing on measures and measure concepts related to equitable access and care rather than identifying specific measure concepts that measure unintended consequences. Stakeholders can use measure concepts included in this Framework Report to identify baseline rates and improvement. The information gathered from the measure concepts proposed in this report can be used to understand the impacts on outcomes and quality and can serve as a precursor to the development of specific measures focused on monitoring for unintended consequences.

Mortality Resulting From Polysubstance Use (e.g., psychostimulants laced with fentanyl)

One of the fundamental drivers of the fourth wave of the opioid crisis is that overdose events and fatalities involving opioids are now occurring among individuals who do not identify as people who use opioids. Specifically, these opioid-related overdoses are increasingly occurring among people who use psychostimulants that acquire drugs, such as crystal methamphetamine and cocaine, on the illicit market that are adulterated with SSSOs or other compounds.[93] This often occurs without the end user's awareness. Because individuals who use stimulants do not necessarily have a tolerance to opioids, they are especially vulnerable to respiratory suppression from exposure to SSSOs, even with a single episode of use. Thus, the final measurement priority is to continue measuring mortality resulting from polysubstance use to understand implications of the current, and any future, waves of the opioid crisis. To increase available data that can be used for improving the accuracy of the true burden and underlying combinations of polysubstance use that led to death, opportunities exist to further incentivize and modernize the U.S. death reporting system.

Measurement Framework Guiding Principles

A measurement framework organizes ideas that are important to measure and describes how measurement should take place. These five overarching guiding principles represent cross-cutting themes and critical considerations for using the measurement framework to help overcome and address overdoses and mortality resulting from polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions. The guiding principles each connect back to the measurement framework by either linking to a specific domain or subdomain or promoting actions that can facilitate the implementation of the framework. Stakeholders should consider the following guiding principles when using the framework to guide their measurement activities:

- Promote health equity
- Reduce stigma
- Emphasize shared decision making and person-centeredness
- Encourage innovation
- Ensure intentionality in measure development and implementation

Promote Health Equity

Health equity is the attainment of the highest level of health for all people.[94] Promoting health equity includes raising awareness and creating systems to help account for and address population-level factors, which have a greater impact on health outcomes than individual-level factors.[94] The promotion of health equity is a foundational guiding principle for this measurement framework because it recognizes the subset of vulnerable populations (e.g., individuals with social risk factors or criminal justice involvement) who are at a higher risk for SUDs/OUD and co-occurring behavioral health conditions, and ultimately overdose.[53,76] Through this principle, the Opioids and Behavioral Health Committee is elevating the need to capture and measure barriers to care, including social risk factors, that impact vulnerable populations with SUDs/OUD and co-occurring behavioral health conditions. To promote health equity, the field should continuously reassess measure specifications to ensure they can provide information on any new vulnerable populations that might have been missed during the first creation of the measure (e.g., stratification by age, gender, sexual orientation, and income level). As a guiding principle, health equity becomes the lens through which healthcare systems and payers promote better care and reduce overdose and mortality. This guiding principle aligns with the Equitable Access domain, which provides a concrete way to measure and address disparities that patients, in particular vulnerable populations, face when accessing SUDs/OUD and mental healthcare services.

Reduce Stigma

Stigma creates a fundamental barrier in the provision of quality care for individuals with SUDs/OUD and co-occurring behavioral health conditions. Healthcare settings must recognize stigmas and biases that exist towards patients, evidence-based treatment methods, and prevention strategies. Stigma can present itself at various points in an individual's care pathway. Providers may have biases or assumptions based on a patient's payment method, medical history, or reported medical history, which can impact their decision making. In addition to recognizing internal systemic biases, healthcare systems must acknowledge and consider the stigma that patients themselves face from those around them. This guiding principle aims to influence the use of the measurement framework to overcome stigma by measuring and assessing care points in which individuals with SUDs/OUD and co-occurring behavioral health conditions may experience stigma, including accessing care, receiving evidence-based interventions and harm reduction services, and/or during care transitions. Although stigma is a complex area to evaluate, the Committee agreed it was important to measure stigma through patient-reported outcomes or by assessing stigma-related unintended consequences. By measuring stigma across the three domains of the framework, healthcare providers may understand gaps in their care provision and ultimately improve their approach to care.

Emphasize Shared Decision Making and Person-Centered Care

Person-centered care builds on the principles of health equity and stigma reduction. Understanding an individual's previous traumas, informed decisions, and desires regarding the provision of their care and SUDs/OUD treatment choices is critical for achieving optimal health outcomes and ultimately reducing mortality. Person-centered care should also incorporate elements of trauma-informed care, which aims to understand a patient's life situations, both past and present, to make informed decisions. Given the high prevalence of trauma among patients in behavioral health settings, it is important for clinicians to recognize how long-ago traumas can continue to impact patient functioning and decision making. *Shared decision making* is defined as a process of communication through which providers and patients work together to make optimal healthcare decisions that align with the patients' goals.[95] Shared

decision making aims to achieve person-centeredness by promoting clear communication, tailoring evidence to individual patients, and placing value on a person's informed goals, preference, values, and concerns.[95] Person-centered care can help providers understand the drivers that lead a particular patient to use opiates and identify harm reduction strategies that best fit the patient's risk profile. This guiding principle dismantles the idea that abstinence is the only outcome to measure for individuals with SUDs/OUD and co-occurring behavioral health conditions and encourages healthcare organizations to collaborate with advanced harm reduction programs conducted by other community organizations to achieve optimal care. Furthermore, the principle aligns with the person-centered care subdomain and promotes the idea that centering care on a patient's goals and focusing on broader sets of outcomes may lead to better health and a reduction in mortality.[96]

Encourage Innovation

The landscape of behavioral health and SUDs/OUD is rapidly changing and evolving, and measurement should be flexible enough to account for these changes while still promoting standardization. Measurement efforts for SUDs/OUD and co-occurring behavioral health conditions should consider new and innovative approaches to care, including trauma-informed care, evidence-based harm reduction strategies, treatments, interventions, telehealth and remote care platforms, and APMs. This principle recognizes that measure development can be a multiyear process. Additionally, it acknowledges that implementation of the measurement framework can be challenging. However, this principle also encourages health systems and payers to be flexible and to begin implementing internal quality measures and metrics for quality improvement efforts, not just accountability. Innovation should be considered in the formation of partnerships and collaboration models. Healthcare organizations should be innovative in partnering with local harm reduction services or organizations and leveraging the voices of influential community leaders. Innovation should also be applied to data collection efforts to help inform care and treatment approaches for people with SUDs/OUD and co-occurring behavioral health conditions.

Ensure Intentionality in Measure Development and Implementation

To address overdose and mortality resulting from polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions, measure development and implementation must be purposeful and actionable. This principle seeks to expand implementation of the measurement framework by ensuring that future measures are intentional in addressing stigma, promoting health equity and person-centeredness, and encouraging innovation. Measurement efforts should consider the medical interventions they promote, the data they require, the accountability they offer, and the outcomes they aim to derive. Intentional measures consider and recognize differences in healthcare settings and resources. Resource limitations, including staffing shortages, often exist when addressing SUDs/OUD and behavioral health conditions, particularly for healthcare settings that care for vulnerable populations. Measure developers should carefully consider the cost implications and reporting burden that new measures may have on providers, as they may inadvertently dismay providers from wanting to care for patients with SUDs/OUD.

Measurement Framework for Opioids, Polysubstance Use, and Mental Health

Building on the work of the 2019 NQF Opioid TEP and the current Committee's environmental scan and measurement gap prioritization exercise, NQF and the Committee developed a measurement framework to address overdose and mortality resulting from polysubstance use among individuals with co-occurring behavioral health conditions. The development of a measurement framework for opioids, polysubstance use, and mental health is a critical step to organizing existing measures, measure concepts, gaps, and opportunities to improve care for individuals with polysubstance use and co-occurring behavioral health conditions. Current measurement efforts tend to focus on portions of this population, such as those with OUD or behavioral health diagnoses, and notably, the environmental scan found no conclusive evidence of any quality measures that directly address polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions.[97] However, given the relationship between behavioral health conditions and substance use, it is essential to move to a comprehensive measurement approach that holistically looks at the intersection of behavioral health and substance use.

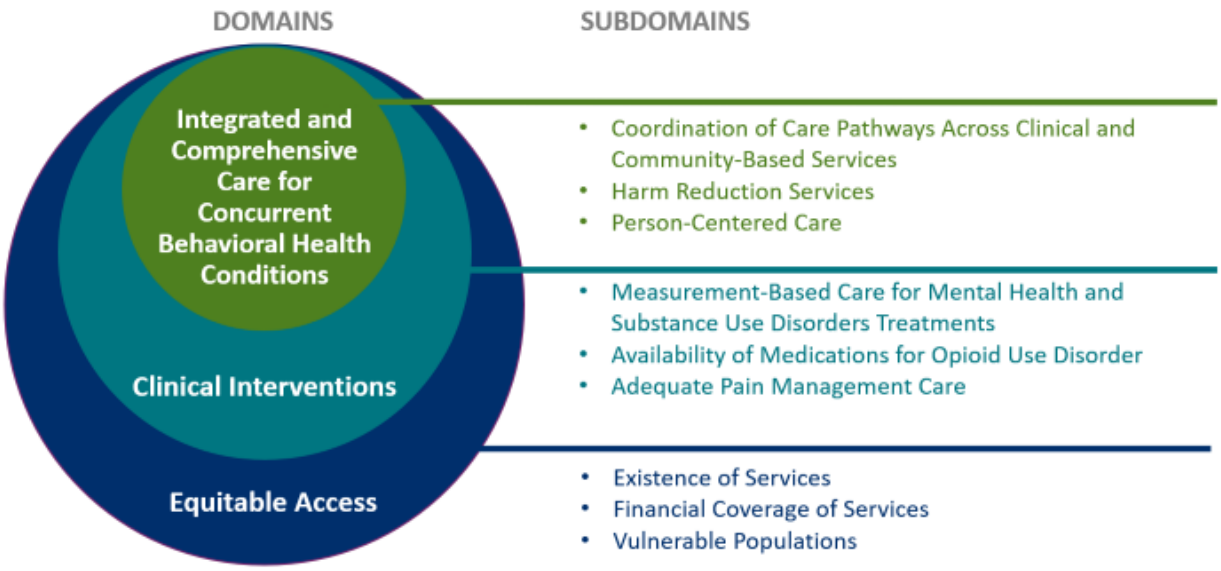
The measurement framework, as shown in Figure 2, includes three domains and nine subdomains. NQF and the Committee identified the three domains of Equitable Access, Clinical Interventions, and Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions by categorizing existing measures, measure concepts, and the results of the measurement gap prioritization exercise into key themes. Each subdomain ties directly to the identified measurement gap areas, identifying potential measure concepts to move the field forward. The framework both references and links to applicable NQF-endorsed measures using NQF's measure-numbering convention and system. Once the three domains were identified, Committee members discussed critical subdomains and areas for measurement within each domain area. Each subdomain represents the key components to measure within the overarching domain area to ensure comprehensive performance measurement for this population.

When discussing the measurement framework, the Committee emphasized the relationship between the three domains (i.e., Equitable Access, Clinical Interventions, and Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions) and decided upon a concentric circle approach. The outermost domain, Equitable Access, is a foundational and essential component to improving outcomes and addressing mortality, and it is critical to support people in having access to evidence-based clinical interventions and harm reduction services. Equitable Access is the broadest part of the measurement framework since access alone is insufficient for connecting individuals to evidence-based clinical interventions and comprehensive care with high quality services. The middle layer is the Clinical Interventions domain. Once people have access to evidence-based care, it is essential for providers to offer clinical and community-based interventions, as well as other types of interventions that improve health, address overdose, and reduce mortality resulting from polysubstance use in individuals with co-occurring behavioral health conditions. High quality care often exists in silos, and for an individual to receive optimal care and clinical interventions, they must receive person-centered, integrated, and comprehensive care across clinical and community-based services. Thus, the innermost circle is the Integrated and Comprehensive Care of Concurrent Behavioral Health Conditions domain. The Committee agreed that a measurement framework must convey the connected relationship between the three domains to demonstrate that it is essential for stakeholders to build on a foundation of

equitable access and evidence-based interventions to support integrated and comprehensive care and achieve optimal outcomes.

For each of the domains and subdomains within the measurement framework, the Committee identified multiple measure concepts. As measurement for individuals with SUDs/OUD and co-occurring behavioral health conditions remains an evolving area, measure concepts and approaches included within the framework range in their level of evidence, research, and science. Measure developers can use the suggested concepts to inform the development and testing of new clinical quality measures. Any measure concepts included in the framework should be fully specified, developed, and tested before full implementation. Notably, many of the measure concepts identified by the Committee are structural or process measures. Despite the growing movement towards outcome measures, the lack of existing quality measures for the population of interest makes it challenging to begin with outcome measures. While some of the subdomains naturally focus more on outcomes and patient-reported outcome measure (PROM) concepts, such as the person-centered care subdomain of the Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions domain, other subdomains naturally include more process-oriented measure concepts to ensure a solid foundation of measurement is in place. A natural measurement progression begins with process measures, with the ultimate goal of evolving to a quality measurement landscape that focuses on outcomes measures, including PROMs.

Figure 2. Measurement Framework to Address Overdose and Mortality Resulting From Polysubstance Use Among Individuals With Co-occurring Behavioral Health Conditions



Equitable Access

The Committee agreed that 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. Equity is a critical area of focus, given that mortality associated with polysubstance use with SSSOs in individuals with behavioral health conditions is increased when SDOH-related factors are present.[97,98] NQF defines *equitable access* as the ability for individuals with social risk factors to easily get care that is affordable, convenient, and able to meet their social risk factor needs.[99]

For individuals with polysubstance use and co-occurring behavioral health conditions, equitable access refers to affordable and convenient prevention, treatment, and recovery services, including clinical interventions, community-based services, and harm reduction services, that advance equity and quality for all, especially priority populations. Stigma can be a barrier for individuals obtaining needed treatment for SUDs/OUD and other behavioral health conditions, and thus, ensuring equitable access to these services can help reduce stigma.[100,101] This is particularly important for harm reduction strategies and MOUD, as sometimes, individuals engaged in abstinence-only treatment programs face stigma when exploring other evidence-based treatment strategies (e.g., MOUD).

Disparities exist across racial and ethnic groups, as well as by geographic location, in access to evidence-based SUDs/OUD treatment, and especially for access to buprenorphine-waivered providers.[102,103] Certain demographic risk factors related to gender, age, race, and ethnicity decrease the odds of individuals with co-occurring mental illness and OUD receiving mental health treatment in the past year, including identifying as the male sex, 18–25 years of age compared with over 35 years of age, and non-Hispanic Black or non-Hispanic other compared with non-Hispanic White.[104] Without equitable access to best-practice programs and services, individuals cannot obtain the services that exist to support better health outcomes and a reduction in overdoses. Equitable access also extends past the clinical setting, ensuring that individuals with SUDs/OUD have access to community-based services that can help them begin and maintain recovery.[105] In its discussions about access to care, the Committee identified three key subdomains to measuring access to services: existence of services, financial coverage of services, and vulnerable populations. Potential measure concepts related to each subdomain are included in Table 1.

Existence of Services

When discussing how to measure the existence of services, the Committee identified that measuring both the availability and accessibility of services is critical to improving outcomes for individuals with co-occurring behavioral health conditions. This subdomain measures whether services that support individuals with polysubstance use and behavioral health conditions exist and are accessible. To measure the existence of services, measure concepts could assess whether a given service exists in a particular region. Measure concepts may include measuring individuals' access to and quality of a range of pain management treatments or the ability of individuals to receive nontraditional care services that are particularly important for individuals with co-occurring behavioral health conditions, such as peer supports, care coordination, and/or transportation support. Accessibility of services builds on the existence of services, and measure concepts could expand further to assess whether the service that exists is truly accessible from a resource and/or feasibility perspective, including whether services are language-accessible to various groups and are culturally appropriate. Measurement considerations should incorporate access challenges that rural populations may face, such as limited internet services and extended driving distances. Over 40 percent of U.S. counties do not have a single buprenorphine-waivered physician, and these counties are disproportionately rural and frontier counties.[106,107] The existence of care services alone will remain inadequate for rural populations when people lack transportation, access to internet, or phone service, and/or have other barriers to care.

Financial Coverage of Services

While the existence of services is an essential component to improving access, Committee members discussed the financial coverage of services as a notable measurement area. This subdomain measures

whether affordability is a barrier for individuals accessing needed services. Measurement can serve as a mechanism and tool for parity requirements, as well as to promote affordable behavioral healthcare coverage for health plan enrollees. Uninsured individuals with SUDs/OUD and co-occurring mental illness have lower odds of receiving mental health treatment within the past year when compared with individuals with private or other insurance.[104] Reimbursement structures and benefit design may unintentionally limit the ability of individuals to access needed services, and measurement opportunities exist to ensure parity between physical healthcare, mental healthcare, and SUDs/OUD treatment services. Measure concepts for measuring the affordability of services include measuring insurance reimbursement for social work services to address SUDs/OUD and behavioral health treatment.

Vulnerable Populations

Health outcomes are often the result of a combination of clinical, demographic, and social risk factors; thus, it is essential to include and understand SDOH and priority; vulnerable populations when identifying quality measures for individuals with polysubstance use, including SSSOs; and co-occurring behavioral health conditions. This subdomain measures whether populations are equitably able to access needed services, including treatment for SUDs/OUD, and whether affordability is a barrier to accessing care. While the previous subdomains extend to the general population, this subdomain emphasizes the importance of emphasizing and measuring access through an equity lens. As identified earlier, these populations include youth, individuals experiencing homelessness, those involved in the criminal justice system, and Veterans, among others.[53]

This subdomain recognizes that disparities in access, treatment, and financial coverage exist across racial and ethnic groups and that certain groups of individuals are at a higher risk of not receiving adequate care.[102,103] Research shows that Black patients are half as likely to obtain follow-up appointments for OUD following release from the ED.[108] Despite an increase in the use of buprenorphine for OUD, research shows that it remains primarily accessible to Whites and beneficiaries of employer-based insurance, further magnifying health inequities.[108] Poverty and substance use, combined with untreated mental health conditions and unstable housing, can lead to an increase in OUD in underserved communities.[109] Despite the importance of SDOH for individuals with polysubstance use and co-occurring behavioral health conditions, there is a lack of existing quality measures that address access and financial coverage for vulnerable populations.

The Committee discussed critical measure gap areas related to equitable access and financial coverage, especially for individuals involved in the criminal justice system and those with social risk factors, including with poverty, unsafe housing, and homelessness. Individuals involved in the criminal justice system represent an additional population in which SDOH play a critical role, and Committee members noted how individuals are at a critical transition point when being released from jail or prison. Quality measures that identify whether these individuals have access to core needs, such as housing and food, when released from incarceration will help to promote health equity. Committee members discussed stigma as an access issue, especially for access to harm reduction services and MOUD. Opportunities also exist to measure whether health plan coverage—including both referrals and access to SUDs/OUD and mental health services—is in place immediately after an individual is released from incarceration.

Lastly, Committee members identified young individuals as a vulnerable population for the development of co-occurring SUDs/OUD and mental health disorders. To effectively prevent drug use and/or SUDs/OUD in youth, it is vital that young people have access to the appropriate care and interventions

where they can be screened for anxiety, depression, trauma, and other mental health concerns. Timely access and coverage can help to support children and adolescents in their development of coping skills to preempt reliance on substances.

Table 1. Examples of Measure Concepts for Access

Measure Concept Description	Subdomain
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)	Existence of Services
Percentage of individuals with access to holistic pain management (e.g., physical therapy, occupational therapy, integrated care, and complementary care)	Existence of Services
Percentage of individuals who reported having access to information in their preferred language, including through modalities appropriate for patients with vision and hearing impairments (e.g., sign language)	Existence of Services
Percentage of individuals with SUD/OUD and mental health conditions who receive case management services that are covered	Financial Coverage of Services
Percentage of individuals released from incarceration with insurance coverage in place that includes SUD/OUD and behavioral health services immediately post-incarceration	Vulnerable Populations
Percentage of adult individuals leaving incarceration with fully reinstated insurance coverage (e.g., Medicaid)	Vulnerable Populations
Percentage of adult individuals leaving incarceration and seeking support for health-related social needs (e.g., housing, food) who received access to services within seven days of release	Vulnerable Populations
Percentage of adult individuals leaving incarceration with SUD/OUD and mental health disorders who obtain wrap-around support within seven days of release	Vulnerable Populations

Clinical Interventions

Building on a foundation of accessible and equitable care, stakeholders can address overdose and mortality resulting from polysubstance use among individuals with co-occurring behavioral health conditions through appropriate, evidence-based clinical interventions. The Committee discussed the close relationship between the subdomains in the Clinical Interventions domain and the other domains, as having access to equitable care is critical to address overdose and mortality for this population. The Committee identified three key subdomains to measuring clinical interventions for individuals with co-occurring behavioral health conditions: (1) MBC for mental health and SUDs/OUD treatment, (2) availability of MOUD, and (3) adequate pain management care. Potential measure concepts related to each subdomain are included in Table 2.

Measurement-Based Care for Mental Health and SUDs/OUD Treatment

This subdomain 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. MBC is an approach to care in which clinical care is based on data collected through patient- or clinician-administered structured assessments of treatment response.[110] Current quality measures related to MBC focus on individuals with either SUDs/OUD or behavioral health conditions; however, quality

measures related to MBC for individuals with SUDs/OUD and co-occurring behavioral health conditions are lacking.

More specifically, providers can measure behavioral health outcomes using scales such as the Montgomery-Asberg Depression Rating Scale (MADRS) or the Patient Health Questionnaire-9 (PHQ-9) to assess depression or anxiety symptom burden with a demonstrated response to treatment within a given time frame. Providers can measure alcohol or drug use disorder outcome response with a standardized screening tool during treatment, such as the 17-item Brief Addiction Monitor (BAM) pioneered by the Veterans Health Administration (VHA). Measurement opportunities exist for assessments that focus on the convergence of these conditions to evaluate whether individuals are moving towards recovery.

MBC has become a high-profile topic in the behavioral healthcare field, considering that providers are moving towards MBC; however, skepticism exists in the SUD treatment field related to the feasibility and reliability of scales that can reflect disparate patient outcomes, given the wide range of individual experiences with SUDs. Notably, The Joint Commission's outcome measure standards for behavioral healthcare and human services include the use of MBC to assess patient outcomes.[111] This tension reflects the need for and growing interest in MBC for patient outcomes for individuals with behavioral health conditions. While there are widely accepted scales to measure response to treatment for mental health conditions in clinical and research settings, the field has struggled to develop scales that reflect recovery from SUDs. The measurement tools that currently exist (e.g., the BAM, Brief Assessment of Recovery Capital [BARC-10]) assess responses to SUD treatment and focus on improvement in positive benefits (e.g., treatment team alliance, coping skills), as well as assessing reductions in distress (e.g., depression symptoms, feelings of hopelessness).[112,113]

Opportunities exist for MBC to assess patient progress over time. While the long-standing Addiction Severity Index (ASI) is widely used in specialty addiction treatment settings, it can be cumbersome and time consuming to administer, and it was not intended for serial administration to reflect the response to treatment as MBC requires. Notably, VHA is now undergoing efforts to create a shorter version of the BAM to facilitate frequent serial administrations to track patient progress in the outpatient addiction treatment setting. While efforts persist for unifying the field on MBC for SUD treatment, the challenges are even greater for populations that have high levels of psychiatric comorbidities alongside of SUDs.

Availability of MOUD

This subdomain focuses on the availability of MOUD, including injectable forms of MOUD. MOUD encompasses three classes of pharmacotherapy: (1) methadone, (2) buprenorphine, and (3) naltrexone (i.e., oral naltrexone and long-acting injectable naltrexone) products. Despite being a highly effective, evidence-based treatment, MOUD are greatly underused in the U.S. compared with other nations.[114–116] Stigma can be a barrier to the availability of MOUD, as healthcare providers may hold stigmatizing attitudes or unconscious bias towards individuals with SUDs and/or OUD, and such stigma may reduce the likelihood of providing MOUD.[117] Additionally, disparities in access to MOUD have an impact on the SUD treatment landscape at the population level. For instance, while low-income urban communities of color are disproportionately likely to attend daily methadone programs, buprenorphine is primarily used by White individuals with employer-based insurance or in Medicaid in Affordable Care Act (ACA) expansion states.[118, 102,103] Measurement approaches highlighting initiation and retention with MOUD should include disparities-sensitive measures to further highlight quality gaps across populations

focusing on demographics and regionality. Including disparity-sensitive measures is an important way for stakeholders to identify and address disparities. Additionally, the lessons learned from improving MOUD equity can inform structural changes that support making future pharmacotherapies available in an equitable manner to vulnerable populations. As one example, access to injectable, extended-release forms of MOUD remains challenging for many populations, and opportunities exist for stakeholders to leverage measurement related to MOUD to identify mechanisms for scaling access to these injectable forms of both buprenorphine and naltrexone.

The Committee discussed critical junctures in which populations interact with the healthcare or social supports system that could initiate MOUD. Existing measures related to MOUD include NQF #3400 *Use of Pharmacotherapy for OUD*, NQF #0004 *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*, and NQF #3175 *Continuity of Pharmacotherapy for OUD*. While these measures do assess initiation, engagement, and/or retention of SUDs/OUD treatment with pharmacotherapy, they do not address comorbidity. The Committee discussed measure concepts that incorporate MOUD for individuals with co-occurring behavioral health conditions. Measure concepts arising from this Committee discussion included the percentage of individuals with behavioral health conditions screened for SUDs/OUD, with MOUD initiated in the ED and/or inpatient hospital setting. The Committee discussed the need for stakeholders to follow up with a patient with a behavioral health condition after an ED or inpatient visit for SUDs/OUD and identified measure concepts related to following up with MOUD within seven days after an SUD/OUD visit.

Due to the recognition of the disparities in access to MOUD, opportunities exist to both initiate MOUD, and in some circumstances, stabilize a patient on a therapeutic maintenance dose prior to discharge from a healthcare or criminal justice setting. Measure concepts could include the percentage of individuals screened for SUDs/OUD with MOUD initiated during incarceration, percentage of individuals inducted and stabilized on a therapeutic dose of MOUD for a minimum of 30 days before their release from incarceration, and MOUD follow-up within seven days after an individual with SUD/OUD is released from incarceration.

Adequate Pain Management Care

This subdomain focuses on measuring 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. Opioids are often prescribed to treat acute and chronic pain. While this subdomain focuses specifically on individuals with SUDs/OUD and co-occurring behavioral health conditions, it is important that all patients with pain participate in shared decision making and experience appropriate, evidence-based pain management approaches. Healthcare providers should partner together with their patients to identify the most appropriate treatment plan for a given patient based on their needs, values, goals, preferences, concerns, and risks. Opioid use risks are magnified for individuals with a history of SUDs and for those with other risk factors, such as recreational drug use and/or mental illness. Current quality measures do not take into account the unique treatment needs of individuals with SUDs/OUD and co-occurring behavioral health conditions.

The Committee identified that prescribing guidelines for opioids are insufficient for addressing the needs of individuals with SUDs/OUD and co-occurring behavioral health conditions. Examples of existing measures related to prescribing practices include NQF #3558 *Initial Opioid Prescribing for Long Duration*

and NQF #2940 *Use of Opioids at High Dosage in Persons Without Cancer*. The Committee discussed the need to measure evidence-based care related to pain management and described potential measure concepts for individuals with SUDs/OUD and behavioral health conditions to build on existing guidelines, including the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain, to reduce risks of polysubstance use. Possible measure concepts included the percentage of individuals with a documented holistic care plan, the percentage of providers implementing and documenting a risk-benefit analysis as part of treatment plan management, and the percentage of patients with an appropriate tapering plan for the careful discontinuation of opioids when warranted.

Table 2. Examples of Measure Concepts for Clinical Interventions

Measure Concept Description	Subdomain
Improvement or maintenance of functioning for all patients seen for mental health and substance use care	Measurement-Based Care for Mental Health and SUD/OUD Treatment
Improvement or maintenance of functioning for dual-diagnosis populations (e.g., through use of the BAM, Patient-Reported Outcomes Measurement Information System [PROMIS])	Measurement-Based Care for Mental Health and SUD/OUD Treatment
Percentage of individuals with SUD/OUD and a co-occurring mental health condition identified as having social risk factors (e.g., food insecurity, transportation insecurity, and homelessness) who have demonstrated improvement in clinical status within a given time frame	Measurement-Based Care for Mental Health and SUD/OUD Treatment
Percentage of individuals with identified SUD/OUD and mental illness with MOUD initiated in the ED	Availability of MOUD
Percentage of individuals with identified SUD/OUD and mental illness (e.g., through screening) with MOUD initiated during incarceration	Availability of MOUD
Percentage of individuals inducted and stabilized on a therapeutic dose of MOUD before release from incarceration	Availability of MOUD
Percentage of patients with chronic pain who received holistic care from a primary care or other provider before being referred to a specialty pain provider	Adequate Pain Management Care

Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions

The Committee agreed that integrated and comprehensive care is a critical domain for measuring the care and outcomes of individuals with polysubstance use and co-occurring behavioral health conditions. Coordination across care settings and collaboration across providers—both those in the medical system and outside of the medical system—are essential to improving outcomes; yet current measurement approaches do not always reflect the importance of integrated care, especially for individuals with

polysubstance use and behavioral health conditions. Furthermore, by recognizing the intricate relationship between SDOH, SUDs/OUD, and behavioral health conditions, measures of integrated and comprehensive care should also acknowledge and incorporate stakeholders outside of traditional healthcare settings. Examples of these stakeholders and settings include housing and employee assistance programs, health literacy efforts, educational settings, harm reduction service providers, and the criminal justice system. Harm reduction service providers are an especially important piece of comprehensive care for individuals, and it is essential to include harm reduction services (e.g., syringe service programs, fentanyl test strips) as part of efforts to increase access to services for individuals with polysubstance use and co-occurring behavioral health conditions.

When discussing the population of interest, Committee members identified different engagement points at which individuals may interact with the healthcare system. Given that different subpopulations (e.g., individuals with SUDs, individuals who use drugs for recreational use, and individuals who are prescribed opioids for pain management) interact with the health system in different ways and at different times, the Committee underscored the importance of measuring integrated, comprehensive, and coordinated care that includes nonmedical stakeholders and nontraditional settings. Individuals with polysubstance use, including SSSOs and co-occurring behavioral health conditions, often interact with several medical professionals, including pharmacists, emergency medical technicians, psychiatrists, social workers, physicians, nurses, and others. It is important for quality measures to encompass this wide range of healthcare professionals and include the various settings that these individuals may present, such as EDs, inpatient hospitals, inpatient psychiatric facilities, primary care, Institution for Mental Disease (IMD) facilities, and others. In its discussions, the Committee identified three key subdomains to measuring integrated and comprehensive care: (1) coordination of care pathways across clinical and community-based services, (2) harm reduction services, and (3) person-centered care. Potential measure concepts related to each subdomain are included in Table 3.

Coordination of Care Pathways Across Clinical and Community-Based Services

Care coordination is considered "the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time."[119] Care coordination encompasses effective communication and facilitates linkages between the community and healthcare system.[120] This subdomain 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. Committee members acknowledged that the measure concepts regarding these care pathway aspects—prevention, screening, diagnosis, and treatment—can and should go beyond traditional healthcare settings. Community-based services and care are important mechanisms for improving and maintaining health for individuals with SUDs/OUD and co-occurring behavioral health conditions outside of the traditional healthcare setting. Community-based services, including but not limited to recovery and peer support services, supportive housing and employment services, and case management, are especially important for individuals who return home from residential care, inpatient care, or incarceration.[105] Linkages to employment services are critical, as employment is known to be a key factor in successful recovery for individuals with SUDs and mental illness. It is imperative for community-based service providers, including case managers, physical healthcare providers, and behavioral healthcare providers to have sufficient time to liaise with one another to support care coordination.

Given that individuals who misuse opioids are more likely to suffer from behavioral health conditions than those who do not, measurement opportunities exist to improve screening processes to ensure at-risk individuals are identified and treated properly. Current silos in care delivery and a lack of coordination between SUD treatment services and mental health providers often result in an individual's full behavioral health state not being assessed and identified. Care for mental health and SUDs is often separated across distinct, specialized care settings. Given the close relationship between SUDs/OUD and mental health disorders, it is imperative that individuals in specialized care settings receive comprehensive assessments, a National Institute on Drug Abuse (NIDA) principle of effective treatment. Gaps in screening exist in primary care, SUD treatment settings, and mental health settings. Committee members also emphasized the need for quality measures focused on healthcare organizations and providers screening for homelessness and SUDs as well as measuring the ability to connect individuals experiencing homelessness to appropriate social and community-based programs. Measure concepts could also include measuring the percentage of individuals with known SUDs/OUD who are screened for psychiatric disorders at SUD treatment centers or the percentage of individuals with mental health disorders who are screened for SUDs at mental health centers. The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program includes measures that assess patients with alcohol misuse who received or refused a brief intervention during their inpatient stay and patients who screened positive for an alcohol or drug use disorder during their inpatient stay who either received or refused a prescription for medications to treat their alcohol or drug use disorder or who received or refused a referral for addiction treatment. The IPFQR Program also includes similar measures for individuals who use tobacco. Many of these measures, including TOB-1 Tobacco Use Screening, TOB-2 Tobacco Use Treatment Provided or Offered & TOB-2a Tobacco Use Treatment, TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge, SUB-1 Alcohol Use Screening, SUB-2 Alcohol Use Brief Intervention Provided or Offered & SUB-2a Alcohol Use Brief Intervention, and SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge & SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge, are no longer endorsed by NQF because the developer is retooling these measures to be eCQMs and did not resubmit them for maintenance of endorsement. eCQMs are preferred because they involve lower burden data sources. Once these measures are developed into eCQMs, they can be used as a model for quality measures for this population in settings outside of an inpatient psychiatric facility.

Measure concepts should also focus on care coordination and linkages between specialists, consultants, and community-based services, and in some instances, they can further focus on the role of telemedicine in supporting coordinated care. While continuity of care measures exist for individuals with SUDs/OUD, such as NQF #3453 *Continuity of Care After Inpatient or Residential Treatment for SUD*, there are no existing measures focused on continuity of care for individuals with co-occurring behavioral health conditions. As stakeholders improve screening and coordinated care, there are measurement opportunities to focus on coordination of care for individuals with concurrent behavioral health conditions and to focus on polypharmacy and polysubstance use. Existing measures, such as NQF #3389 *Concurrent Use of Opioids and Benzodiazepines*, provide an example of measuring polypharmacy and can be leveraged as a model to measure other instances of polypharmacy that are particularly relevant for individuals with co-occurring behavioral health conditions, such as concurrent use of opioids and gabapentinoids.[121] Measuring the number of providers who are screening for other substances can help to promote data sharing, integration, and awareness of potential risks for overdose and/or mortality for patients with polysubstance use. Of note, efforts to address polysubstance use should not compromise

or stigmatize care for complex patients who require multiple medications; rather, they should focus on improving communication and data sharing to identify and mitigate potential harm and overdose risks.

Opportunities also exist for measure concepts to assess the appropriate follow-up and treatment transitions after an individual overdoses and to assess whether referrals to appropriate, clinical, and evidence-based treatment programs occur. Existing measures, such as NQF #2605 *Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence*, NQF #3488 *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*, NQF #3489 *Follow-Up After Emergency Department Visit for Mental Illness*, and NQF #0576 *Follow-Up After Hospitalization for Mental Illness*, focus on subsets of the population of interest; however, measuring appropriate follow-up for individuals with SUDs/OUD and co-occurring behavioral health conditions is a gap area. Additionally, many mental health and SUD treatment settings do not thoroughly screen, diagnose, and treat tobacco use disorder over the course of care episodes. The Committee discussed how appropriate follow-up looks different in different communities and described how successful models have engaged social workers and certified peer recovery specialists in conducting outreach and follow-up after an overdose or inpatient admission.

This subdomain also includes concepts about the processes in place to promote coordination between clinical and community-based providers and systems, such as the co-location of mental health and SUDs/OUD treatment services. Individuals who leave the criminal justice system are particularly vulnerable to lapses in care, and opportunities exist to ensure previously incarcerated individuals have a primary care relationship established upon leaving incarceration. Community-based services also offer an important opportunity to support individuals with SUDs/OUD and behavioral health conditions who transition out of the criminal justice system.

Harm Reduction Services

This subdomain highlights opportunities to measure the use and implementation of harm reduction services to reduce overdose and mortality resulting from polysubstance use among individuals with co-occurring behavioral health conditions. Harm reduction activities include practical strategies focused on reducing negative consequences associated with drug use.[122] Over the past several years, stakeholders have begun distributing naloxone to reverse an opioid overdose. Although it is not specific to individuals with SUDs/OUD and co-occurring behavioral health conditions, there is one existing quality measure that assesses the percentage of individuals discharged with naloxone after opioid poisoning or overdose. The Committee identified several potential measure concepts focused on naloxone, such as the percentage of high-risk patients who are co-prescribed naloxone with an opioid prescription, especially with higher-risk prescribing or when opioids are co-prescribed with sedative-hypnotics. The Committee discussed the need to promote youth access to naloxone, which could be accomplished through a school nurse. Committee members also discussed exploring overdose response training and safety planning as a potential measure concept to evaluate whether patients who are co-prescribed naloxone also receive education in overdose prevention and response.

Additional harm reduction strategies include testing for human immunodeficiency virus (HIV) and Hepatitis C and enrolling individuals in assistance programs (e.g., Medicaid, Supplemental Nutrition Assistance Program [SNAP], and MOUD). Other harm reduction strategies that the Committee discussed included measuring the use of syringe services programs and the distribution of fentanyl test strips to people who inject drugs. Of note, harm reduction strategies are often limited by state or local laws, and

the ability of harm reduction strategies to be implemented—and thus measured—may vary based on geographic location and regulations.

Person-Centered Care

Individuals should be at the center of their care, and the Committee identified person-centered care as a subdomain in the integrated and comprehensive care for individuals with polysubstance use and co-occurring behavioral health conditions. Person-centered planning, which is a facilitated, individual-directed, and positive approach to the planning and coordination of a person's services and supports based on individual aspirations, needs, preferences, and values, is central to person-centered care.[123] Providers and patients should use person-centered planning and shared decision making to make informed, person-centered decisions about the most appropriate treatment plan and path to recovery for each individual.[124] Current quality measures related to person-centered care, including NQF #0166 *Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS) *Survey* and NQF #2483 *Gains in Patient Activation Scores at 12 Months*, are not explicitly focused on individuals with SUDs/OUD and co-occurring behavioral health conditions, and there are opportunities to further assess and improve person-centered care for this population. Although the path to recovery may look different for each individual, the Committee identified measures of recovery and quality of life as important measurement opportunities for individuals with polysubstance use and co-occurring behavioral health conditions. Patient-reported outcomes (PROs), such as the ability to achieve functional goals and patient-reported recovery, play an important role in understanding whether treatment is effective for a given individual based on their own unique circumstances and goals. Measuring patient and family engagement and experience also provides an opportunity to assess care approaches for person-centeredness. Opportunities exist to measure the inclusion of the voices of individuals, families, and/or caregivers with lived experience in assessing care for people affected by co-occurring pain, behavioral health, and/or SUDs/OUD to ensure a person-centered perspective is encompassed throughout care approaches.

Table 3. Examples of Measure Concepts for Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions

Measure Concept Description	Subdomain
Percentage of mental health providers who screen for SUD/OUD in behavioral health settings	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of individuals with diagnosed SUD/OUD who are screened for mental disorders in SUD treatment settings	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of providers screening for polysubstance use and polypharmacy (e.g., through a prescription drug monitoring program [PDMP], collateral information from outside providers, or another identified mechanism)	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of individuals with SUD/OUD who are referred to an evidence-based treatment program (e.g., from the ED)	Coordination of Care Pathways Across Clinical and Community-Based Services

Measure Concept Description	Subdomain
Percentage of individuals with SUD/OUD who are referred to a community-based service (e.g., supportive housing and employment services)	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of individuals with SUD/OUD and mental health conditions who receive home and community-based services (e.g., peer support, care coordination, and nonmedical transportation)	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of individuals experiencing homelessness who are connected to social and community-based programs related to their specific social risk needs	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of SUDs/OUD treatment providers with co-located mental health services	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of providers who have a shared/integrated treatment plan between general health and behavioral health providers	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of high-risk patients who are co-prescribed naloxone with an opioid prescription at least once annually	Harm Reduction Services
Percentage of patients with OUD discharged from care episodes (e.g., residential treatment or an inpatient admission) with naloxone	Harm Reduction Services
Patient-reported recovery (e.g., MBC with the BAM or World Health Organization Quality of Life [WHOQOL])	Person-Centered Care
Percentage of behavioral healthcare teams that include individuals with lived experience (e.g., lived experience with a behavioral health condition) on the care team	Person-Centered Care
Percentage of patients who reported that their mental health and SUDs/OUD treatment was coordinated	Person-Centered Care
Patient experience of care for all patients seen for mental health and substance use care	Person-Centered Care

Opioid and Behavioral Health Use Case: Measurement Framework in Action

The Committee created a use case to support the implementation and application of the Opioids and Behavioral Health Measurement Framework. The use case includes three distinct sections that help demonstrate how the framework can be applied to providing and assessing care for individuals with SUD/OUD and co-occurring behavioral health conditions:

- Five critical stakeholders who are significantly affected by existing gaps in care and measurement: patients, providers, payers, measure developers, and policymakers

- The top five overarching barriers and corresponding solutions for implementing the measurement framework: stigma, limited resources, payment, data inconsistencies and limitations, and a rapidly evolving measurement landscape
- Three specific case exemplars, one for each of the framework domains, that depict how the stakeholders can use the solutions to overcome barriers related to measurement of individuals with SUD/OUD and co-occurring behavioral health conditions

The use case allows diverse readers to view the framework and its application through their own unique clinical experiences and perspectives.

Critical Stakeholders

In considering the overarching measurement framework barriers and solutions, the Committee identified five critical stakeholders who are most affected by existing gaps in care and/or can help address measurement across the framework domains and their corresponding subdomains:

- **Patients and their support systems** – Patients are people who need care, regardless of whether they are successful or unsuccessful in accessing it. A patient's support systems can include their immediate family or anyone the patient may choose, including but not limited to friends or colleagues. As showcased by the measurement framework, patients should be at the center of healthcare, as they are the most affected by poor quality services.
- **Providers and allied health professionals** – This stakeholder group encompasses healthcare systems, physicians, nurses, pharmacists, social workers, peer support specialists, community health workers, recovery specialists, and all other clinical and community-based members of a care team a patient may come across. This stakeholder group may also include payers who offer care services (e.g., Kaiser Permanente). A patient's main encounter with the healthcare system is through the care they receive from providers. Providers are often affected by limited resources and challenging payment structures of their healthcare system. However, providers can make a difference in the stigma patients experience and can contribute to the rapidly evolving measurement landscape.
- **Private and public payers** – This stakeholder group constitutes public payers, such as Medicare or Medicaid, private insurance plans, and large employer groups, as well as different systems, such as accountable care organizations (ACOs). Payers can create or help to eliminate the barriers that patients and clinicians face through their reimbursement and payment structures. Payers can also initiate quality improvement through reimbursement mechanisms.
- **Measure developers** – Measure developers can actively consult with other stakeholder groups to understand the challenges and needs for providing care for individuals with SUD/OUD and co-occurring behavioral health conditions. Developers must then design and test measures that help address the identified need and challenges.
- **Policymakers** – Policymakers and regulatory bodies play a substantial role in creating measurement requirements at both the state and local levels. Currently, there are variations in reporting structures and requirements that make standardization challenging. Policymakers can help create standardization and move the field forward.

Overarching Measurement Framework Barriers and Solutions

Implementing a measurement framework may require substantial changes from end-users of this report. To help achieve the goals of the measurement framework, this section identifies challenges related to implementing measurement across the framework domains and subdomains, and corresponding solutions and strategies. The five overarching barriers were identified as common challenges for the critical stakeholders and are presented as obstacles in the case exemplars. The identified solutions provide examples of how to overcome these challenges and can range depending on the level of resources or infrastructure required for implementation.

Stigma

Barriers

Stigma can be a significant barrier in the provision of person-centered care. As a result of stigma, providers may fail to understand a patient's goal and may not actively align their care plans with the patient's preferences or needs. Stigma exists at the individual, organization, and system-wide level. Stigma in providers, patients, and health plans may limit patients' access to community-based resources that help address social risk factors that may contribute to poor health outcomes.

Solutions

Solutions to address stigma fall into three themes, as described in Table 4. Solutions related to person-centered care address active engagement between the patient and the care team, such as goal setting and coordination of care. Solutions related to policies and approaches address ways that healthcare organizations can redefine practices across individual, organizational, and system levels to diminish stigma. Solutions related to education address opportunities to help stakeholders learn how to recognize and reduce stigma, including through the lens of harm reduction and trauma-informed care.

Table 4: Overarching Solutions to Address Stigma

Themes	Solutions
Person-Centered Care	• Promote person-centered care (e.g., use goal attainment scales) and educate providers to elicit patient-specific goals • Bring payers, providers, peer advisors, and patients together through advisory panels /councils • Require the inclusion of individuals with SUD/OUD experience as part of the care team for peer support
Policies and Approaches	• Examine and update existing organizational policies and practices that may unintentionally reinforce stigma • Identify and broaden generally expected outcomes of SUDs/OUD interventions beyond abstinence • Broaden the definition of a patient's support system to include community organizations and members, peer support groups, or any individual identified by the patient • Establish an individual(s) who patients, patient support systems, or patient advocates can call for acute concerns or stigma-related challenges and barriers

Themes	Solutions

Education	• Educate all employees of a healthcare system (including administrative and non-clinical staff within acute and outpatient settings) on how stigma is perpetuated and how it can impact care
	• Educate providers, patients, and community-based service organizations on the following:
	  ○ The differences between withdrawal and physical dependence and SUD, and how they impact a patient's quality of life
	  ○ Harm reduction strategies that go beyond providing naloxone
	  ○ Treatment strategies that go beyond abstinence
	  ○ The importance and value of trauma-informed care
	• Implement ongoing antibias and anti-stigma training and support for providers who treat people with OUD and co-occurring behavioral health conditions
	  ○ Use person-first language (e.g., individuals with OUD) and refrain from using stigmatizing language (e.g., "user" or "addict") to promote an open and inclusive environment for patients
	  ○ Educate on the positive and negative ways healthcare organizations may impact individuals who use drugs and their communities
	• Educate patients on how their information is shared between different healthcare providers and how firewalls work to prevent general access to promote honest disclosures
	• Utilize public campaigns to reduce stigma and support interventions and harm reduction services for OUD/SUD as a medical condition that impacts the brain
	  ○ Leverage advocates such as local chaplains, recovery coaches, or respected community leaders to advocate and discuss anti-stigma tactics and become ambassadors

Limited Resources

Barriers

Limited resources can impede the provision and quality of care that individuals with SUD/OUD and co-occurring behavioral health conditions receive. Providers are often working within healthcare systems that are understaffed, have limited leadership buy-in and internal funding, and are managing patients with complex needs, which can make data collection an added burden. Resource constraints can ultimately prevent providers and healthcare systems from implementing evidence-based practices and/or other essential nonmedical services, such as case management or discharge planning. Measurement is best supported by a robust healthcare system that has the required personnel and budget to establish a strong data collection and reporting infrastructure.

Solutions

Table 5 describes three themes that address limited resources, along with examples of corresponding solutions. The solutions related to external funding address opportunities to secure and use revenue streams that support SUD/OUD treatment. Solutions related to partnerships and collaborations address ways for providers to expand services by working alongside a broad range of organizations. Solutions related to structural changes address opportunities to create efficiencies in care processes that prevent gaps in care/treatment and reduce adverse events.

Table 5: Overarching Solutions to Address Limited Resources

Themes	Solutions
External Funding	• Apply for Medicaid 1115 waivers to expand covered services • Seek and apply for local or state funds, or foundational grants, that cover the cost of providing MOUD and allow the healthcare organization to move to a sustainable financing system • Partner with payers to promote full coverage of SUD/OUD treatment, including harm reduction services, to eliminate and/or reduce patient co-pays • Increase funding for SUD/OUD professionals • Identify funding sources that can support or help minimize patients' social risk factors (e.g., unstable housing) to allow focus on recovery
Partnerships and Collaborations	• Partner with community-based organizations, including faith-based organizations, to expand resources and knowledge • Use a hub-and-spoke model to increase a system's capacity to treat patients by providing access to care through satellite locations • Expand the workforce and build capacity by engaging interns, house staff, medical and nursing students, social workers, psychologists, family and marital therapy students, and peer coaches • Utilize online consultations with specialists to connect care teams with patients who present at the ED • Encourage or incentivize services that allow for better care transitions • Join an (ACO), independent physician association (IPA), or another aggregated practice accountable for managing a population using (APMs) • Partner with and advocate for federal and state regulators to remove barriers that impede service delivery and quality improvement activities
Structural Changes	• Increase number of buprenorphine prescribers, including in underserved areas, and increase the number of patients each waivered provider can treat • Create structural investment in the workforce to allow sufficient time to deploy best practices, implement person-centered care, gather documents, and discuss care goals • Create a continuous education curriculum that includes training on measurement-based and outcome-driven care • Assess internal barriers for hiring staff with the necessary expertise (e.g., clinical social workers, addiction and treatment specialists, and peer support specialists) and make the case for resources to executive leadership • Examine current staffing models and identify whether patient follow-up processes are clearly defined, and if not, create a task force to create processes and educate staff • Use an EHR system that all care team members can use to link data and patient information, identify high-risk uses of illicit substances, and help mitigate use or harm

Payment Challenges

Barriers

Challenges related to payment often exist in tandem with the previous barrier (i.e., limited resources) and have far-reaching impacts. Payment challenges prevent providers from offering services and patients from accessing the care they need.[125] Reimbursement structures are limited for SUD/OUD interventions and harm reduction services, which ultimately reduces access to these services. Individuals with SUD/OUD may lack or have limited insurance coverage for services and medications, and providers

may face complex systems that make reimbursement or coverage challenging. Silos between physical and behavioral care exacerbate the complexity of payment processes and protocols, which can make obtaining referrals or continuity of care challenging.

Solutions

Solutions to address payment challenges are grouped into three themes, as described in Table 6. Solutions related to parity in reimbursement and coverage address strategies to mitigate financial barriers to care. Solutions related to expanded resources address opportunities to improve access to care. Solutions related to continuity of care address ways that care teams and technology can improve communication about patient care.

Table 6: Overarching Solutions to Address Payment Challenges

Themes	Solutions
Parity in Reimbursement and Coverage	• Expand methadone maintenance coverage to commercial insurers • Ensure pharmacy coverage for all forms of MOUD • Provide reimbursement to support complex discharge planning, transitions of care, and care coordination services • Increase flexibility of reimbursement mechanisms to align better with patient needs and clinical presentations (e.g., bundled payments to cover complex and co-occurring conditions, Medicaid 1115 waivers to improve flexibility) • Invest in reimbursement parity for SUD/OUD treatment activities and harm reduction strategies
Expanded Resources	• Educate patients and providers on payment structures, benefits, and parity to make navigation of complex systems easier • Support and implement no-wrong-door policies • Improve coordination between healthcare SUD/OUD services and the criminal justice system • Expand telemedicine to include reimbursed case management and other services that address housing, transportation, and other SDOH • Create a 24/7 network that provides care beyond regular business hours and includes access to specialists, mental health crisis services, and case management
Continuity of Care	• Create a universal referral process that uses established standards (e.g., Fast Healthcare Interoperability Resources [FHIR] and United States Core Data for Interoperability [USCDI]) to facilitate interoperable communication among the diverse providers involved in the referral process • Establish an accountability program or attribution model that assigns accountability to all providers who co-manage a patient with an anchor provider (e.g., primary care provider)

Data Inconsistency and Limitations

Barriers

Data inconsistency and limitations have led to challenging data collection processes, poor data quality, and a lack of available patient-level data on diagnosis, medication prescription and administration, and treatment. Many factors result in poor data, including the lack of consistent guidance on how stakeholders can be accountable for collecting, verifying, and storing high quality data. Inconsistencies can exist at the individual level in which providers may collect more information than is necessary, or patients may experience distrust or reporting burden. Larger systematic inconsistencies can exist

between the prescriber shown on the data report and the individuals making prescription decisions or having incomplete data due to differences in payment methods used by a patient. Privacy concerns can also create challenging scenarios and cause gaps in a patients' medical records.

Solutions

Solutions to address data inconsistency and limitations fall within two themes, as described in Table 7. Solutions related to integration of systems address interoperability of data across providers, health systems, and payers, while solutions related to standardization address opportunities for diverse stakeholders to create and utilize standard practices for information sharing.

Table 7: Overarching Solutions to Address Data Inconsistency and Limitations

Themes	Solutions
Integration of Systems	• Integrate EHR systems across settings so that information is available to more providers • Standardize existing EHR data infrastructure (e.g., collection and storage of standardized data elements) to allow for better outcome tracking and measurement • Establish all-payer claims databases and registries with consistent and up-to-date information from EHRs and other data resources that can allow for more holistic measurement • Assign an "anchor provider" who takes responsibility for a population with a specific diagnosis by co-managing care with specialists and other providers to ensure the patients' needs are met
Standardization	• Include patients in the measure development process to ensure measures yield meaningful outcomes that can be used for accountability • Create accountability through regulatory measures and payment processes • Create incentives to encourage EHR vendors to cohesively work toward standardized data specifications and other aspects of interoperability • Incentivize healthcare organizations to participate in activities that reduce burden, decrease internal resource competition, and increase measurement • Create patient-generated surveys and leverage patient registries • Create hybrid measures using claims and clinical data that provide insights into unique challenges of this population • Standardize systems and handoff processes to allow claims and clinical data to be interoperable and make it easier for data to follow the patient should they change payers or care settings

Rapidly Evolving Measurement Landscape

Barriers

The healthcare system is evolving and requires new and better data systems to support the development of quality measures. This rapidly evolving measurement landscape poses a barrier to the quality of the care patients receive, as healthcare organizations may not be equipped or prepared to implement new measures. New measures can require amendments to network contracts, which require time and resources. When a new measure is established, multiple data sources may be needed for each quality measure (e.g., enrollment, medical claims, and pharmacy claims), which can create a reporting burden for providers and administrative staff. Reporting burden is further exacerbated by the challenges related to selecting, implementing, and using validated PRO scales for data collection. Lastly, providers

may have limited knowledge on measurement and data science and may not understand the full value that measures add to quality of care.

Solutions

Two overarching themes and their related solutions address the rapidly evolving measurement landscape, which are described in Table 8. Solutions related to education address ways that quality measurement can be incorporated into academic and on-the-job training. Solutions related to the expansion of collected data address ways to incorporate different types of information into the measurement of SUDs/OUD treatment.

Table 8: Overarching Solutions to a Rapidly Evolving Measurement Landscape

Themes	Solutions
Education	• Incorporate information on quality measures and the measure development process into residency and pre-graduate level provider programs • Engage patients, patient advocates, and peer navigators in measure development and advisory groups to inform measure development • Educate practicing providers on current SUD/OUD measures and data elements being collected to highlight how measures add value and support better approaches to care
Expansion of Data Collected	• Ensure all medications administered during a hospitalization are reflected in the EHR • Obtain funding to support the development of patient-generated surveys, which will help identify and improve the gaps in care • Use validated patient-reported outcome measures (PROMs) at beginning of SUD/OUD and mental health-related interventions at standardized, incremental time periods

Case Exemplar Selection Process

The Committee developed three case exemplars to provide more detailed guidance on implementing the Opioids and Behavioral Health Measurement Framework. To identify the case exemplars, the Committee sought scenarios that showcase the following:

- Prevalent challenges or barriers in SUDs/OUD and behavioral healthcare pathways
- Challenges, barriers, or performance gaps that can be attributable to a known entity and can be addressed
- Diversification of settings that show variation in performance and can be applicable to many stakeholders

Each case exemplar begins with a clinical narrative for one measurement framework domain that showcases common challenges and barriers experienced by stakeholders in a healthcare setting. This approach allows readers to apply their own unique experiences to the framework. Following the narrative, each case exemplar lists a series of barriers and solutions. This is followed by a table that identifies broad categories and specific examples of solutions that stakeholders can implement to overcome the barriers identified. Where feasible, the strategies include relevant existing measures or measure concepts to showcase the framework in action.

Case Exemplar: Equitable Access Domain

Case Narrative: Equitable Access

The patient is a 32-year-old White, homeless male with a history of severe OUD, frequent methamphetamine use, and bipolar affective disorder. The patient also has a family history of SUD/OUD. The patient was brought to the local ED, which he has frequented various times in the past few years, via Emergency Medical Services (EMS) with an abscess on his right forearm, diaphoresis, and a fever of 104 °F. 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.

The patient has erythematous streaks on his forearm and reports he feels light-headed and nauseous. The patient is started on intravenous (IV) antibiotics after blood cultures are sent to the laboratory. Upon reviewing the patient's medical record, the resident in the ED identifies that the patient was revived at the ED six months ago after an opioid overdose. After that visit, the patient was referred for OUD treatment but states he was never able to be seen by the treatment center and could not afford the transportation to visit the center frequently. He does not have any family support to assist him with transportation. The patient reports also going to another hospital within the last year, but the resident is unable to access any records or data from that visit.

The resident asks the attending physician whether they can start the patient on buprenorphine, but the resident is told they cannot keep the patient long enough to enter moderate withdrawal before induction due to limited beds. Given how busy the physicians are, no one has an in-depth discussion with the patient about his treatment goals and preferences. The patient is slated to be discharged and a social worker provides a printout listing nearby methadone program addresses and phone numbers; however, no one verbally communicates about the information on the printout with him. The patient is unclear on how much money the treatment programs will cost him and does not think he can afford treatment, nor does he have the finances to afford transportation to get to the program. The patient ultimately decides not to pursue further treatment after he is discharged from the ED with a prescription for antibiotics.

Case Exemplar Barriers and Solutions: Equitable Access

Barriers

The case exemplar illustrates four fundamental barriers that prohibit individuals with polysubstance use involving SSSOs with co-occurring behavioral health conditions from accessing adequate and timely care: (1) lack of interoperability, data, and data collection infrastructure; (2) limited workforce, resources, and education; (3) cost, or perceived cost, and limited access to treatment services; and (4) stigma. The following list provides examples of alternative approaches, strategies, and solutions the stakeholders within the case could take to overcome these barriers:

Solutions for the lack of interoperability, data, and data collection infrastructure:

- The hospital implements a communication protocol and data sharing agreements between ED and hospital providers, EMS, and integrated case management system, including participation in a Health Information Exchange (HIE).

- The hospital captures better data points to inform treatment approaches through the following items:
    - Measure *concepts*, such as the 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); the percentage of individuals with access to holistic pain management (e.g., physical therapy, occupational therapy, integrated care, and complementary care); and the percentage of individuals with SUD/OUD and mental health conditions who receive case management services that are covered by insurance

Solutions for limited workforce, resources, and provider education:

- The provider coordinates with in-house social worker, who arranges a warm handoff that same day with the local treatment center and other appropriate resources based on patient's preference.
- The case worker connects the patient with a member of the hospital's peer support group who meets with the patient prior to discharge.
- The hospital contracts with a 24/7 network to provide access to specialists and/or providers with SUD expertise.
- The 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:

- The 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.
- The patient is initiated on appropriate treatment (e.g., buprenorphine) prior to discharge while taking into account the time period between discharge and the follow-up appointment with the treatment center.
- The social worker addresses the transportation limitations and provides options for virtual OUD treatment services, and the case worker offers the patient a list of community resources that are near his preferred location.
- The hospital expands telemedicine offerings to include case management services that address housing, transportation, and other SDOH.
- The hospital establishes a no-out-of-pocket-cost buprenorphine Bridge Clinic in the hospital.

Solutions for stigma:

- The hospital implements antibias and anti-stigma training for ED staff and providers who may come across individuals with SUDs/OUD and co-occurring behavioral health conditions to address the overlapping stigmas that exist for SUD, SDOH, and vulnerable populations.
- The hospital facilitates opportunities for trainees to gain experience in OUD/SUD treatment and care provision in outpatient drug treatment settings
- The hospital provides continuing education credits to staff to increase knowledge and awareness of diversity, anti-stigma, and antibias, including grand rounds that feature individuals with SUD/OUD and cases of successful treatment.

Care Exemplar: Clinical Interventions Domain

Case Narrative: Clinical Interventions

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 late at night. Her chest x-ray was sent to radiology and showed an enlarged heart. During her first night in the hospital, the patient became increasingly irritable, diaphoretic, and nauseous. She had difficulty falling asleep and reported lower back and leg pain to the overnight nurses, asking for opioids for pain relief. While the patient is experiencing withdrawal, the care team does not accurately recognize the symptoms, nor do they request a pain consult for the patient. Instead, the team mistakenly believes she is stubborn and irritable. By morning, her cardiopulmonary workup revealed signs of congestive heart failure, and during morning rounds, her team found "track marks" on her arms. The nurse realizes the patient was likely in opioid withdrawal, but the patient went untreated, and no addiction medicine consultation was requested.

The patient reports she became depressed after her mother's death several years ago and began to occasionally use heroin with her new boyfriend, first sniffing, and then ultimately injecting up to five to six bags a day within a year. The physician makes a mental note that the heroin was likely adulterated with fentanyl but does not mention this to the patient. The patient also shared she has had a long history of depression since childhood and chronic back pain following injuries from a fall. She has never received any mental health services for her depression. The patient revealed that six months ago, she entered a methadone treatment plan, which was initially successful, but she stopped treatment due to worsening depression. Despite being referred by the same ED system, there was limited information and only one BAM screening in the patient's medical history. The results of the BAM were not acted on, and there was no mention of follow-up regarding her referral.

The patient reports wanting to attempt another form of medication treatment for OUD, as she found it challenging to get to the methadone program each day. While the inpatient physician is considering prescribing her buprenorphine, he is worried that her heart condition is a contraindication. The physician also only believes she can afford a methadone maintenance program; however, the patient's treatment and payment options were not explored, nor were her goals discussed at any point. The patient is monitored for another night and is sent home with an appointment in the cardiology clinic for next month and a list of nearby meetings for an abstinence-only treatment program. No additional follow-up was conducted.

Case Exemplar Barriers and Solutions: Clinical Interventions

Barriers

The case exemplar illustrates four fundamental barriers that prohibit individuals with polysubstance use involving SSSOs with co-occurring behavioral health conditions from receiving appropriate and timely clinical intervention: (1) limited MBC and validated assessment tools, (2) inadequate use of evidence-based treatment for SUDs/OUD and co-occurring behavioral health conditions, (3) lack of shared decision making and patient education, and (4) insufficient follow-up processes and strategies. The following list provides examples of alternative approaches, strategies, and solutions the stakeholders within the case could take to overcome these barriers:

Solutions for the limited use of measurement-based care and validated assessment tools

- The 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
- The hospital assesses MBC:
    - 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 the BAM or Patient-Reported Outcomes Measurement Information System [PROMIS]) and/or the percentage of individuals with SUD/OUD and a co-occurring mental health condition identified as having social risk factors who have demonstrated improvement in clinical status within a given time frame

Solutions for the inadequate use of evidence-based treatment for SUDs/OUD and co-occurring behavioral health conditions

- The 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, which they give to the patient and with her consent, her peer support.
- The provider conducts a screening early in the intake process, which reveals patient is in withdrawal, subsequently triggering adequate treatment of her symptoms.
- The hospital drives improvement in care by measuring and evaluating the availability and use of MOUD using measure concepts, such as the percentage of individuals with identified SUD/OUD and mental illness with MOUD initiated in the ED.

Solutions for the lack of shared decision making and patient education

- The 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 centered on those goals.
    - Measure *concepts*, such as PROs on whether the patient feels engaged and heard
- The hospital uses peer navigators to guide the patient through transitions of care and follow-up planning.
- The provider educates the patient on harm reduction strategies before discharge (e.g., requesting an addiction consult service to provide overdose education and distribute naloxone to the patient prior to discharge).

Solutions for insufficient follow-up processes and strategies

- The provider 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, alongside a peer navigator, who ensures the patient understands and can follow through with the follow-up plan.
- The case worker connects the patient to services that can address the patient's housing status.
- The care team asks the patient who they consider their support network, and with the patient's permission, the team provides the identified individual(s) with the follow-up plan.
- The EHR alerts the case worker to contact the patient within a week following discharge to confirm whether the patient followed up with a referral and whether any support is needed.

- The hospital monitors and tracks follow-up processes and strategies.
    - Existing quality measures, such as Discharged to the Community With Behavioral Problems

Case Exemplar: Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions Domain

Case Narrative: Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions

The patient is a 62-year-old married Hispanic woman with three grown children and four grandchildren, who retired from working at a local preschool a decade ago and lives in a rural area. She has a history of rheumatoid arthritis, asthma, general anxiety disorder, and long-term opioid use. She is currently taking high-dose, extended-release oxycodone three times a day with morphine as needed for breakthrough pain. Despite long term use of a high-dose, extended-release opioid, and her 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, who is part of a separate healthcare system, every six to 12 months to review her pain regimen. There is a long wait to be seen by her rheumatologist, and the patient often needs to fill her pain prescriptions early but cannot get through to the front desk on the phone. Her anxiety has worsened over the past year as two of her children, along with all her grandchildren, moved further away 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 partners in her care.

Although she saw a psychiatrist ten years ago for anxiety, she has not taken anxiety medication regularly since her retirement, and the nearby FQHC no longer has a full-time mental health clinician on staff. She was referred to a psychiatric nurse practitioner (NP) over telehealth and had a virtual intake conducted, but her Wi-Fi often cut out, she could not understand the clinician well, and she had unanswered questions about medication options. The NP does not have access to the medical records, and given the connectivity issues, the NP did not hear the patient report she is on oxycodone. The NP discussed prescribing a selective serotonin reuptake inhibitor (SSRI) or clonazepam. The patient chose clonazepam since the NP said it will help her feel better faster. There was no discussion of any behavioral 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 of picking up the refill, and as a result, she has been trying to augment it with other unknown pain relief options. She gets pills from a neighbor who she occasionally visits when she feels especially anxious or lonely. The patient says she would like to take fewer medications but is scared the pain will get worse if she makes any changes.

Case Exemplar Barriers and Solutions: Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions

Barriers

The case exemplar illustrates four fundamental barriers that prohibit individuals with polysubstance use involving SSSOs with co-occurring behavioral health conditions from receiving integrated and comprehensive care: (1) care is not tailored to individualized patient needs, (2) silos between physical and mental care, (3) limited or nonexistent interaction and engagement of the patient's support system, and (4) lack of connectivity. The following list provides examples of alternative approaches, strategies, and solutions the stakeholders within the case could take to overcome these barriers:

Solutions for when care is not tailored to individualized patient needs

- The hospital has a system in place to obtain feedback on the patient experience and cultural competencies.
    - *Measure concepts*, such as the percentage of patients who reported that their mental health and SUDs/OUD treatment was coordinated or the patient's experience of care for all patients seen for mental health and substance use care
- The provider conducts regular screening to help identify solutions for instances in which medications are not being taken as prescribed.
    - Existing quality measures, such as Evaluation or Interview for Risk of Opioid Misuse
- The health system actively measures high-risk prescriptions.
    - Existing quality measures, such as Avoidance of Co-Prescribing of Opioid Analgesic and Benzodiazepine and/or Co-occurring Use of Opioids and Benzodiazepines (COB)
- The provider raises and discusses the patient's individual risks and circumstances, care decisions, and potential harm reduction services based on identified risks.
    - Existing quality measures, such as Risk of Continued Opioid Use (COU)
- The hospital has an "anchor provider" who coordinates care for a population with a specific diagnosis and helps to ensure that co-managing providers (e.g., specialists) are accountable for meeting the patients' needs.

Solutions for silos between physical and behavioral healthcare

- The health system has an interdisciplinary team who conducts case reviews across specialists and disciplines (e.g., pain management, psychiatry, rheumatology, and pharmacy) for patients with SUDs/OUD and co-occurring behavioral health conditions.
- The health system uses information systems, including EHRs, that facilitate collaboration across physical and mental health services and contribute to improved coordination processes.
    - Measure *concepts,* such as the percentage of providers who have a shared/integrated treatment plan between general health and behavioral health providers to track progress
- The health system provides early career training and ongoing professional education to foster a culture of integrated care as a standard practice among its providers.
- The provider appoints a case manager to help the patient communicate with her providers and establish options for virtual care.
- The health system uses health plan data and a prescription drug monitoring program (PDMP) to identify polypharmacy risks and/or high-risk medication regimens, and the system alerts and informs the telehealth provider.

- The hospital system maintains documentation of medication reconciliation and adverse drug reaction (ADR) monitoring.
    - 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

- The provider appoints a patient advocate/peer navigator to assist the patient with a follow-up appointment and interpretation of medical information.
- Both the provider and peer navigator engage members of the patient's chosen support network (e.g., her husband, children, and/or neighbor) by answering their questions and providing them with relevant information (e.g., transition plan) to help the patient.
- The hospital collects, disseminates, and routinely updates information on resources and services that can help patients with SUDs/OUD and co-occurring behavioral health conditions (e.g., support groups, faith-based organizations).
- The organization has 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 the lack of connectivity

- The provider asks about the patient's resources and telehealth limitations early to establish and use the best method of care (e.g., phone call, video call).
- The provider trains the patient when a new care method/platform is implemented (e.g., teaches her to use the video conferencing platform).
- The telehealth provider communicates with "anchor provider" to acquire access to the complete health record and explore alternative methods for speaking with the patient.

Discussion

Leveraging the Measurement Framework in a Coordinated Approach

The measurement framework is intended to support a comprehensive measurement approach for individuals with polysubstance use involving SSSOs who have co-occurring behavioral health conditions. While specific measures and measure concepts can be used for either accountability or quality improvement, quality measures related to SUDs/OUD are a critical mechanism to holding care providers, payers, and policymakers accountable for providing optimal care for individuals with SUDs/OUD and behavioral health conditions. The three domains within the measurement framework—Equitable Access, Clinical Interventions, and Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions—are interwoven. Each one depends on the foundation of the preceding domain. For instance, if individuals do not first have access to affordable care, the quality and coordination of care are irrelevant.

As organizations begin to implement a coordinated measurement framework for populations with co-occurring SUDs/OUD and mental health disorders, leaders should ensure selected measures encompass equity and person-centeredness, with specific attention to areas in which priority populations intersect (e.g., individuals who are Black, male, and involved with the justice system).[126] Given the disparities that exist for individuals with SUDs/OUD and behavioral health conditions, equity should be a foundational element in ensuring priority populations are obtaining the services needed to promote better outcomes and reduce mortality in an effective way.

To further understand and target disparities that exist for individuals with SUDs/OUD and behavioral health conditions, the Committee identified that quality measurement for the population of interest should explore the use of risk adjustment. *Risk adjustment* is a statistical approach that allows patient-related factors to be factored in when computing performance measure scores.[127] Given the complexity of individuals with SUDs/OUD and co-occurring behavioral health conditions, failure to consider risk adjustment or stratification (e.g., by age or SES) could potentially penalize providers and health systems that care for higher-risk patient groups and populations. Furthermore, risk adjustment can allow for a clearer pathway to understanding the needs of people with SUDs/OUD and co-occurring behavioral health conditions. Potential social risk factors that are often adjusted for in measurement include race and ethnicity, insurance, relationship status, SES, income, disadvantaged areas, and housing instability. Given the correlation between deaths from polysubstance use and high levels of poverty, accurate benchmarks of economic and social challenges at the community level should be developed as a risk factor for SUDs in a given community.[128]

While an overall focus on the measurement of behavioral health services is appropriate, organizations may also consider risk stratification by the type of provider to understand areas in which disparities exist. It may be helpful to stratify by a mental health provider or an SUD provider to understand where to focus improvement efforts.

Opportunities to Overcome Barriers to Measurement and Care

To support the implementation of the measurement framework and to advance measurement for the population of interest, opportunities exist for stakeholders to assess how to best overcome barriers to care for individuals with polysubstance use involving SSSOs who have co-occurring behavioral health conditions. Common barriers to care, including insurance coverage disruptions, burdensome regulations or policies, and financial disincentives, often limit the availability and/or provision of evidence-based services for individuals with SUDs/OUD and co-occurring behavioral health conditions, especially in under-resourced areas. Opportunities exist for states to submit proposals for Medicaid Section 1115 demonstration waivers to test comprehensive approaches to furnish care for beneficiaries with SUDs and co-occurring behavioral health conditions.[129] Many states currently have demonstration projects underway, with the goal of improving care for individuals with SUD and/or behavioral health conditions without increasing overall costs. Examples of current demonstration projects include reimbursing for care coordinators, transportation services, and expanding coverage for SUD treatment-related inpatient admissions in settings previously subjected to Medicaid's IMD exclusion.[130] Opportunities exist to ensure that all states with Medicaid Section 1115 demonstrations are making meaningful progress, especially as it relates to access and the coordination of clinical and community-based services.[105]

To support integrated and comprehensive care for individuals with SUDs/OUD and concurrent behavioral health conditions, diverse stakeholders must act on opportunities that exist to overcome structural barriers to coordinated care. More specifically, stakeholders can leverage the need for coordinated care for this population to support further co-location of SUD and behavioral health services, reimbursement for nonmedical services (e.g., peer navigation, care coordination, transportation, and internet services), and bundled payment plans that pay capitated rates rather than fee-for-service (FFS) schedules that disallow reimbursement for adjunctive services that may enhance treatment adherence and retention. Opportunities exist to strengthen payment and benefit parity across physical healthcare, behavioral healthcare, and SUDs/OUD treatment, and it is important for

providers, including behavioral healthcare providers working in general medical care settings, to have adequate payment and reimbursement rates. In addition to payment structures, payers have an opportunity to address overdose and mortality by supporting data continuity and sharing across health plans. Payers have a wealth of patient data that they use to identify whether patients are at risk for overdose or mortality from SUD and/or behavioral health conditions. However, as individuals move through different stages of life and change health plans, these data and information do not move with the individual. For example, this data continuity would be particularly beneficial for young adults who might need care at the same time that they are no longer able to remain on a parent's commercial health plan (i.e., over age 25). Stakeholders should identify opportunities to support data continuity across plans to leverage existing data in a manner that supports individuals who may be at risk of overdose or mortality. EHRs may serve as a tool to support data sharing, considering they have the ability to track both medical and behavioral health symptoms and interventions for an individual. The use of integrated treatment plans between physical and behavioral healthcare providers may also provide an opportunity to support data continuity and sharing.

Coordinated efforts are critical to providing life-saving physical, mental, and emotional health support to individuals facing a behavioral health crisis. The newly approved 988, three-digit crisis phone number affords an opportunity to improve integration and care coordination.[131] In 2022, when individuals with an urgent mental health need call 988, they will be connected to trained crisis workers who can offer support, crisis intervention, and safety planning.[131] The shift to 988 supports the movement from a law enforcement and justice system response to a response focused more on connecting individuals in suicidal, mental health, and substance use crises to care immediately.[131] As first responders, paramedics and EMS also play an important role in a coordinated approach to measurement and care for individuals with SUDs/OUD and co-occurring behavioral health conditions. Obtaining data on the type of emergency response, the diagnosis, and any medications administered in the field can be challenging. Opportunities exist to encourage more consistent and thorough documentation of these critical aspects of care to better understand risk profiles for patients and related health outcomes. When data are available, they can be difficult to interpret. Standardization of the reporting of EMS events could support measurement efforts and can help to identify which events are related to substance use and/or overdose.

Opportunities exist to improve integrated and continuous care for individuals involved in the criminal justice system. MOUD is greatly underutilized in corrections programs, such as probation, parole, and treatment courts. Although a proliferation of drug courts and other alternative sentencing models has occurred in recent years, the great majority of individuals with OUD in the justice system do not receive evidence-based care with MOUD while incarcerated or following release.[80] Moreover, criminal justice involvement is a missed opportunity to ensure continuous insurance coverage and to engage high-risk individuals in comprehensive care.[126] While Medicaid expansion has been associated with improving rates of MOUD post-incarceration,[132] enrollment assistance programs are likely necessary to increase rates of effective insurance coverage at release.[88]

Unique challenges and opportunities also exist for rural and frontier communities. Notably, rural and frontier counties often lack buprenorphine-waivered physicians, which limits access to evidence-based SUDs/OUD treatment. Although 95 percent of Americans live within five miles of a community pharmacy, current regulations do not allow for pharmacy-based care, such as MOUD with methadone maintenance or injectable medications. Opportunities exist to identify how care for remote individuals, especially those with co-occurring SUDs and behavioral health conditions, can be optimized and

accessible. The temporary changes supporting telehealth during the COVID-19 pandemic provide a successful model of increased access and decreased no-show rates and should be leveraged as fundamental pieces of the care infrastructure moving forward.[133]

Lastly, opportunities exist to further explore the use of evidence-based treatment and harm reduction services. Education and training programs provide an opportunity to support the use of evidence-based treatment for individuals with SUDs/OUD, and they offer an opportunity to ensure care providers are trained on the value of integrated and comprehensive care. While some training programs require providers to obtain a buprenorphine waiver, research shows that many prescribers with the buprenorphine waiver do not actively prescribe or only treat a limited number of patients.[134] Opportunities exist for training programs and medical professional societies to encourage, or even require, trainees to treat patients with MOUD during their training. If providers obtain supervised experience with MOUD before graduating from training programs, they will likely be more comfortable using MOUD during their clinical practice.

Many barriers counterproductively limit the existence and widespread use of harm reduction services. Barriers include legal barriers (e.g., harm reduction services, such as syringe exchanges, being illegal), reimbursement barriers (e.g., harm reduction services considered *out of network* and not reimbursable), and geographic and transportation-based barriers (e.g., lack of existence of harm reduction services in rural communities). Because of these barriers, traditional healthcare, criminal justice, and SUD treatment settings do not have clear linkages and referral networks to accessible harm reduction services. To support access to and measurement of harm reduction activities, payers can explore their ability to reimburse for the provision of harm reduction services, including syringe service programs, naloxone distribution and overdose education, and/or drug testing services.

Conclusion and Next Steps

The U.S. continues to face new challenges related to combatting the evolving opioid and SUD crisis. The crisis, which has entered a fourth wave that is driven by psychostimulant involvement, has been further magnified by the impacts of the COVID-19 pandemic. Individuals with SUDs/OUD and co-occurring behavioral health conditions are particularly vulnerable to overdose and mortality resulting from substance use.

A coordinated care and measurement approach can be an important mechanism to support the almost 10 million adults with SUDs/OUD and co-occurring mental health disorders.[135] Recognizing the importance, the Committee identified a series of measurement gaps and priorities relevant to these populations to incorporate in an equitable, person-centered measurement approach. Building on the identified measurement gaps and priority areas, the Committee developed a measurement framework during the Base Year to address overdose and mortality resulting from polysubstance use involving SSSOs among individuals with co-occurring behavioral health conditions. The measurement framework reflects the intricate and connected relationship between many aspects of care, including equitable access to care, evidence-based clinical interventions, and coordinated and integrated care.

Equitable Access is considered a foundational domain within the measurement framework because without access, individuals cannot obtain the services that exist to protect life and improve outcomes. The next domain, Clinical Interventions, builds on a foundation of accessible, equitable, and evidence-

based services. While access to evidence-based clinical interventions may exist for some, the availability of integrated and comprehensive care is essential for all individuals with SUDs/OUD and co-occurring behavioral health conditions. Thus, at the heart of the framework is the Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions domain.

Recognizing the importance of equity and vulnerable populations, the Committee also identified opportunities to advance the field forward to promote access to evidence-based, integrated care for individuals with SUDs/OUD and co-occurring behavioral health conditions. Opportunities include further leveraging Medicaid Section 1115 demonstrations, supporting co-location of services, reimbursing for community-based services, exploring greater use of harm reduction services, supporting economic development in communities with high poverty levels, and expanding access to MOUD within the criminal justice system.[128]

In the Option Year of this work, the Committee sought to drive implementation of the measurement framework by identifying guiding principles, overarching barriers and solutions, and generating a use case to demonstrate the framework in action. While these additions identify critical areas for readers to consider, the Committee encourages the continuation of this work. Specifically, future work could identify specific challenges and gaps faced by each of the identified key stakeholders and provide tailored strategies to help them overcome these barriers. The continuation of this work towards increased implementation can ensure that individuals with SUDs/OUD and co-occurring behavioral health conditions receive equitable and safe care from any service they seek.

With over 280 individuals dying each day from a drug overdose—and with nearly 80 percent of all drug overdose deaths involving an opioid—it is essential for stakeholders to take action to address overdose and mortality related to the ongoing SUD crisis.[1,2,11] The measurement framework and its measure concepts provide a starting point for the measure developer community, researchers, healthcare providers, social service providers, the criminal justice system, community-based organizations, and federal agencies to come together to address overdose and mortality for individuals experiencing SUDs/OUD with co-occurring behavioral health conditions. Through the use of quality measures that align with the coordinated measurement framework, stakeholders can assess and understand opportunities for improvement in the management of patients and clients with SUDs/OUD and co-occurring behavioral health conditions. Beyond the development of quality measures themselves, further structural and regulatory reform can enhance measurement efforts and improve outcomes. Examples include removing barriers to co-located services, using bundled reimbursements, and expanding coverage for nontraditional services, including care coordination, transportation, Wi-Fi connectivity, and harm reduction services. Expanded use of Medicaid 1115 waivers and the creation of new funding streams could support these efforts. Collaboration and coordination across diverse stakeholders are critical to moving beyond this starting point and transitioning from measure concepts to quality measures that can be used in future accountability programs to improve health and outcomes.

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Appendices

Appendix A: Committee Members, CMS Liaisons, Federal Liaisons, and NQF Staff

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Appendix B: Measure Inventory

This appendix includes measures found by National Quality Forum (NQF) that were used by the Opioids and Behavioral Health Committee to inform the Measurement Framework. The table below includes quality measures identified during the Base Year Environmental Scan and during the measure inventory update of the Option Year. Measures preceded by an asterisk (*) were also previously identified in the 2019 NQF Opioids and Opioid Use Disorder Final Environmental Scan, and measures preceded by a dagger (†) represent new measures identified during the Option Year. These measures are drawn from measure repositories, such as the Centers for Medicare & Medicaid Services (CMS) Measures Inventory Tool, NQF's Quality Positioning System (QPS), and Qualified Clinical Data Registries, as well as measures identified by Committee members and NQF staff through review of articles, grey literature, and measure developer websites.

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
(SUB)-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge*	1664	Endorse-ment Removed	This facility-level measure estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 24 months. Data from the start of the measurement period through 30 days after the close of the measurement period are used to identify readmissions. Data from 12 months prior to the start of the measurement period through the measurement period are used to identify risk factors.	Process
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)†	2860	Endorsed	"This facility-level measure estimates an all-cause, unplanned, 30-day, risk-standardized readmission rate for adult Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The performance period for the measure is 24 months."	Outcome
Acute Care Use Due to Opioid Overdose†	3492	Not Endorsed	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	Outcome

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	1879	Endorsed	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	Inter-mediate Outcome
Adolescent Mental Health and/or Depression Screening	N/A	Not Endorsed	The percentage of patients ages 12-17 who were screened for mental health and/or depression at a well-child visit using a specified tool. Note: Adolescents diagnosed with depression are excluded from this measure.	Process
Adult Depression: 12-Month Remission	N/A	Not Endorsed	The percentage of patients with depression who reached remission (PHQ-9 score less than five) 12 months after the index event (+/- 30 days)	Outcome
Adult Depression: 12-Month Response	N/A	Not Endorsed	The percentage of patients with depression who demonstrated a response to treatment (at least 50 percent improvement) 12 months after the index event (+/- 30 days)	Outcome
Adult Depression: PHQ-9 Follow-Up at 12 Months	N/A	Not Endorsed	The percentage of patients with depression who have a completed PHQ-9 tool within 12 months after the index event (+/- 30 days)	Process
Adult Depression: PHQ-9 Follow-Up at Six Months	N/A	Not Endorsed	The percentage of patients with depression who have a completed PHQ-9 tool within six months after the index event (+/- 30 days)	Process
Adult Depression: Six-Month Remission	N/A	Not Endorsed	The percentage of patients with depression who reached remission (PHQ-9 score less than five) six months after the index event (+/- 30 days)	Outcome
Adult Depression: Six-Month Response	N/A	Not Endorsed	The percentage of patients with depression who demonstrated a response to treatment (at least 50 percent improvement) six months after the index event (+/- 30 days)	Outcome
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (eCQM)	0104e	Endorsed	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Process
Adult PHQ-9 Utilization	N/A	Not Endorsed	The percentage of patients with a diagnosis of Major Depression or Dysthymia who also have a completed PHQ-9 tool during the measurement period.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
ALC: Alcohol Use Disorder: Alcohol Pharmacotherapy Use Not Including Topiramate	N/A	Not Endorsed	VHA patients with an alcohol use disorder receiving alcohol use disorder pharmacotherapy	Process
ALC_top: Alcohol Use Disorder: Alcohol Pharmacotherapy Use	N/A	Not Endorsed	VHA patients with an alcohol use disorder receiving alcohol use disorder pharmacotherapy	Process
Alcohol Problem Use Assessment & Brief Intervention for Home-Based Primary Care and Palliative Care Patients*	N/A	Not Endorsed	Percentage of newly enrolled and active home-based primary care and palliative care patients who were assessed for a problem with alcohol use at enrollment AND if positive, have a brief intervention for problematic alcohol use documented on the date of the positive assessment.	Process
Alcohol Screening and Follow-up for People With Serious Mental Illness†	N/A	Not Endorsed	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.	Process
Alcohol Use Disorder Outcome Response	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) who report problems with drinking alcohol AND with documentation of a standardized screening tool (e.g., AUDIT, AUDIT-C, DAST, TAPS) AND demonstrated a response to treatment at three months (+/- 60 days) after the index visit.	Patient Reported Outcome (PRO)
All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries in Need of Integrated Physical and Behavioral Health Care†	9999	Not Endorsed	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.	Outcome
Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)	351	Endorsed	The percentage of individuals 18 years of age and older who are on long-term opioid therapy and have not received a drug test at least once during the measurement year.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Antidepressant Medication Management (AMM)†	105	Endorsed	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).	Process
Anxiety Response at Six Months	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) with an anxiety disorder (generalized anxiety disorder, social anxiety disorder, post-traumatic stress disorder, or panic disorder) who demonstrated a response to treatment at six months (+/- 60 days) after an index visit.	Patient Reported Outcome (PRO)
Anxiety Screening	N/A	Not Endorsed	The percentage of adult patients (18 years and older) with an anxiety disorder diagnosis (generalized anxiety disorder, social anxiety disorder, post-traumatic stress disorder, or panic disorder) who have completed a standardized tool (e.g., GAD-7, GAD-2, BAI) during measurement period.	Process
Any SUD Treatment	N/A	Not Endorsed	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.	Process
Assessed for SUD Treatment Needs Using a Standardized Screening Tool	N/A	Not Endorsed	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period.	Process
Average Length of Stay in IMDs	N/A	Not Endorsed	The average length of stay for beneficiaries discharged from IMD residential treatment for SUD.	Process
Avoidance of Co-Prescribing of Opioid Analgesic and Benzodiazepine	N/A	Not Endorsed	Percentage of Patients Who Were Not Concurrently Prescribed Opioid Analgesic and Benzodiazepine Medications.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Avoidance of Long-Acting (LA) or Extended-Release (ER) Opiate Prescriptions and Opiate Prescriptions for Greater Than Three Days Duration for Acute Pain*	N/A	Not Endorsed	Percentage of Adult Patients Who Were Prescribed an Opiate Who Were Not Prescribed a Long-Acting (LA) or Extended-Release (ER) Formulation.	Process
Avoidance of Opiates for Low Back Pain or Migraines*	N/A	Not Endorsed	Percentage of Patients with Low Back Pain and/or Migraines Who Were Not Prescribed an Opiate.	Process
Avoidance of Opioid Prescriptions for Reconstruction After Skin Cancer Resection	N/A	Not Endorsed	Percentage of patients aged 18 and older who underwent reconstruction after skin cancer resection who were prescribed opioid/narcotic therapy* as first line therapy (as defined by a prescription in anticipation of or at time of surgery) by the reconstructing surgeon for post-operative pain management. (Inverse measure).	Process
Avoidance of Opioid therapy for migraine, low back pain, dental pain†	N/A	N/A	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.	Process
BENZO_noMHnoMED_new: Benzodiazepine (Active): No Recent Encounter for a Psychiatric Dx or Medical Indication	N/A	Not Endorsed	VHA patients who had at least one outpatient prescription of a benzodiazepine and did not have a psychiatric diagnosis in the same time period or at least one medical indication within specified ICD codes	Process
BENZO_Opioid_OP: Opioid and Benzodiazepine: Concurrent Active Prescriptions	N/A	Not Endorsed	VHA patients with active benzodiazepine and opioid prescriptions	Process
BENZO_PTSD_OP: PTSD: Benzodiazepine Use	N/A	Not Endorsed	VHA patients diagnosed with PTSD with an active benzodiazepine prescription	Process
BENZO_SUD_OP: SUD: Benzodiazepine Use	N/A	Not Endorsed	VHA patients with AUD, OUD, or sedative-hypnotic use disorder and an active outpatient benzodiazepine prescription	Process
Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use*	0110	Endorse-ment Removed	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	1933	Endorsed	The percentage of patients 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	Process
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (eCQM)	1365e	Endorsed	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Process
Clinical Depression Screening and Follow-Up	N/A	Not Endorsed	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age- appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Process
CLO: Schizophrenia: Clozapine Use	N/A	Not Endorsed	VHA patients with schizophrenia with one or more fills for an antipsychotic receiving one or more fills of Clozapine	Process
Concurrent Use of Opioids and Benzodiazepines (COB)*	3389	Endorsed	"The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year. A lower rate indicates better performance."	Process
Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)*	3453	Endorsed	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.	Process
Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs	3312	Endorsed	Percentage of discharges from a medically managed withdrawal episode for adult Medicaid beneficiaries, ages 18–64, that were followed by a treatment service for SUD (including the prescription or receipt of a medication to treat a SUD [pharmacotherapy]) within 7 or 14 days after discharge.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment	3590	Under Consider-ation	Percentage of Medicaid discharges, ages 18 to 64, being treated for a substance use disorder (SUD) from an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD follow-up treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within 7 and 30 days after discharge.	Process
Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)*	3175	Endorsed	Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	Process
DEPOT_new: Schizophrenia: Antipsychotic Depot Use in Outpatient Setting	N/A	Not Endorsed	VHA patients with a confirmed diagnoses of schizophrenia, at least 1 outpatient encounter and received one or more outpatient fill, clinic order or CPT code for an antipsychotic who received one or more fill for a depot antipsychotic	Process
Depression Remission at 12 Months (eCQM)	0710e	Endorsed	The percentage of patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 30 days) after an index visit.	Outcome
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	1934	Endorsed	The percentage of patients 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	Process
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	1932	Endorsed	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Process
Discharge Prescription of Naloxone After Opioid Poisoning or Overdose*	N/A	Not Endorsed	Percentage of Opioid Poisoning or Overdose Patients Presenting to An Acute Care Facility Who Were Prescribed Naloxone at Discharge.	Process
Discharged to the Community With Behavioral Problems	N/A	Not Endorsed	Percentage of home health quality episodes of care at the end of which the patient was discharged, with no assistance available, demonstrating behavior problems.	Outcome

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Documentation of Signed Opioid Treatment Agreement*	N/A	Not Endorsed	All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during Opioid Therapy documented in the medical record.	Process
Early Intervention	N/A	Not Endorsed	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.	Process
Elimination of Narcotic Medication Use Following Spinal Fusion Surgery	N/A	Not Endorsed	Calculation of the percent of patients who report a reduction in narcotic medication intake from 'Daily use' or 'Occasional use' to "No use' following a spine surgical intervention (cervical or lumbar).	Patient Reported Outcome (PRO)
Evaluation or Interview for Risk of Opioid Misuse	N/A	Not Endorsed	All patients 18 and older prescribed opiates for longer than six weeks duration evaluated for risk of opioid misuse using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or patient interview documented at least once during COT in the medical record.	Process
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	3488	Endorsed	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	Process
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	3489	Endorsed	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Follow-Up After High Intensity Care for Substance Use Disorder (FUI)†	N/A	Endorsed	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.	Process
Follow-Up After Hospitalization for Mental Illness (FUH)	576	Endorsed	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: The percentage of discharges for which the patient received follow-up within 30 days of discharge and The percentage of discharges for which the patient received follow-up within 7 days of discharge	Process
Follow-Up After Psychiatric Hospitalization†	N/A	Not Endorsed	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.	Process
Follow-Up Care for Adult Medicaid Beneficiaries Who Are Newly Prescribed an Antipsychotic Medication	3313	Endorsed	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Gains in Patient Activation (PAM) Scores at 12 Months	2483	Endorsed	"The Patient Activation Measure® (PAM®) is a 10 or 13 item questionnaire that assesses an individual´s knowledge, skill and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale. There are 4 levels of activation, from low (1) to high (4). The measure is not disease specific, but has been successfully used with a wide variety of chronic conditions, as well as with people with no conditions. The performance score would be the change in score from the baseline measurement to follow-up measurement, or the change in activation score over time for the eligible patients associated with the accountable unit. The outcome of interest is the patient's ability to self-manage. High quality care should result in gains in ability to self-manage for most chronic disease patients. The outcome measured is a change in activation over time. The change score would indicate a change in the patient´s knowledge, skills, and confidence for self-management. A positive change would mean the patient is gaining in their ability to manage their health. A "passing" score for eligible patients would be to show an average net 3-point PAM score increase in a 6-12 month period. An "excellent" score for eligible patients would be to show an average net 6-point PAM score increase in a 6-12 month period."	Outcome: PRO-PM
GE3CLASS_dep: Depression: 60+ Day Overlap of 3+ Classes of Psychotropics	N/A	Not Endorsed	VHA patients with depression receiving medication from 3 or more of 4 psychotropic classes concurrently for 60 or more continuous days.	Process
GE3CLASS_PTSD: PTSD: 60+ Day Overlap 3+ Classes Psychotropics	N/A	Not Endorsed	VHA patients with PTSD receiving medication from 3 or more of 4 psychotropic classes concurrently for 60 or more continuous days.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey*	0166	Endorsed	"HCAHPS (NQF #0166) is a 29-item survey instrument that produces 10 publicly reported measures: 6 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, communication about medicines, discharge information and care transition); and 4 single-item measures (cleanliness of the hospital environment, quietness of the hospital environment, overall rating of the hospital, and recommendation of hospital).	Outcome
Hospice and Palliative Care Composite Process Measure Comprehensive Assessment at Admission (hereafter referred to as the HIS Comprehensive Assessment Measure)*	3235	Endorsed	For patients 18 years and older, percentage of patient stays during which the patient received all care processes captured by quality measures NQF #1641 Hospice and Palliative Care Treatment Preferences; NQF #1647 (modified) Beliefs/Values Addressed (if desired by the patient); NQF #1634 Hospice and Palliative Care Pain Screening; NQF #1637 Hospice and Palliative Care Pain Assessment; NQF #1639 Hospice and Palliative Care Dyspnea Screening; NQF #1638 Hospice and Palliative Care Dyspnea Treatment; NQF #1617 Patients Treated with an Opioid Who Are Given a Bowel Regimen, as applicable.	Composite
Hospital Harm – Opioid-related Adverse Events†	3501e	Not Endorsed	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.	Outcome
Hours of Physical Restraint Use	640	Endorsed	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.	Process
Hours of Seclusion Use	641	Endorsed	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.	Process
Improvement in Pain Interfering With Activity*	177	Endorsed	Percentage of home health episodes of care during which the patient's frequency of pain when moving around improved.	Outcome

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Improvement or Maintenance of Functioning for All Individuals Seen for Mental Health and/or Substance Use Care†	N/A	N/A	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.	Outcome
Improving or Maintaining Mental Health*	N/A	Not Endorsed	Percent of all plan members whose mental health was the same or better than expected after two years.	Outcome
Initial Opioid Prescribing at High Dosage (IOP-HD)	N/A	Not Endorsed	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions with an average daily morphine milligram equivalent (MME) of ≥50. A lower rate indicates better performance.	Process
Initial Opioid Prescribing for Long Duration (IOP-LD)	3558	Endorsed	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for >7 cumulative days' supply. A lower rate indicates better performance.	Process
Initial Opioid Prescribing for Long-Acting or Extended-Release Opioids (IOP-LA)	N/A	Not Endorsed	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for long-acting or extended-release opioids. A lower rate indicates better performance.	Process
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*	4	Endorsed	This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported: Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis. Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Intensive Outpatient and Partial Hospitalization Services	N/A	Not Endorsed	Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period.	Process
Kidney Stones: Opioid Utilization After Ureteroscopy and Shockwave Lithotripsy*	N/A	Not Endorsed	Percentage of patients who underwent ureteroscopy or shockwave lithotripsy and are discharged on NSAIDS, Acetaminophen, or "Other" and who were not prescribed opioids for pain control.	Process
loMPR: Antipsychotic (Active): Medication Possession Ratio <0.8	N/A	Not Endorsed	VHA outpatients with schizophrenia or schizoaffective disorder who have a low antipsychotic medication possession ratio (less than .8)	Outcome
Measurement-based Care Processes: Baseline Assessment, Monitoring and Treatment Adjustment†	N/A	N/A	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	Process
Medicaid Beneficiaries Treated in an IMD for SUD	N/A	Not Endorsed	Number of beneficiaries with a claim for residential treatment for SUD in an IMD during the reporting year.	Process
Medicaid Beneficiaries With Newly Initiated SUD Treatment/Diagnosis	N/A	Not Endorsed	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period but not in the three months before the measurement period.	Process
Medicaid Beneficiaries With SUD Diagnosis (annually)	N/A	Not Endorsed	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period.	Process
Medicaid Beneficiaries With SUD Diagnosis (monthly)	N/A	Not Endorsed	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 11 months before the measurement period.	Process
Medication-Assisted Treatment (MAT)	N/A	Not Endorsed	Number of beneficiaries who have a claim for MAT for SUD during the measurement period.	Process
Mental Health Utilization†	9999	Not Endorsed	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.	Cost/Reso urce Use
Multimodal Pain Management*	N/A	Not Endorsed	Percentage of patients, aged 18 years and older, undergoing selected surgical procedures that were managed with multimodal pain medicine.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Non-Opioid Pain Management Following Mohs Micrographic Surgery	N/A	Not Endorsed	Percentage of cases of Mohs surgery who received a prescription for opioid / narcotic pain medication (prescription prior to or at the time of surgical discharge from the Mohs surgeon) following Mohs micrographic surgery.	Process
OAT: Opioid Use Disorder (OUD): Opioid Agonist Treatment	N/A	Not Endorsed	Opioid dependent patients receiving Opioid Agonist Treatment in either a clinic (including fee-basis) or office-based setting	Process
Oncology: Medical and Radiation - Plan of Care for Pain*	0383	Endorsed	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.	Process
Opioid Therapy Follow-Up Evaluation*	N/A	Not Endorsed	All patients 18 and older prescribed opiates for longer than six weeks duration who had a follow-up evaluation conducted at least every three months during Opioid Therapy documented in the medical record.	Process
Outpatient Services	N/A	Not Endorsed	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period.	Process
Overuse of Opioid Containing Medications for Primary Headache Disorders†	N/A	Not Endorsed	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.	Process
Pain Interference Response Utilizing PROMIS*	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) who report pain issues and demonstrated a response to treatment at one month from the index score.	Patient Reported Outcome (PRO)

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Patients Discharged on Multiple Antipsychotic Medications With Appropriate Justification	560	Endorsed	The proportion of patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-1: Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths completed, HBIPS-2: Physical Restraint, HBIPS3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission s accreditation process. Note that this is a paired measure with HBIPS-4 (Patients discharged on multiple antipsychotic medications).	Process
Patients Treated With an Opioid Who Are Given a Bowel Regimen*	1617	Endorsed	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed.	Process
PDMP_Benzo: Benzodiazepine: Prescription Drug Monitoring Program (PDMP) Checks	N/A	Not Endorsed	VHA patients prescribed a benzodiazepine with a PDMP check documented in the past year	Process
Post-Operative Opioid Management Following Ocular Surgery	N/A	Not Endorsed	Percentage of patients aged 18 years and older who underwent ocular surgical procedures who were assessed for opioid use/requirements post-operatively, defined by either not receiving opioids post-operatively, receiving opioids for pain for 7 days or less post-operatively, or if expected to require opioids for more than 7 days after the surgical procedure, having an opioid use management plan documented.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Post-Traumatic Stress Disorder (PTSD) Screening and Outcome Assessment	N/A	Not Endorsed	The percentage of patients with a history of a traumatic event (i.e., an experience that was unusually or especially frightening, horrible, or traumatic) who report symptoms consistent with PTSD for at least one month following the traumatic event AND with documentation of a standardized symptom monitor (PCL-5 for adults, CATS for child/adolescent) AND demonstrated a response to treatment at three months (+/- 60 days) after the index visit.This measure is a multi-strata measure, which addresses symptom monitoring for both child and adult patients being treated for post-traumatic stress symptoms. Assessment instruments monitoring severity of symptoms for PTSD are validated either for adult or child populations. Thus, while the measurement structure will be similar for both populations, the specified instruments for symptom monitoring will be different.	Patient Reported Outcome (PRO)
Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)†	3589	Endorsed	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.	Process
Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)*	0418e	Endorsed	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Process
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling*	2152	Endorsed	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	Process
Prostate Cancer: Opioid Utilization After Radical Prostatectomy	N/A	Not Endorsed	Percentage of patients who underwent radical prostatectomy and are discharged with ≤ 6 opioid pain pills (5mg oxycodone or equivalent) and do not get a prescription for opioids within 30 days of surgery.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Query of Prescription Drug Monitoring Program (PDMP)*	N/A	Not Endorsed	For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.	Process
Residential and Inpatient Services	N/A	Not Endorsed	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.	Process
Risk of Continued Opioid Use (COU)	N/A	Endorsed	The percentage of individuals 18 years of age and older who are on long-term opioid therapy and have not received a drug test at least once during the measurement year.	Process
Risk-standardized Prolonged Opioid Prescribing Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Knee Arthroplasty†	N/A	Not Endorsed	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.	Outcome
Safe Opioid-Prescribing Practices*	N/A	Not Endorsed	Percentage of patients, aged 18 years and older, prescribed opioid medications for longer than six weeks' duration for whom ALL of the following opioid prescribing best practices are followed: 1. Chemical dependency screening (includes laboratory testing and/or questionnaire) within the immediate 6 months prior to the encounter 2. Co-prescription of naloxone or documented discussion regarding offer of Naloxone co-prescription, if prescription is ≥50 MME/day 3. Non co-prescription of benzodiazepine medications by prescribing pain physician and documentation of a discussion with patient regarding risks of concomitant use of benzodiazepine and opioid medications.	Process
Safe Use of Opioids – Concurrent Prescribing*	3316e	Endorsed	Patients age 18 years and older prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge from a hospital-based encounter (inpatient or emergency department [ED], including observation stays).	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Screening and Monitoring for Psychosocial Problems Among Children and Youth*	N/A	Not Endorsed	Percentage of children from 3.00 to 17.99 years of age who are administered a parent-report, standardized and validated screening tool to assess broad-band psychosocial problems during an intake visit AND who demonstrated a reliable change in parent-reported problem behaviors 2 to 6 months after initial positive screen for externalizing and internalizing behavior problems.	Patient Reported Outcome (PRO)
Shared Decision Making for Post-Operative Management of Discomfort Following Rhinoplasty	N/A	Not Endorsed	Percentage of patients aged 15 years and older who had a rhinoplasty procedure who had documentation of a pre-operative shared-decision making strategy for multi-modal post-operative management of discomfort. Definitions: Documentation of discussion of at least two mechanisms of pain management from the following terms or phrases (one term or phrase from each list) will meet the measure: List 1) Non-opioid analgesics: Non-narcotic/Non-opioid, Acetaminophen/Tylenol, Cox-II inhibitor (Celecoxib), Local/Marcaine/Block, Anxiolytic, Tramadol, NSAID/ibuprofen List 2) Non-systemic: Ice/Cooling, Elevation, Rest, Mindfulness, Meditation	Process
Sleep Quality Screening and Sleep Response at Three Months	N/A	Not Endorsed	Percentage of patients 18 years and older who reported sleep quality concerns (e.g., insomnia) with documentation of a standardized tool AND demonstrated a response to treatment at three months (+/- 60 days) after index visit.	Patient Reported Outcome (PRO)
Social Role Functioning Outcome Utilizing PROMIS	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) with a mood or anxiety disorder who report concerns related to their psychosocial function and demonstrated a response to treatment two months (+/- 30 days) after the index visit.	Patient Reported Outcome (PRO)
SUB 2 - Alcohol Use Brief Intervention Provided or Offered	1663	Endorse ment Removed	Hospitalized patients 18 years of age and older who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge [temporarily suspended]).	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
SUD Provider Availability	N/A	Not Endorsed	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.	Process
SUD Provider Availability – MAT	N/A	Not Endorsed	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.	Process
SUD16: Opioid Use Disorder (OUD): Medication-Assisted Therapy	N/A	Not Endorsed	Opioid dependent patients receiving Medication Assisted Therapy in either a clinic (including fee-basis) or office-based setting	Process
Symptom Improvement in Adults With ADHD	N/A	Not Endorsed	The percentage of adult patients (18 years of age or older) with a diagnosis of ADHD who show a reduction in symptoms of .25 (25%) on the Adult ADHD Self-Report Scale (ASRS-v1.1 - referred to as ASRS) 18 item self-report scale of ADHD symptoms within 2 to 6 months after initially reporting significant symptoms.	Patient Reported Outcome (PRO)
Unsafe Opioid Prescriptions at the Dialysis Practitioner Group Level†	3616	Not Endorsed	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	Process
Unsafe Opioid Prescriptions at the Prescriber Group Level†	3615	Not Endorsed	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	Process
Use and Adherence to Antipsychotics Among Members With Schizophrenia	544	Endorse ment Removed	Assess the use of and the adherence of antipsychotics among members with schizophrenia during the measurement year.	Outcome
Use of a "PEG Test" to Manage Patients Receiving Opioids	N/A	Not Endorsed	Percentage of patients in an outpatient setting, aged 18 and older, in whom a stable dose of opioids are prescribed for greater than 6 weeks for pain control, and the results of a "PEG Test" are correctly interpreted and applied to the management of their opioid prescriptions.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	2801	Endorsed	Percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication, but no U.S. Food and Drug Administration primary indication for antipsychotics, and had documentation of psychosocial care as first-line treatment.	Process
Use of Opioids at High Dosage in Persons Without Cancer*	2940	Endorsed	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	Process
Use of Opioids From Multiple Providers and at High Dosage in Persons Without Cancer*	2951	Endorsed	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	Process
Use of Opioids From Multiple Providers in Persons Without Cancer*	2950	Endorsed	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	Process
Use of Pharmacotherapy for Opioid Use Disorder (OUD)*	3400	Endorsed	The percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.	Process
Verify Opioid Treatment Agreement*	N/A	Not Endorsed	For at least one unique patient for whom a Schedule II opioid was electronically prescribed by the MIPS eligible clinician using CEHRT during the performance period, if the total duration of the patient s Schedule II opioid prescriptions is at least 30 cumulative days within a 6-month look-back period, the MIPS eligible clinician seeks to identify the existence of a signed opioid treatment agreement and incorporates it into the patient s electronic health record using CEHRT.	Process

Measure Title	NQF #	NQF Endorse-ment Status	Measure Description	Measure Type
Withdrawal Management	N/A	Not Endorsed	Number of beneficiaries who use withdrawal management services (such as inpatient, outpatient, or residential) during the measurement period.	Process

Appendix C: Measure Concept Inventory Scan

These measure concepts are a combination of those identified by the Opioids and Behavioral Health Committee and those previously published in the 2019 NQF Opioids and Opioid Use Disorder Final Environmental Scan.

#	Description	Measure Type
1	Average inpatient daily MMEs administered during hospitalization	Process
2	Behavioral health integration in medical care instrument	Process
3	Clinical Opiate Withdrawal Scale	Process
4	Continuity of Pharmacotherapy for Opioid Use	Process
5	Current Opioid Misuse Measure is a 17-item survey useful in assessing prescription opioid use in SUD treatment settings	Process
6	Daily MMEs prescribed at discharge	Process
7	Days' supply of initial opioid prescription for acute pain.	Process
8	Discharges from opioid use	Process
9	Extended-release opioid prescriptions as a proportion of all initial opioid prescriptions for acute pain.	Process
10	Extended-release opioid prescriptions as a proportion of all initial opioid prescriptions for chronic pain.	Process
11	Hospital-level risk-standardized opioid extended use following elective THA and/or TKA	Process
12	Hospital-level risk-standardized opioid respiratory depression following elective THA and/or TKA	Outcome
13	Improvement or maintenance of functioning for all patients seen for mental health and substance use care	Outcome
14	Improvement or maintenance of symptoms for patients with opioid misuse	Outcome
15	Morphine milligram equivalent (MME) of initial opioid prescription for chronic pain.	Process
16	Neonatal Infant Pain Scale	Process
17	Neonatal Pain Agitation and Sedation Scale	Process

#	Description	Measure Type
18	Number of opioid prescribers for single patient	Process
19	Number of opioid prescriptions per 1,000 office visits	Process
20	Number of pills prescribed at discharge	Process
21	OD death synthetic opioids	Outcome
22	Opioid administration among the headache/migraine patients who visited ED	Process
23	Opioid burden	Outcome
24	Opioid covered-days prescribed to the patients who were discharged from ED	Process
25	Overdose deaths any opioid	Outcome
26	Pain measure for children in inpatient; pain reduction by 30% within 120 minutes of complaint	Outcome: PRO-PM
27	Patient experience of care for all patients seen with mental health and substance use care	Outcome: PRO-PM
28	Percentage of hospitalized patients with OUD on medication management	Process
29	Percentage of opioid prescriptions for acute pain with less than 7-day supply	Process
30	Percentage of opioid prescriptions with partial fill instructions	Process
31	Percentage of opioid-naïve patients prescribed C-II & C-III opioid on emergency department discharge	Process
32	Percentage of patients administered long-acting opioid during hospital stay	Process
33	Percentage of Patients Prescribed Chronic Opioid with Risk and Plan Documented	Process
34	Percentage of patients prescribed long-acting opioid at hospital discharge	Process
35	Percentage of patients prescribed opioid	Process

#	Description	Measure Type
36	Percentage of patients prescribed opioid at discharge	Process
37	Percentage of patients prescribed opioid more than 3 months after surgery	Process
38	Percentage of patients prescribed opioid with daily MME > 90 among those who were prescribed	Process
39	Percentage of patients that received more than 50 MME during at least one day of their hospitalization	Process
40	Percentage of patients treated for opioid overdose in emergency department	Process
41	Percentage of patients with documented Opioid Risk Tool assessment among those on chronic opioids	Process
42	Percentage of patients with Naloxone on medication list while they received opioid with daily MME > 90	Process
43	Percentage of patients with office visits within prior 3 months among chronic opioid users	Process
44	Percentage of patients with OUD discharged with naloxone	Process
45	Percentage of patients with urine drug toxicology among chronic opioid users	Process
46	Percentage of prescribers who have written for 1+ prescription of buprenorphine/naloxone	Process
47	Percentage of prescribers with a suboxone waiver	Process
48	Proportion of patients who received a urine drug test within 30 days before initial opioid prescription (initial screening) and within 365 days after initial opioid prescription (annual screening) for chronic pain.	Process
49	Proportion of patients with a follow-up visit (based on E&M CPT codes) within 30 days after the initial opioid prescription for chronic pain.	Process
50	Quantity of opioid prescribed to the patients who were discharged from ED	Process
51	Rapid Recovery Progression Measure: 6-item	Intermediate Outcome

#	Description	Measure Type
52	Rate of NY Office of Alcoholism and Substance Abuse Services (OUD treatment program) Use	Process
53	Recovery Progression Measure: 36-item	Intermediate Outcome
54	Subjective Opiate Withdrawal Scale	Process
55	The percentage of patients on long-term opioid therapy (the clinician counseled on the risks and benefits of opioids at least annually.)	Process
56	The percentage of patients on long-term opioid therapy who had a follow-up visit at least quarterly.	Process
57	The percentage of patients on long-term opioid therapy who had at least quarterly pain and functional assessments.	Process
58	The percentage of patients on long-term opioid therapy who had documentation that a PDMP was checked at least quarterly.	Process
59	The percentage of patients on long-term opioid therapy who were counseled on the purpose and use of naloxone and either prescribed or referred to obtain naloxone	Process
60	The percentage of patients on long-term opioid therapy with documentation that a urine drug test was performed at least annually.	Process
61	The percentage of patients with a follow-up visit within 4 weeks of starting an opioid for chronic pain.	Process
62	The percentage of patients with a new opioid prescription for acute pain for a three days' supply or less	Process
63	The percentage of patients with a new opioid prescription for an immediate-release opioid.	Process
64	The percentage of patients with a new opioid prescription for chronic pain with documentation that a PDMP was checked prior to prescribing.	Process
65	The percentage of patients with a new opioid prescription for chronic pain with documentation that a urine drug test was performed prior to prescribing.	Process
66	The percentage of patients with chronic pain who had at least one referral or visit to nonpharmacologic therapy as a treatment for pain.	Process
67	PROMIS Pain Interference Instruments	Outcome: PRO-PM

#	Description	Measure Type
68	PROMIS Physical Function - Short Form	Outcome: PRO-PM
69	PROMIS Pain Intensity Scale	Outcome: PRO-PM
70	PROMIS Emotional Distress-Depression Short Form	Outcome: PRO-PM
71	PROMIS Emotional Distress-Anxiety Short Form	Outcome: PRO-PM

Appendix D: List of Identified Measurement Gaps

These measurement gaps and concepts represent those identified by the Opioids and Behavioral Health Committee through a prioritization survey. They are organized by the domain and subdomains of the Measurement Framework.

Measurement Gap	Domain	Subdomain
State level access to appropriate MOUD	Equitable Access	Existence of Services
Access to and quality of nonmedication pain management (e.g., physical therapy, occupational therapy)	Equitable Access	Existence of Services
ED utilization rates for SUD/OUD/mental health needs (and not just for overdoses)	Equitable Access	Existence of Services
Health plan level measures, including opioid-associated ED visits, hospitalization, and mortality	Equitable Access	Existence of Services
Global availability of treatment for patients with unaddressed behavioral health problems	Equitable Access	Existence of Services
Health plan level access to SUD/OUD/mental health treatment	Equitable Access	Financial Coverage of Services
Insurance reimbursement for social work related to opioid and behavioral health treatment	Equitable Access	Financial Coverage of Services
Post-incarceration support for other core needs (e.g., housing, food)	Equitable Access	Vulnerable Populations
Appropriate screening and prevention for housing insecurity and homelessness	Equitable Access	Vulnerable Populations
Health equity for SUDs/OUD/mental health	Equitable Access	Vulnerable Populations
Ensuring health plan coverage in place immediately post-incarceration with access and referral to SUD/OUD/mental health services	Equitable Access	Vulnerable Populations
Insurance coverage lapses during and after incarceration	Equitable Access	Vulnerable Populations

Measurement Gap	Domain	Subdomain
MOUD follow-up for OUD after ED or inpatient visit (e.g., at 7 and 30 days)	Clinical Interventions	Availability of Medications for Opioid Use Disorder (MOUD)
Screening and initiation of MOUD in the ED and/or inpatient for OUD	Clinical Interventions	Availability of MOUD
MOUD follow-up for OUD after incarceration (e.g., at 7 and 30 days)	Clinical Interventions	Availability of MOUD
Screening and initiation of MOUD during incarceration	Clinical Interventions	Availability of MOUD
Management of suicidality due to pain catastrophizing	Clinical Interventions	Measurement-Based Care for Mental Health and SUD Treatment
Documentation of non-opioid pain management treatment plan before prescribing opioid analgesics	Clinical Interventions	Adequate Pain Management Care
Implementation of risk-benefit analysis during opioid treatment considerations	Clinical Interventions	Adequate Pain Management Care
Appropriate tapering and discontinuation of opioids	Clinical Interventions	Adequate Pain Management Care
Pain care plan for at-risk youth after a sports injury	Clinical Interventions	Adequate Pain Management Care
Documentation of offering opioid tapering for patients on long-term, high-dose opioid therapy for non-cancer pain	Clinical Interventions	Adequate Pain Management Care
Inappropriate discontinuity of pain management treatment at the health plan level (e.g., providers abruptly dropping patients)	Clinical Interventions	Adequate Pain Management Care
Appropriate follow-up and treatment post-overdose	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Receipt of nontraditional care services (e.g., peer navigation, care coordination, transportation, and internet)	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Referral to appropriate, evidence-based clinical recovery program after an SUD-related sentinel event	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services

Measurement Gap	Domain	Subdomain
Role of telemedicine for consultations, coordinated care, and linkages to specialists	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Establishment of a primary care relationship for patients previously incarcerated	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Screening for psychiatric disorders for SUD patients	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Improving screening in primary care and mental health settings	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Communication across settings regarding overdose events	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Management of multiple behavioral health conditions within single coordinated care team	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Polypharmacy for controlled substances and psychopharmaceuticals	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Screening and prevention for at-risk youth	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Deprescribing measures associated with opioid polypharmacy	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Appropriate screening and prevention within foster care	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services

Measurement Gap	Domain	Subdomain
Polypharmacy with opioid use	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Existence of a centralized pain care treatment plan	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Identification of child/adolescent behavioral health risk factors and effective screening and intervention	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Screening across settings before prescribing opioids or opioid dose escalations	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Percentage of opioid prescriptions with diagnosis codes	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Referrals to clinical settings from nonclinical settings	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Screening, brief intervention, and referral to treatment with every opioid prescription	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Smoking cessation among individuals who use drugs and/or have SUD	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Vaping among youth	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Coordination of Care Pathways Across Clinical and Community-Based Services
Co-prescription of naloxone with every opioid prescription	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Harm Reduction Services

Measurement Gap	Domain	Subdomain
Percentage of high-risk patients with opioid prescriptions who are co-dispensed naloxone	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Harm Reduction Services
Youth access to naloxone within educational settings	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Harm Reduction Services
Provision of fentanyl test strips to injectable drug users	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Harm Reduction Services
Measures of recovery and quality of life	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Person-Centered Care
Patient-reported outcomes on an individual's ability to work and socialize and on SDOH	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Person-Centered Care
Inclusion of patient and family voices in assessing care for patients affected by combinations of pain, behavioral health conditions, and/or opioids	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Person-Centered Care
Shared decision making regarding opioid tapering for patients on long-term, high-dose opioid therapy for noncancer pain	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Person-Centered Care
Cultural acceptability of SUD prevention and treatment modalities through a survey	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Person-Centered Care
Patient-reported success and recovery	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Person-Centered Care
Patient- and family-derived assessments of care in the context of SUDs/OUD and mental health conditions	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Person-Centered Care

Measurement Gap	Domain	Subdomain
Familial-associated risk and familial engagement in treatment	Integrated and Comprehensive Care for Concurrent Behavioral Health Conditions	Person-Centered Care