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Opioids and Opioid Use Disorder: Quality Measurement Priorities

Final Report

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Contents

Executive Summary 3
Introduction and Background 3
Priority Areas of Gaps in Measure Concepts for Opioids and Opioid Use Disorders 5
Process 5
Results 7
Discussion 13
Conclusions Regarding Priority Gaps 16
Guidance on Opioid and OUD Measurement for Federal Programs 17
Overarching Themes 18
Medicare Shared Savings Program (SSP) 18
The Merit- Incentive Payment System (MIPS) 20
Alternative Payment Models (APM) 22
Hospital Inpatient Quality Reporting (IQR) Program 22
Hospital Value-Based Purchasing (VBP) Program 23
Conclusions Regarding Federal Programs 23
Conclusion and Next Steps 24
References 25
Appendix A: Committee Members, NQF Staff, and Federal Liaisons 28
Appendix B: Prioritization Criteria Survey Results 32
Appendix C: Measure Inventory from Opioid TEP Environmental Scan 34
Appendix D: Measure Concept Inventory from Opioid TEP Environmental Scan 99
Appendix E: Measure Set for the Shatterproof Quality Measurement System for Addiction Treatment Facilities 103
Appendix F: Opioid Crisis Indicators Evident in State Dashboards* 104
Appendix G: Public Comments on Draft Report 105

Executive Summary

Through this report, the National Quality Forum (NQF) offers the Centers for Medicare & Medicaid Services (CMS) and other stakeholders a review of healthcare quality measures (QM) relevant to addressing America's opioid crisis. The report considers issues related to acute and chronic pain management and substance use disorders (SUD). It answers two guiding questions: (1) What are the priority gaps in QM science that need to be filled in order to reduce opioid use disorders (OUD) and opioid overdose deaths without undermining effective pain management? (2) What existing and conceptual measures should be deployed in the following types of federal medical payment programs to best address the opioid crisis moving forward: Merit-Based Incentive Payment System (MIPS), alternative payment models (APMs), the Medicare Shared Savings Program (SSP), the Hospital Inpatient Quality Reporting Program (IQR), and the Hospital Value-Based Purchasing Program (VBP)?

The conclusions of this report emerged from an NQF-facilitated consensus development process engaging a 28-member Technical Expert Panel (TEP). The TEP was composed of physicians, nurses, patients, pharmacists, and others with expertise and experience in pain management and OUD. CMS funded this work pursuant to enabling legislation from the U.S. Congress, the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Section 6093. Ultimately, the guidance proffered here aims to achieve the application of the proper healthcare quality metrics across the U.S. healthcare system. Using the best metrics, in turn, aims both to continue to reduce opioid deaths verifiably, to encourage the implementation of best practices of pain management, to decrease the incidence of other SUDs, and to decrease illegal drug use by those unable to obtain prescription pain medication.

Introduction and Background

The opioid overdose epidemic continues to be a national public health crisis. It compels the attention of many citizens and policymakers across the political spectrum. This has resulted in significant effort to curb prescription and illegal opioid misuse and .[1–5]

Recent data from the U.S. National Survey on Drug Use and Health (NSDUH), the Centers for Disease Control and Prevention (CDC), and local sources show that opioid overdose deaths and rates of opioid use disorder (OUD) are beginning to recede but remain high. In 2018 the NSDUH revealed that rates of prescription opioid use were at 3.7 percent among persons age 12 or older, down significantly from 4.7 percent in 2015. Additionally, the NSDUH revealed that in 2018 pain reliever misuse initiators numbered 1.9 million, down slightly (though not significantly) from the 2015 level of 2.1 million. Finally, the NSDUH revealed that overall numbers of OUD cases remained flat during the last several years at around 2 million persons in the U.S.[9]

With regard to overdose mortality, data from the CDC and individual states have shown slight declines in opioid-related deaths.[10–13] The inference that might be drawn from these recent trends is either that opioid-related morbidity and mortality are gradually receding based on factors external to the healthcare system, or that medical and public health policies in place nationally and locally are having some desired effect. In all probability, both factors are likely in play.

There are many measurement challenges associated with the opioid crises. For example, many opioid overdoses are not directly connected to the regular provision of pain management care. A recent study that examined opioid overdoses in Massachusetts indicated that only 1.3 percent of decedents had an active prescription for an opioid; most decedents had used heroin or fentanyl.[14] Three major changes have recently been identified as the crisis has matured: overall decreases in opioid overdose deaths; decrease in prescription opioid deaths without co-involved illicit opioids or synthetic opioids; and increases in illicit fentanyl deaths and nonopioid drugs present in opioid deaths, such as cocaine, methamphetamine, and benzodiazepines. The CDC has described the latter as a new "fourth wave" of the opioid crisis: polysubstance use.

Increasingly, the conversation around quality measurement for opioid use disorder and overdose prevention cannot be isolated from a broader discussion of measurement for substance use disorder. Moreover, reports about declines in opioid overdoses note that a variety of factors are correlated to declines in overdoses including tougher policing, treatment program expansion, limiting painkiller use, and expanding the use of the overdose antidote naloxone.[15] Considerations for measurement risk adjustment also come into play within opioid utilization and OUD measures, further complicating the picture of best measurement practice. Geographic epidemiological work demonstrates variations in opioid-related overdoses that are presumed to be related to differences in "opportunities and resources" at the U.S. county level which include rates of disability, employment, housing crowding, insurance, and racial and ethnic diversity.[16]

This report is pursuant to Section 6093 the SUPPORT Act signed by President Trump in October of 2018.[17,18,19] The SUPPORT Act called for the establishment of a "technical expert panel for the purpose of reviewing quality measures relating to opioids and opioid use disorders including care, prevention, diagnosis, health outcomes and treatment furnished to individuals with opioid use disorders." Under the authority of this law, the Department of Health and Human Services (HHS) contracted with the National Quality Forum (NQF) to establish a technical expert panel (TEP) (Appendix A) to consider opioid and OUD-related quality measures, including an inventory of existing measures, measure concepts (i.e., measures that have not been fully specified and tested), and apparent gaps.

As called for in the SUPPORT Act, the TEP was directed to do the following:

1. Review quality measures that relate to opioids and opioid use disorders, including those that are fully developed or are under development;
2. Identify gaps in areas that relate to opioids and opioid use disorders, and identify measure development priorities for such measure gaps; and
3. Make recommendations to HHS on quality measures with respect to opioids and opioid use disorders for purposes of improving care, prevention, diagnosis, health outcomes, and treatment, including recommendations for revisions of such measures, need for development of new measures, and recommendations for including such measures in the Merit-Based Incentive Payment System (MIPS), alternative payment models (APMs), the Share Savings Program (SSP), the quality reporting requirements for inpatient hospitals, and the Hospital Value-Based Purchasing (VBP) program.

To fulfill the first mandate, NQF and the TEP conducted a review of existing quality measure databases, recent literature including technical reports, state laws and policies, and key informant interviews. The scan reflects the current state of measurement science directly (i.e., opioids specifically) and indirectly (e.g., broader SUD issues) related to OUD as well as the TEP's general consensus regarding the U.S. opioid epidemic's antecedents, challenges, and potential remedies. NQF published the findings of this review in an environmental scan report in September 2019.[20]

To fulfill the second and third mandates, between August and October 2019, the TEP focused on two tasks: (1) identifying gaps in healthcare quality measurement of most immediate importance to address the current crisis and creating a list of priority areas and a list of measure gaps based on the consideration of the over 270 measures and measure concepts identified by the above described environmental scan; and (2) providing guidance for the inclusion of measures in various federal healthcare accountability programs such as the Merit-Based Incentive Payment System (MIPS), alternative payment models (APMs), the Medicare Shared Savings Program (SSP), the Hospital Inpatient Quality Reporting Program (IQR), and the Hospital Value-Based Purchasing Program (VBP). Note that the term "gaps" in this context generally refers to *missing* measures, measure concepts, or measure components.

These above listed federal programs are targeted explicitly because they represent substantial and ongoing efforts by the U.S. national healthcare infrastructure to manage and innovate simultaneously within this complex and far-reaching system.

Priority Areas of Gaps in Measure Concepts for Opioids and Opioid Use Disorders

The work described here addresses the opioid crisis by tapping the knowledge of medical experts and others experienced in the fields of pain and the prevention and treatment of substance use disorders (SUD). This focus is manifest in the TEP's philosophy and composition. Accordingly, this work has a key goal to identify priorities for measurement science as it relates to the opioid crisis. That is, the initiative seeks to form measurement ideas currently missing from the quality measurement enterprise which have high potential to help policymakers, practitioners, researchers, and the public follow the course of the epidemic by using precise indicators that both promote appropriate responses and verify whether or not such interventions are yielding desired benefits and minimizing negative consequences (such as impeding appropriate access to pain treatment, or access to SUD treatment).

Process

NQF assembled a group of technical experts to participate in the TEP TEP members were vetted through a nominations process as well as public review and comment. liaisons and NQF staff (Appendix A). Over the course of four web meetings between April and August 2019, the TEP deliberated over background information and existing measures and measure concepts related to the use of opioids for pain and to the issue of OUD. NQF engaged the Opioid and Opioid Use Disorder TEP to prioritize the gaps evident from that comprehensive review.

During web meeting 4, the TEP discussed the results of the environmental scan and the resulting apparent gaps in available measures and measure concepts. The environmental scan resulted in 207 fully developed measures and 71 measure concepts. To organize this large volume of material, the environmental scan was divided into the following four broad domains:

1. Pain management
2. OUD treatment
3. Harm reduction (pursuant to OUD)
4. Social issues (e.g., violence, crime, economics, and other determinants of health)

Staff presented an assessment of the quantity or quality gaps related to measures and measure concepts for each domain. From the Panel's subsequent discussion, NQF staff identified 32 priority gap areas in the form of measure concepts, i.e., one-sentence measure descriptions. The Panel discussed this draft list in depth and suggested refinements. During its deliberations, the TEP considered extant measures to understand the present state of the quality measurement enterprise related to opioid use, but also to detect apparent omissions (i.e., gaps in measurement which should be filled). Following the web meeting, NQF staff incorporated the Panel's recommendations to create a formal listing of the top 32 identified priority areas and measure concepts.

The above described list of 32 was then used to poll TEP members (via internet survey) to obtain their very highest priority measure concept gaps within that list (Appendix B). Twenty of 28 TEP members completed the prioritization survey. To guide the Panel's decisions, NQF staff and the Panel developed the following prioritization criteria:

1. Impact on morbidity and mortality
2. Feasibility to implement as a quality measure
3. Contemporary performance gap (i.e., current need for improvement)
4. Patient-centeredness (i.e., considers patient desires)
5. Fairness (i.e., minimizes disparities)

For each of the five prioritization criteria, the Panel "voted" using a Likert scale to rate each measure concept as either low, moderate, or high priority with regard to each of the five prioritization criteria. A rating of a low priority received a score of 1; a rating of moderate priority received a score 2; and a rating of high priority received a score of 3.

The NQF staff used three methods to summarize the results of the prioritization voting exercise:

> **Method 1 – Simple Average**. Each prioritization criterion received an equal weight, and a score was calculated by computing the simple average.
> **Method 2 – Weighted-Sum Average.** A score was calculated using a weighted-sum average schema. The weighting emphasized morbidity and mortality over other criteria, and further emphasized performance gap, patient-centeredness, and fairness, over feasibility. The weighted values (Table 1) reflect the Panel's deliberations on the relative importance of each criterion in the prioritization exercise.

Table 1. Weights Used in Method 2 – Weighted-Sum Average

Prioritization criteria	Weight
Impact on morbidity and mortality	2.5
Feasibility to implement as a quality measure	1
Contemporary performance gap, i.e., current need for improvement	1.5
Patient-centeredness, (i.e., considers patient desires)	1.5
Fairness, (i.e., minimizes disparities)	1.5

NQF staff accordingly used the following formula to compute the weighted-sum average:

- Weighted-sum average = {2.5*(morbidity and mortality) + 1*(feasibility) + 1.5*(performance gap) + 1.5*(patient-centeredness) + 1.5*(fairness)} ÷ 5

Method 3 – Average Morbidity and Mortality Score. A score was calculated using the average of the results of the prioritization criterion "impact on morbidity and mortality." As noted in method 2, the Panel identified "impact on morbidity and mortality" as being of the highest relative importance within the prioritization criteria. This individual score was calculated separately from the other four criteria in order to identify the measure concepts that the Panel felt were of highest priority.

Using these three methods, the staff rank ordered the top 10 from each of the three scoring methods above and brought them into one list. Due to overlap in the lists, this resulted in 15 top-priority measure concepts from the survey list of 32. The staff presented the results of this prioritization exercise to the TEP for review and comment. The following section describes the results of the prioritization exercise and the discussion of the Panel.

Results

As noted above, the TEP identified 15 top-priority areas and measure concepts. The top 15 items were all those which ranked in the top 10 based on any of the three ranking methods described above. The Panel chose the arbitrary threshold of the top 10 to reduce the number of priority areas and concepts to a narrower list for consideration.

The average sum and average-weighted sum scores yielded nearly identical top 10 lists (see Table 2) with only small shifts in the order of items. For example, the top prioritized concept item by simple sum and weightedsum was "patient centered pain management: proper tapering…," and the "special population for OUD treatment such as lesbian, gay, bisexual, transgender, and questioning (or queer) (LGBTQ), pregnant women, criminal justice, homeless populations…" ranked as items 3 and 4 on these lists, respectively. Moreover, method 1 (the simple sum) included "quality of life, level of functioning measures for pain and/or OUD treatments…" in the 10th priority position, while method 2 (weightedsum) placed it in the 11th position.

By contrast, method 3 (morbidity and mortality average, in isolation) prioritized the measures somewhat differently. For example, the top-ranked item based on a simple or weightedsum is the 14th

ranked item using the morbidity and mortality score ranking. These differences between ranking method 3 and the other two methods reflect unexplained variability between the scoring strategies. This uncertainty led NQF staff to ask the TEP to consider all items that ranked in the top 10 with any of the three methods, thus the list contains the 15 total entries (Table 2).

Table 2. Opioid TEP Gap Priority Scores for the Most Highly Ranked Measure Concepts

Reference #	Measure concept description	Simple-sum average score	Weighted-sum average score	Morbidity and mortality average score
1	Patient-centered pain management: proper tapering strategies for opioid analgesics (i.e., record of full and comprehensive pain and quality of life tracking for persons being removed from an opioid pain treatment regimen, including SUD history assessment and monitoring and sleep disorder risk)	2.71	4.44	2.30
2	Recovery: short-term outcomes (30, 60, and 90 day), transition between inpatient and outpatient settings, and long-term outcomes (i.e., change in OUD symptomology such as cravings, mood, work/social, etc. 12, 18, and 24 months or even longer after treatment initiation for OUD)	2.67	4.35	2.90
3	Special populations for OUD treatment such as LGBTQ, pregnant women, criminal justice-involved populations, homeless populations, adolescents, Native Americans and other racial minorities, and rural residents	2.59	4.24	2.40
4	Benefits/coverage/reimbursement (i.e., by region or payer average reimbursement rates for the continuum of American Society of Addiction Medicine [ASAM] level services, SUD service average population coverage [benefits] limits)	2.59	4.22	1.85

Reference #	Measure concept description	Simple-sum average score	Weighted-sum average score	Morbidity and mortality average score
5	OUD treatment with comorbidities: physical treatment such as cardiovascular etc. (i.e., regular screening for physical ailments in persons being treated for OUD)	2.58	4.24	2.75
6	Neonatal Abstinence (Withdrawal) Syndrome (NAS): follow-up for children (i.e., parental support classes for caregivers of NAS cases)	2.55	4.22	2.20
7	Patient-centered pain management: pain care plan (i.e., for those receiving opioids for pain management that exceeds 3 days, a specific plan for monitoring and eventual tapering of opioid use is documented and endorsed by the clinician and patient, and/or use of nonopioid pain management approaches.)	2.54	4.14	2.40
8	OUD treatment with comorbidities: psychiatric treatment (i.e., regular screening for other psychiatric illness in persons with OUD [e.g., SUD codependences, depression, anxiety, psychosis, etc.])	2.47	3.94	2.85
9	Quality of life, level of functioning measures for pain and/or OUD treatments (i.e., composite change in physical, work, social, and emotional functioning—all relative to functioning before onset of pain or OUD)	2.40	3.9	2.35
10	Special populations: the elderly (i.e., access to insurance with essential benefits [per the Affordable Care Act (ACA)] for elderly persons with a history of OUD)	2.39	3.88	2.89

Reference #	Measure concept description	Simple-sum average score	Weighted-sum average score	Morbidity and mortality average score
11	Harm reduction: access to harm reduction programs (i.e., access to harm reduction strategies for persons with OUD [needles/syringes, naloxone, fentanyl test strips, overdose prevention sites])	2.37	3.94	2.85
12	Criminal justice involvement in relation to OUD: screening/treatment during and post-incarceration (i.e., OUD successful referral to treatment rates for those with OUD history discharged from a detention facility)	2.34	3.76	2.80
13	Social risk factors: social support (i.e., social supports assessment for those being treated for OUD)	2.25	3.64	2.60
14	Neonatal abstinence syndrome: prenatal or perinatal counseling (i.e., SUD counseling rates for expectant mothers)	2.12	3.40	2.80
15	Criminal justice involvement in relation to OUD (i.e., record of criminal justice history for persons diagnosed with OUD)	2.11	3.45	2.45
Reference #	Measure concept description	Simple sum average score	Weighted-sum average score	Morbidity and mortality average score
1	Patient-centered pain management: proper tapering strategies for opioid analgesics (i.e., record of full and comprehensive pain and quality of life tracking for persons being removed from an opioid pain treatment regimen, including SUD history assessment and monitoring, and sleep disorder risk)	2.71	4.44	2.30

Reference #	Measure concept description	Simple-sum average score	Weighted-sum average score	Morbidity and mortality average score
2	OUD recovery: short-term outcomes (30, 60 and 90 day), transition between inpatient and outpatient settings, and long-term outcomes (i.e., change in OUD symptomology such as cravings, mood, work/social, etc. 12, 18, and 24 months or even longer after treatment initiation for OUD)	2.67	4.35	2.90
3	Special populations for OUD treatment such as LGBTQ, pregnant women, criminal justice-involved populations, homeless populations, adolescents, Native Americans and other racial minorities, and rural residents	2.59	4.24	2.40
4	Benefits/coverage/reimbursement (i.e., by region or payer average reimbursement rates for the continuum of American Society of Addiction Medicine (ASAM) level services, SUD service average population coverage (benefits) limits)	2.59	4.22	1.85
5	OUD treatment with comorbidities: physical treatment such as cardiovascular etc. (i.e., regular screening for physical ailments in persons being treated for OUD)	2.58	4.24	2.75
6	Neonatal Abstinence (Withdrawal) Syndrome: Follow-up for children (i.e., parental support classes for caregivers of NAS cases)	2.55	4.22	2.20

Reference #	Measure concept description	Simple-sum average score	Weighted-sum average score	Morbidity and mortality average score
7	Patient-centered pain management: pain care plan (i.e. For those receiving opioids for pain management that exceeds 3 days, a specific plan for monitoring and eventual tapering of opioid use is documented and endorsed by the clinician and patient, and/or use of non-opioid pain management approaches.)	2.54	4.14	2.40
8	OUD Treatment with comorbidities: psychiatric treatment (i.e., regular screening for other psychiatric illness in persons with OUD [e.g., SUD codependences, depression, anxiety, psychosis etc.])	2.47	3.94	2.85
9	Quality of life, level of functioning measures for pain and/or OUD treatments (i.e. Composite change in physical, work, social, and emotional functioning—all relative to functioning before onset of pain or OUD)	2.40	3.9	2.35
10	Special populations: the elderly (i.e., access to insurance with essential benefits [per the Affordable Care Act (ACA)] for elderly persons with a history of OUD)	2.39	3.88	2.89
11	Harm reduction: access to harm reduction programs (i.e., access to harm reduction strategies for persons with OUD [needles/syringes, naloxone, fentanyl test strips, overdose prevention sites])	2.37	3.94	2.85

Reference #	Measure concept description	Simple-sum average score	Weighted-sum average score	Morbidity and mortality average score
12	Criminal justice involvement in relation to OUD: screening/treatment during and post-incarceration (i.e., OUD successful referral to treatment rates for those with OUD history discharged from a detention facility)	2.34	3.76	2.80
13	Social risk factors: social support (i.e., social supports assessment for those being treated for OUD)	2.25	3.64	2.60
14	Neonatal abstinence syndrome: prenatal or perinatal counseling (i.e., SUD counseling rates for expectant mothers)	2.12	3.40	2.80
15	Criminal justice involvement in relation to OUD (i.e., record of criminal justice history for persons diagnosed with OUD)	2.11	3.45	2.45

Discussion

In reviewing overarching, across-measure concept summary statistics (Table 3), the following observations were noted. The average priority score across the 32 items evaluated was moderate to high based on all three survey summary methods. This simple observation validates that these 32 priority areas and measure concepts developed from the environmental scan list of 277 measures and measure concepts were indeed ones that the TEP considers as moderate priority gaps on the low to high (i.e., 1 to 3) scale employed. Second, the standard deviations are roughly 10 percent of the means, providing a quantitative heuristic which can be used to consider if different measure concepts score differently from one another. For example, use of this "10 percent equals 1 standard deviation rule-of-thumb" shows that rankings under method 1 in Table 2 are relatively homogenous (i.e., within 1 standard deviation) for measure concepts 1 through 9.

Use of the three different ranking methods described above introduced some uncertainty both with regards to homogeneity and difference between the three ranking methods. To resolve this, a "sum of all ranks" indicator was used as a fourth and final method by NQF staff to proffer for the TEP a list of their apparent top five priorities—five was selected as a manageable subsample for consideration. This choice resulted in these five measure gaps having the highest priority:

1. Long-term recovery from OUD
2. Physical health co-morbidities in OUD
3. Opioid tapering strategies
4. Special populations in OUD treatment (e.g., LGBTQ, pregnant women, criminal justice-involved populations, homeless, adolescents, Native Americans and other racial minorities, rural communities)
5. Psychiatric comorbidities in OUD

Table 3. Summary of Results of Committee Assigned Measure Gap Priority Scores by Scoring Method

Scoring method	Mean	Standard deviation	Empirical range	Possible range (moderate score)
Simple-sum item average	2.3	0.21	1.84-2.71	1-3 (2)
Weighted-sum item average	3.74	0.36	2.93-4.44	2.66-8 (3.33)
Average morbidity and mortality score	2.31	0.33	1.55-2.9	1-3 (2)

The TEP reviewed Table 2 and the top five list noted above and affirmed that these focus areas are a solid representation of their priority gaps. The TEP agreed that the top five list should further be summarized by combining items 2 and 5 into a single element that targets any comorbidity (physical or psychiatric) to OUD. The TEP then agreed to add the sixth ranked gap priority (per Table 2, the last column), yielding a new and final top five list as follows:

The TEP reviewed Table 2 and the top five list and affirmed that these focus areas are a solid representation of their priority gaps, yielding a final top five list as follows:

1. OUD recovery: short-term, transitioning between inpatient and outpatient care, and long-term
2. Physical and/or psychiatric (i.e., mental health) co-morbidities in OUD
3. Physical, psychiatric (i.e., mental health), and SUD co-morbidities in OUD
4. Opioid tapering strategies
5. Special populations in OUD treatment (e.g., LGBTQ, pregnant women, criminal justice-involved populations, homeless, adolescents, Native Americans and other racial minorities, and rural communities)
6. Patient-centered pain management: pain care plan

The TEP deemed valid the recasting of the top five gap priorities because it added pain management balance to a list where OUD measures were previously more dominant. Moreover, the TEP approved the suggestion that pain management items should include patient-centered planning well beyond tapering strategies which are important, but which can be harmful if they are applied too quickly, indiscriminately across all pain patients, or otherwise inappropriately.[21] The list also is in line with the overall tally of the 15 gap priorities identified in Table 2 and more simply clustered in Table 4. Table 4 reveals that OUD gaps predominate, consistent with the top five gap list. Table 4 also emphasizes social

risk factors which emerged in the top 10 lists prominently (Table 2, rows: 3, 11, 13, 16) including mention of criminal justice-involved, homeless, adolescent, rural, and elderly populations.

The TEP noted that educational interventions (to inform consumers about the hazards of prolonged opioid use or the evidence behind OUD treatments) do not appear among the gaps identified, though the TEP accepted that certain gaps like "pain management plan" and "patient-centered care" generally imply consumer involvement as an essential component of care and associated measurement. The TEP also emphasized a strong preference for measures that improve quality of life, reduce harms, and result in deeper social engagement for patients with OUD.

Table 4. Analysis of the Top 15 Priority Areas of Gaps in Measure Concepts by Major Domain

Domain	**Count***
Pain management	3
OUD treatment	12
Harm reduction (related to SUD)	1
Social issues	9
Domain	Count*
Pain management	3
OUD treatment	12
Harm Reduction (related to SUD)	1
Social issues	9

*Counts are not mutually exclusive.

The TEP expressed interest in more explicit emphasis on the medications for OUD (e.g., methadone and buprenorphine) as a gap not in form (as measures do exist), but instead as a gap in measure deployment. The TEP believes increased use of evidence-based pharmacotherapies to treat OUD critical, and measures that are currently available should be both improved and more widely used.

The TEP—in considering its fourth priority (special populations)—requested that this report explicitly refer to racial disparities given that disparities exist in OUD treatment rates and corresponding outcomes. The TEP noted a recent observational study that shows substantial disparities exist in use of medications to treat OUD with marked favorable effects when such medications are prescribed. Across a population of just over 3,600 adolescents to young adults—an age group at high risk for OUD and overdose—black non-Hispanics receive medication treatment for OUD treatment at about half the rate of whites, and people who receive such medications are approximately twice as likely to remain in SUD

treatment 180 and 360 days after initiation. These treatment retention effects include adjustments for age, gender, race, disability status, clinical characteristics, and behavioral health service use at baseline.[22] The TEP also noted the importance of consideration of geographic disparities and rural communities, as well as gender and sexual minorities, among other special populations that are strongly impacted by the opioid crisis.

Finally, the TEP agreed that while OUD is the focus of this report and of the current crisis, long-lasting scrutiny should be paid to SUD overall because OUD and overdoses are commonly associated with other SUDs.[9,14,16]

Conclusions Regarding Priority Gaps

The TEP has taken a list of 32 priority gaps, prioritized it to a top 15 list, and reduced it again to five. Each of the concepts has multiple dimensions and may have multiple level-of-analysis targets. Keeping a list at 32 or even at 15 risks overburdening measure developers and users, thus prompting the decision to limit the list to five, which are further summarized here:

- Measures of opioid tapering, and more general measures related to the treatment of acute and chronic pain, are essential to addressing the opioid crisis.
- The inclusion of some measures for special populations such as LGBTQ, pregnant women, newborns, racial subgroups, and detained persons is important.
- Short-term transition between inpatient and outpatient settings, and long-term follow-up of clients being treated for OUD across time and providers, is important to assess even though there are data challenges.
- Short-term, transitional between inpatient and outpatient settings, and long-term follow-up of clients being treated for OUD across time and providers is important to assess even though there are data challenges.
- Pain management, OUD treatment, SUD treatment, and treatment of physical and mental health comorbidities are all important.

Absent other ideas, organizations developing or deploying measures to address the opioid epidemic should start with the ideas described immediately above.

Though harm reduction strategies were not among the top items identified, they did make the top 15. The TEP generally metrics that encourage the proper (and evidence-based) expansion of naloxone distribution and other more controversial harm reduction strategies such as overdose prevention sites or needle exchange efforts.

Finally, TEP discourse on priority gaps included thinking about more comprehensive measurement sets germane to the federal program review component of their work (see next section) for the simple reason that gap measures typically do not compose comprehensive measure sets, but instead aim to complement metrics available or already in use to address a certain domain of healthcare. Accordingly, NQF staff compiled and briefly described for the TEP measure concept sets for SUD programs, and sets from several state dashboards that target the opioid crisis. Those measurement efforts (summarized in Appendices E and F) are offered as organizational touchstones relevant to the formation of measure

clusters that address the opioid crisis or other similar SUD-related challenges. These metric sets align well with this gap analysis and with the related NQF environmental scan.[20]

Guidance on Opioid and OUD Measurement for Federal Programs

TEP shall "make recommendations to the Secretary on quality measures with respect to opioids and opioid use disorders for purposes of improving care, prevention, diagnosis, health outcomes, and treatment, including recommendations for revisions of such measures, need for development of new measures, and recommendations for including such measures in the

- Merit-Based Incentive Payment System under section 1848(q);
- The alternative payment models under section 1833(z)(3)(C);
- The shared savings program under section 1899;
- The quality reporting requirements for inpatient hospitals under section 1886(b)(3)(B)(viii), and;
- The hospital value-based purchasing program under section 1886(o)."[19]

To meet the mandate related to recommendations for the aforementioned federal quality and performance programs, the TEP was asked to consider the incentive structure and quality measure components and put forward recommendations and guidance for including measures within each of the programs above. To accomplish this, the TEP reviewed the measures and measure concepts (Appendix C and Appendix D) found in the environmental scan as potential measures to recommend to CMS for the programs under consideration, as well as the prioritized measure gaps discussed in the first portion of this report.[20] The last column of the tables in Appendices C and D specifies federal programs that the TEP believed would benefit from the listed measure or a comparable measure. The TEP did not consider whether the measures were in the same state of readiness to be considered for implementation (e.g., appropriateness of specification, evidence, scientific acceptability, feasibility, etc.), but only if the measures a high-priority measurement domain for implementation. An additional selection of measures deployed by Shatterproof—a national nonprofit focused on reducing the impact of addiction—to create a quality measurement system for addiction treatment facilities was also considered. (See Appendix E).

In its consideration of each of these programs, the TEP was asked to use basic principles of healthcare quality measure sets and systems. The concepts of measure set and system are closely related.[23] Measure sets are groups of individual measures, often created based on intent to assess quality in a specific aspect of care; measurement systems are groups of individual measures that, based on a predefined methodology, work together to assess quality or cost in relationship to a goal.

The approach included the review of the intent of each of the programs, including the current set of programmatic quality measures, how accountable units will influence measures used in the set, as well as the topic area, level of analysis, target population, and care settings. In addition, the TEP considered the criteria for measure inclusion, especially those focus areas outlined in the 2019 CMS Program-Specific Measure Needs and Priorities, and language used in proposed and final regulation from each of the programs.[24] The goal of this approach is to ensure that measure recommendations put forward by the TEP align with the process of implementation, the intent of the measure set, and the overall goals of

each of the programs stipulated by the SUPPORT Act for review by the TEP, especially as they pertain to addressing the U.S. opioid crisis.

Overarching Themes

Several themes became apparent in the discussion related to recommendations specific to the five programs assessed by the TEP. First, the TEP encouraged filling the need implied by the gap analysis to add or expand measures related to pain management and for SUD treatment. This included the need for increased, appropriate co-prescribing of naloxone with opioids (for pain or for persons with OUD) that is consistent across the programs as a means of harm reduction.

Similarly, the TEP called for better initial prescribing measures to balance appropriate use of opioids for pain management with associated risks. Additionally, there was a theme around the need in each program for new measures assessing patient-centered analgesia treatment planning, including appropriate tapering strategies to reasonably decrease or discontinue opioid treatment. This last measure was drawn directly from the prioritization exercise, and other measures emphasized by the TEP have potential application to several of the programs below, including measures of short-term transition between inpatient and outpatient settings, and long-term recovery from OUD, measures of physical and mental health comorbidities to OUD, and measures addressing specific populations for OUD treatment.

Medicare Shared Savings Program (SSP)

The Medicare Shared Savings Program is a voluntary program that allows groups of doctors, hospitals, and other healthcare providers to come together to form an Accountable Care Organization (ACO) to deliver coordinated and comprehensive care to Medicare patients. The goal of such organizations is to move CMS' payment system away from volume and toward value and outcomes by promoting accountability for a patient population, coordinating care, and encouraging investment in high-quality and efficient services.[25] Through SSP, ACOs that succeed in delivering high-quality care while simultaneously reducing the costs per beneficiary will share in the savings for the Medicare program.[25]

In order to share in savings, the ACO must both reduce the cost of care for Medicare fee-for-service beneficiaries, as well as perform on a set of quality measures. The TEP was asked to review the measures included in the program, as well as policy changes that went into effect in December 2018, which include improving information sharing on opioid use to combat OUD.

In the review of measures, the TEP found no measures directly related to opioids but identified four quality measures that were peripherally related. These measures were *Tobacco Use: Screening and Cessation Intervention, Screening for Clinical Depression and Follow-up Plan, Depression Remission at Twelve Months,* and *Access to Specialists.*

The TEP also reviewed information related to quality measures included in the SSP Opioid Utilization Reports—quarterly reports that are separate from scoring on the ACO measure set. These reports contain information on an opioid utilization according to four quality metrics, which align with measures found in Medicare Part D related quality programs, including three Pharmacy Quality Alliance measures—*Use of Opioids at High Dosage, Use of Opioids from Multiple Providers,* and *Use of Opioids at*

High Dosage and from Multiple Providers—as well as the Overutilization Monitoring System measure examining high opioid doses and high numbers of prescribers and pharmacies.

TEP Discussion and Recommendations

The TEP took notice of the tobacco screening measure currently in use among the existing 23 SSP measures. The TEP recommended to CMS that this metric be expanded to a comprehensive SUD screening measure, inclusive of tobacco, alcohol, opioids, and other substances. For this approach to be more comprehensive by extending into follow-up for positive screens, it should encompass additional measurement of pharmacotherapy for SUD being offered, initiated, or an appropriate referral made to specialty care for treatment of the underlying SUD.

The following NQF-endorsed measures are relevant to this recommendation: *Substance Use Screening and Intervention Composite* (NQF 2597); *Prevention Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling* (NQF 2152); *Continuity of Care for Medicaid Beneficiaries after Detoxification From Alcohol and/or Drugs* (NQF 3312); *Continuity of Care after inpatient or residential treatment for substance use disorder* (NQF 3453); *Continuity of Pharmacotherapy for OUD* (NQF 3175); *Use of pharmacotherapy for OUD* (NQF 3400); and *Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment* (NQF 0004).

Moreover, priority gap measures which should be included in this program include those related to long-term recovery surveillance for persons with a history of SUD, healthcare integration (between SUD, mental disorders, and somatic illnesses), and specialty populations that include those with a history of criminal justice involvement or homelessness.

The TEP made note of CMS' relatively low tally of beneficiaries who are appearing in the SSP Opioid Utilization Reports. As guidance, the TEP urges CMS to identify measures that are meaningful for the patient population based on identified quality gaps related to opioid prescribing behaviors prior to their inclusion within the SSP Opioid Utilization Reports. This will require data collection and analysis to identify meaningful opioid measures with opportunities for improvement within SSP ACOs. The TEP noted that if measures are topped out, this may indicate changing opioid-related behaviors such as reductions in doctor or pharmacy "shopping."

The TEP further recommended that CMS look at quality gaps for several other measures with potential for inclusion in the SSP Opioid Utilization Reports, beginning with a measure of co-prescribing of opioids with benzodiazepines. This would further align the measures in SSP safety reports with the *Concurrent Use of Opioids and Benzodiazepines* (NQF 3389) metric, the opioid measure developed by the Pharmacy Quality Alliance (PQA) currently used in the Medicare Part C & D patient safety reports and slated for the Part C & D display page within current rules. The TEP also recommended CMS consider quality gaps for other potential measures in the SSP Opioid Utilization Reports related to other initial prescribing behaviors, including *Initial Opioid Prescribing at High Dosage* for opioid prescriptions initiated at greater than or equal to 50 morphine milligram equivalents; *Initial Opioid Prescribing for Long Duration* for opioid prescriptions lasting greater than seven supply; and *Initial Opioid Prescribing for Long-Acting or Extended-Release High Dosage* for prescriptions of long-acting or extended-release opioids.

The TEP also put forward other potential quality gaps for CMS to analyze, which include the identification of useful best practice process measures. One such measure was naloxone co-prescription with opioids for at-risk patients such as those on high dose opioids, those who have just overdosed, or those prescribed medication-assisted treatment (MAT). The TEP also recommended the assessment of quality gaps for a potential new measure of nonopioid management strategies, though the TEP also noted that such a measure would likely need accompanying expansion of access and reimbursement for many alternative or complementary and integrative therapies such as acupuncture, chiropractic care, nutrition, exercise programs, and even behavioral and physical therapies. These are not always covered by insurance or are otherwise not accessible or affordable for patients.

As general guidance, the TEP also recommended that CMS consider the measure gaps prioritized by the TEP (outlined in the previous section), as they would improve care and potentially decrease costs, especially for OUD patients through measures concerning recovery from OUD, measures of physical and mental health comorbidities to OUD, and measures addressing specific populations for OUD treatment.

All recommendations above come with the stipulation that each of these measures be appropriately specified and tested for the care setting and level of analysis for their intended use. The TEP also recommends that these measures be submitted for NQF endorsement prior to implementation a federal program.

The Merit- Incentive Payment System (MIPS)

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 resulted in the concurrent repeal of the Medicare Part B Sustainable Growth Rate and the creation of the Quality Payment Program (QPP), the value-based reimbursement system designed to address payments made to physicians and other clinicians through Medicare Part B. The QPP rule consists of two tracks designed to control increasing healthcare costs and improve the quality of care:

- The Merit- Incentive Payment System
- Alternative Payment Models

With the introduction of MIPS, CMS combined three legacy programs into a single program: the Physician Quality Reporting System, the Value- Payment Modifier, and the Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals. Clinicians' Medicare payments through MIPS are determined based on performance across four categories, including performance on healthcare quality metrics. To implement new quality measures into the performance category of MIPS, CMS uses the Annual Call for Measures that lets clinicians and organizations—including professional associations representing MIPS eligible clinicians, researchers, consumer groups, and other stakeholders—submit quality measures for consideration.[26] The recommended list of new quality measures is made publicly available for comment through the rulemaking process before making a final selection of new measures. This list will not include Qualified Clinical Data Registry (QCDR) measures as those are proposed and selected through a separate process.[27]

The quality performance category focuses on measures from quality priorities defined in the rulemaking process and from CMS' Meaningful Measure Areas.[28] The TEP reviewed these priorities, along with the opioid specific measures currently available for clinicians in MIPS listed below:

- Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)
- Documentation of Signed Opioid Treatment Agreement
- Evaluation or Interview for Risk of Opioid Misuse
- Opioid Therapy Follow-Up Evaluation
- Tobacco Use and Help with Quitting Among Adolescents
- Tobacco Use – Screening and Cessation Intervention
- Unhealthy Alcohol Use –Screening and Counseling
- Alcohol and Other Drug Dependence Treatment
- Anesthesiology Smoking Abstinence
- Anti-depressant Medication Management
- Pain Assessment and Follow-Up
- Pain Brought Under Control Within 48 Hours
- Osteoarthritis (OA): Function and Pain Assessment

TEP Discussion and Recommendations

The TEP noted a measure gap within MIPS related to co-prescription of naloxone for chronic opioid treatment in patients who are at especially high risk for overdose (e.g., high daily dose, history of dependence). The TEP recommends that CMS add a measure of this type within the MIPS program.

The TEP also noted the existence of the measure, *Osteoarthritis: Function and Pain Assessment,* and recommended the application of a broader measure of function and pain assessment within MIPS. The TEP especially emphasized the need for measures of functional improvement over measures of pain scoring or pain reduction. The TEP recommends that CMS identify and incorporate into MIPS more measures addressing functional improvement and ensure that MIPS does not include measures that strictly focus on pain reduction. The TEP emphasized that adding measures to MIPS that focus on decreases in pain score—with the exception of measures used for palliative care—creates problems, as such measures may introduce challenges to clinician prescribing behaviors. The measure, *Pain Brought Under Control Within 48 Hours,* is an example such a measure. The TEP encourages CMS not to include such measures within MIPS and other programs.

In addition to these considerations for MIPS, the TEP recommended the prescribing measures also identified for the Medicare Shared Savings Program, namely, *Initial Opioid Prescribing at High Dosage* for opioid prescriptions initiated at greater than or equal to 50 morphine milligram equivalents; *Initial Opioid Prescribing for Long Duration* for opioid prescriptions lasting greater than seven supply; and *Initial Opioid Prescribing for Long-Acting or Extended-Release High Dosage.* As with the SSP measures, this recommendation is contingent upon the measures being appropriately specified for their care setting and level of analysis and receipt of NQF endorsement.

From the prioritization exercise, the TEP emphasized the need to incorporate not just measures related to prescribing for pain management, but also measures to treat SUD. Many of these measures are

missing from MIPS. These include measures around recovery from OUD, measures of physical and mental health comorbidities to OUD, annual outpatient screening for OUD in at-risk patients, and measures addressing specific populations for OUD treatment.

Alternative Payment Models (APM)

An alternative payment model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care.[4] As the name implies, this federal initiative is an alternative to MIPS, and consists of a collection of initiatives that aim to encourage, via financial support (with conditions including demonstrated cost-savings), novel ways of paying for healthcare which contrast with traditional approaches that predominate in Medicare. Additional details on the operating APMs as of November 2018 can be viewed on the Quality Payment Program webpage.[30]

TEP Discussion and Recommendations

The TEP acknowledged a particular challenge associated with making general recommendations for measures comparable to those used in the MIPS quality performance category in APMs given the variety of APM structures, types, and populations served. APMs can apply to a specific clinical condition, a care episode, or a patient population. The TEP noted that measurement needs differ depending on which APM structure is considered.

For MIPS APMs, the TEP guidance provided for MIPS healthcare quality measures applies. As guidance for a programmatic approach for advanced APMs, the TEP recommends that CMS require assessments of quality gaps for providers under APMs related to MIPS-like measures of opioid use and OUD at a time appropriate for either receiving or maintaining advanced APM status, and appropriate to the type of advanced APM. This means that the APM should perform analyses of opioid-related quality issues to identify which measures are appropriate based on opportunity for improvement. The TEP emphasized that the opioid-related risk factors associated with the individual population should play a role in the selection and approval of the quality measures used within any given APM.

CMS has also introduced several models that are condition specific, such as those for oncology or renal care. Particularly for the oncology specific APMs, the TEP emphasized the need for measures of appropriate opioid tapering if and when the cancer remits. As with MIPS, APMs would also benefit from measures around short-term recovery, recovery measures for transition from inpatient to outpatient settings and long-term recovery from OUD, measures of physical and mental health comorbidities to OUD, and measures addressing specific populations for OUD treatment. The TEP was especially supportive of using such measures within behavioral health home APMs.

Hospital Inpatient Quality Reporting (IQR) Program

The Hospital Inpatient Quality Reporting Program is a pay-for-reporting program that requires hospitals paid under the Inpatient Prospective Payment System (IPPS) to report on process, structure, outcomes, patient perspectives on care, efficiency, and costs of care measures. Hospitals that do not participate or fail to meet program requirements receive a 25 percent reduction of the annual payment update. The program has two goals: first, to provide an incentive for hospitals to report quality information about

their services, and second, to provide consumers information about hospital quality so they can make informed choices about their care.

TEP Discussion and Recommendations

The TEP suggested assessing whether patients were counselled about and had reasonable access to nonopioid options (in addition to, or in lieu of opioids) to manage pain; the patients who are identified with SUD that are offered or initiated on medication for OUD (e.g., buprenorphine) prior to discharge, or referred to an appropriate SUD provider; transitions in care who are timely linked to ongoing care in the community; proportion of patients treated for an overdose who are in treatment 30 days later; proportion of patients who had an opioid overdose who were given a prescription for naloxone at discharge; presence of a patient-centered pain care plan for patients discharged with an opioid prescription; and presence of a multimodal pain treatment plan including both medication-based treatments and complementary approaches to pain management.

Hospital Value-Based Purchasing (VBP) Program

The Hospital Value-Based Purchasing Program is a payment system designed to reward health systems for the quality of care that they provide by adjusting hospital Medicare payments received through the IPPS based on performance on quality and cost metrics.

VBP was established by the Affordable Care Act with stipulations on the types of measures to be included in the program. The Secretary of HHS is required to select measures, other than measures of readmissions, for purposes of the program. In addition, a measure of Medicare Spending Per Beneficiary must be included. Measures are eligible for adoption in VBP based on the statutory requirements, including specification under the IQR and posting dates on the Hospital Compare website.

TEP Discussion and Recommendations

The TEP noted that the measures used inside of the VBP are drawn from IQR, meaning that they would naturally overlap with the recommendations put forward in the previous section. However, the TEP particularly emphasized the need to have strong process measures included in value-based purchasing arrangements. Measures of pain management care at discharge and the prescribing of naloxone at discharge (for persons with OUD, high opioid dosages or on MAT) were emphasized, along with measures that promote a multimodal approach to pain using a personalized pain management plan including both medication-based treatment and complementary and integrative care.[31]

Conclusions Regarding Federal Programs

Across the five federal programs reviewed, there are many holes to fill regarding opioid and OUDrelated measures. For the SSP, the TEP advocated for building on tobacco, depression, and specialty care measurements as well as measures that assess high-dose opioid analgesia use while avoiding the pitfalls of inappropriate tapering. For IQR and VBP, the emphasis shifts to admission and discharge planning, including referrals for those with OUD indications or post-hospital analgesia needs. And finally, for APMs, an important touchstone is measures of population-specific health homes which aim to integrate care across physical and mental health.

Conclusion and Next Steps

This report describes Opioid and Opioid Use Technical Expert Panel's recommendations and guidance for prioritizing gaps and priority measure concepts in areas that relate to opioids and opioid use disorders and guidance for the inclusion of measures in various federal healthcare accountability programs such as the Merit-Based Incentive Payment System (MIPS), alternative payment models (APMs), the Medicare Shared Savings Program (SSP), the Hospital Inpatient Quality Reporting Program (IQR), and the Hospital Value-Based Purchasing Program (VBP). This final report includes all comments submitted on the draft report previously released for public comment (Appendix G).

References

1 *Chasing Heroin*. PBS; 2016. https://www.pbs.org/wgbh/frontline/film/chasing-heroin/. Last accessed October 2019.

2 Vance JD. *Hillbilly Elegy: A Memoir of a Family and Culture in Crisis*. First edition. New York, NY: Harper, an imprint of HarperCollinsPublishers; 2016.

3 Hampton R, Foster CR. *American Fix: Inside the Opioid Addiction Crisis - and How to End It*. First edition. New York: All Points Books; 2018.

4 Macy B. *Dopesick: Dealers, Doctors, and the Drug Company That Addicted America*. New York, NY: Little, Brown and Company; 2019.

5 Higham S. Johnson & Johnson reaches $20.4 million settlement in huge opioid case. *Washington Post*. https://www.washingtonpost.com/investigations/johnson-and-johnson-reaches-tentative-204-million-settlement-in-massive-opioid-case/2019/10/01/6a8a9670-e48e-11e9-b403-f738899982d2_story.html. Accessed October 2, 2019.

6 Whitaker B. Whistleblowers: DEA attorneys went easy on McKesson, the country's largest drug distributor. *60 Minutes*. https://www.cbsnews.com/news/whistleblowers-dea-attorneys-went-easy-on-mckesson-the-countrys-largest-drug-distributor/. Last accessed October 2019.

7 Drugmakers look to use Purdue Pharma's bankruptcy to settle U.S. opioid suits: WSJ - Reuters. https://www.reuters.com/article/us-purduepharma-bankruptcy-idUSKBN1WG2HJ. Last accessed October 2019.

8 America's opioid epidemic is driven by supply - Another prescription. *The Economist*. https://www.economist.com/democracy-in-america/2018/01/29/americas-opioid-epidemic-is-driven-by-supply. Accessed October 2, 2019.

9 Substance Abuse and Mental Health Services Administration (SAMHSA). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*. Rockville, MD: SAMHSA; 2019. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf. Last accessed June 2019.

10 Rhode Island Department of Health (RIDOH). Overdose Death Data. https://preventoverdoseri.org/overdose-deaths/. Last accessed October 2019.

11 Kentucky Injury Prevention and Research Center. County profiles for drug-related inpatient hospitalizations and emergency department visits. http://www.mc.uky.edu/kiprc/pubs/overdose/county-profiles.html. Last accessed October 2019.

12 Ducharme J. Drug overdose deaths finally dropped in 2018. *Time*. [online] https://time.com/5628293/drug-overdose-deaths-2018/. 2019. Last accessed October 2019.

13 HHS. Secretary Azar statement on 2018 provisional drug overdose death data. HHS.gov. https://www.hhs.gov/about/news/2019/07/17/secretary-azar-statement-on-2018-provisional-drug-overdose-death-data.html. Published July 17, 2019. Last accessed October 2019.

14 Walley AY, Bernson D, Larochelle MR, et al. The contribution of prescribed and illicit opioids to fatal overdoses in Massachusetts, 2013-2015. *Public Health Rep*. 2019;134(6):667-674.

15 Associated Press. Drug overdose deaths in the U.S. appear to be falling, CDC data show. *Los Angeles Times*. https://www.latimes.com/science/story/2019-07-17/us-drug-overdose-deaths-falling. Published July 17, 2019.

16 Frankenfeld CL, Leslie TF. County-level socioeconomic factors and residential racial, Hispanic, poverty, and unemployment segregation associated with drug overdose deaths in the United States, 2013–2017. *Ann Epidemiol*. 2019;35:12-19.

17 Musumeci M, Tolbert J. Federal Legislation to Address the Opioid Crisis: Medicaid Provisions in the SUPPORT Act. https://www.kff.org/medicaid/issue-brief/federal-legislation-to-address-the-opioid-crisis-medicaid-provisions-in-the-support-act/ Last accessed October 2019.

18 MACPAC. Payment for services in Institutions for Mental Diseases (IMDs). https://www.macpac.gov/subtopic/payment-for-services-in-institutions-for-mental-diseases-imds/. Last accessed October 2019.

19 Walden G. H.R.6 - 115th Congress (2017-2018): SUPPORT for Patients and Communities Act. https://www.congress.gov/bill/115th-congress/house-bill/6. Published October 24, 2018. Last accessed October 2019.

20 National Quality Forum (NQF). *Opioids and Opioid Use Disorder: An Environmental Scan of Quality Measures*. Washington, DC: NQF; 2019. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=90916.

21 Dowell D, Compton WM, Giroir BP. Patient-centered reduction or discontinuation of long-term opioid analgesics: The HHS guide for clinicians. *JAMA*. 2019;322(19):1855-1856.

21 Dowell D, Compton WM, Giroir BP. Patient-centered reduction or discontinuation of long-term opioid analgesics: The HHS guide for clinicians. *JAMA*. October 2019:1.

22 Hadland SE, Bagley SM, Rodean J, et al. Receipt of timely addiction treatment and association of early medication treatment with retention in care among youths with opioid use disorder. *JAMA Pediatr*. 2018;172(11):1029.

23 Landrum MB, Nguyen C, O'Rourke E, et al. *Measurement Systems: A Framework for Next Generation Measurement of Quality in Healthcare*. Washington, DC: National Quality Forum; 2019. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=89595.

24 2019 Measures under Consideration List Program-Specific Measure Needs and Priorities. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/2019-CMS-Measurement-Priorities-and-Needs.pdf.

25 Centers for Medicare & Medicaid Services (CMS). Shared Savings Program. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html. Published July 29, 2019. Last accessed October 2019.

26 Centers for Medicare & Medicaid Services (CMS). MACRA: MIPS & APMs. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html. Published June 14, 2019. Last accessed October 2019.

27 Centers for Medicare & Medicaid Services

28 Centers for Medicare & Medicaid Services (CMS). Meaningful measures hub. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html. Published September 10, 2019. Last accessed October 2019.

29 Centers for Medicare & Medicaid Services. Alternative Payment Models (APMs) overview. Quality Payment Program. https://qpp.cms.gov/apms/overview. Last accessed October 2019.

30 Centers for Medicare & Medicaid Services. Alternative Payment Models in the Quality Payment Program as of November 2018. November 2018. https://qpp-cm-prod-content.s3.amazonaws.com/uploads/113/2018%20Comprehensive%20List%20of%20APMs.pdf.

31 U.S. Department of Health & Human Services. *Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations*. Rockville, MD: HHS; 2019. https://www.hhs.gov/ash/advisory-committees/pain/index.html.

32 National Quality Forum (NQF). *Measuring Quality of Care in Substance Use Disorder Treatment Programs*. Washington, DC: NQF; 2019.

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Appendix B: Prioritization Criteria Survey Results

Measure/ Measure Concept	Rank Order by Total Average	Rank Order Weighted Average	Rank Order Morbidity Mortality Average	Total Average	Weighted Average	Morbidity and Mortality Average
Patient-Centered Pain Management: Proper tapering strategies for opioid analgesics (i.e. Record of full and comprehensive pain and quality of life tracking for persons being removed from an opioid pain treatment regimen, included SUD history assessment and monitoring, and sleep disorder risk)	1	1	14	2.71	4.44	2.30
Recovery: short-term outcomes (30, 60 and 90 day), transition between inpatient and outpatient settings, and long-term outcomes (i.e., change in OUD symptomology such as cravings, mood, work/social, etc. 12, 18, and 24 months or even longer after treatment initiation for OUD)	2	2	1	2.67	4.35	2.90
Special populations for OUD treatment such as LGBTQ, pregnant women, criminal justice-involved populations, homeless populations, adolescents, Native Americans and other racial minorities, and rural residents	3	4	10	2.59	4.24	2.40
Benefits/Coverage/Reimbursement (i.e. By region or payer average reimbursement rates for full continuum of ASAM level services, SUD service average population coverage (benefits) limits)	4	5	30	2.59	4.22	1.85
OUD Treatment with Comorbidities: Physical Treatment such as cardiovascular, ID etc. (i.e. Regular screening for physical ailments in persons being treated for OUD)	5	3	7	2.58	4.24	2.75
Neonatal Abstinence Syndrome: Follow-up for children (i.e. Parental support classes for caregivers of NAS cases)	6	6	19	2.55	4.22	2.20
Patient-centered pain management: pain care plan (i.e. For those receiving opioids for pain management that exceeds 3 days, a specific plan for monitoring and eventual tapering of opioid use is documented and endorsed by the clinician and patient, and/or use of non-opioid pain management approaches.)	7	7	11	2.54	4.14	2.40
Benefits/Coverage/Reimbursement (i.e. By region payer SUD service average population coverage (benefits) limits)	8	8	26	2.51	4.05	2.05
OUD Treatment with Comorbidities: Psychiatric Treatment (i.e. Regular screening for other psychiatric illness in persons with OUD (e.g., SUD codependency, depression, anxiety, psychosis etc.))	8	8	3	2.47	3.94	2.85
Quality of life, level of functioning measures for pain and/or OUD treatments (i.e. Composite change in physical, work, social, and emotional functioning—all relative to functioning before onset of pain or OUD)	9	10	12	2.40	3.92	2.35
Special populations: the elderly (i.e. Access to insurance with essential benefits (per the ACA) for elderly persons with a history of OUD)	10	11	2	2.39	3.88	2.89
Harm Reduction: Access to Harm Reduction Methods (i.e. Access to harm reduction strategies for persons with OUD (needles, naloxone, fentanyl test strips, overdose prevention sites))	11	9	4	2.37	3.94	2.85
Criminal Justice Involvement in relation to OUD: Screening/Treatment during and post-incarceration (i.e. OUD successful referral to treatment rates for those with OUD history discharged from a detention facility)	12	13	5	2.34	3.76	2.80
Recovery: sensitive to incremental change not limited to abstinence (i.e. Change in OUD symptomology such as cravings, mood, work/social, etc. 12, 18, and 24 months after treatment initiation for OUD)	13	15	25	2.33	3.75	2.10

Measure/ Measure Concept	Rank Order by Total Average	Rank Order Weighted Average	Rank Order Morbidity Mortality Average	Total Average	Weighted Average	Morbidity and Mortality Average
Social Risk Factors: Housing, socioeconomic status, employment (i.e. Housing/Employment/Financial/Insurance status of those being treated for OUD: 1. Rates, 2. Use of mitigation services)	14	14	20	2.32	3.75	2.20
Special populations: the elderly (i.e. Therapeutic use in incident elderly (>65) population with OUD of buprenorphine or methadone for these populations)	15	16	15	2.31	3.73	2.30
Screening (i.e. SBIRT or other population screening and for OUD)	16	12	16	2.31	3.77	2.30
OUD Treatment with Comorbidities: Other Substance use (i.e. Regular screening for other SUDs in persons with OUD (e.g., methamphetamine, tobacco, alcohol, etc.))	17	19	17	2.28	3.67	2.25
Patient-Centered Pain Management: Transition from acute to chronic care (i.e. Record of specific evaluation and treatment plan for patients who progress for 1 week of opioid treatment to longer-term regimens)	18	18	26	2.27	3.71	2.05
Harm Reduction: Morbidity tracking (i.e. Population and geographic reporting of overdose deaths by substances implicated)	19	17	27	2.27	3.71	2.05
Social Risk Factors: Social Support (i.e. Social supports assessment for those being treated for OUD)	20	21	8	2.25	3.64	2.60
Patient-Centered Pain Management: Proper use of complementary or alternative pain remedies (i.e. Percent of chronic pain patients who exclusively rely on long-term pain therapies that do not include opioids)	21	20	32	2.24	3.66	1.55
Process Measures; process measures showing evidence-based OUD care is delivered (i.e. initiation of buprenorphine or methadone with incident cases)	22	22	13	2.23	3.62	2.35
Criminal Justice Involvement in relation to OUD: Jail diversion programs (i.e. Availability of Jail Diversion Programs for Persons Arrested for OUD-related activity)	23	23	31	2.18	3.54	1.80
Social Risk factors: Stigma in relation to Public Attitudes (i.e. By region public health announcement volume regarding harm reduction and treatment resources for persons impacted by OUD)	24	26	23	2.13	3.42	2.15
Successful referral to treatment, initiation in, and retention in OUD treatment and retention of care (i.e. Number OUD cases that show significant declines in opioid misuse at 6, 12, 18, and 24 months after treatment initiation)	25	28	21	2.12	3.37	2.20
Neonatal Abstinence Syndrome: Prenatal or Perinatal Counseling (i.e. SUD counseling rates for expectant mothers)	26	27	6	2.12	3.40	2.80
Criminal Justice Involvement in relation to OUD (i.e. Record of criminal justice history for persons diagnosed with OUD)	27	24	9	2.11	3.45	2.45
Social Risk Factors: Patient and family health literacy (i.e. Patient/family education regarding opioid use, misuse, and pain management for all at risk (pain and OUD patients))	28	25	18	2.10	3.42	2.25
Social Risk Factors: Stigma associated with Provider Attitudes (i.e. Stigma “myth” education programs for providers encountering persons with OUD)	29	29	29	2.04	3.33	2.00
Social Risk Factors: Violence and Trauma (i.e. Violence and trauma screening and mitigation for newly identified SUD cases.)	30	30	22	1.99	3.27	2.20
QoL, function and appropriate pain management within the population of patients with OUD	31	31	28	1.89	3.04	2.05
Overall Cost of OUD (i.e. Annual geographic reporting of the full human costs (DALYs) associated with OUD)	32	32	24	1.85	2.93	2.15

Appendix C: Measure Inventory from Opioid TEP Environmental Scan

SSP – Shared Savings Program
MIPS – Merit-based Incentive Payment System
APMs – Alternative Payment Models
IQR – In-Patient Quality Reporting Program
VBP – Value-based Purchasing Program

Note that the "Relevant Federal Programs for Measure Type" column indicates that based on Opioid TEP discussions, the TEP regards this measure or an appropriately specified version of the measure to be appropriate for consideration in the indicated program.

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
1		Activity counseling for back pain	Percentage of patients 18 to 65 years of age who were counseled to remain active and exercise or were referred to physical therapy	Process	Pain Management	Alternatives to Opioids	
2		Acute Medication Prescribed for Cluster Headache	Percentage of patients age 18 years old and older with a diagnosis of cluster headache (CH) who were prescribed a guideline recommended acute medication for cluster headache within the 12-month measurement period.	Process	Pain Management	Alternatives to Opioids	
3		Adult smoking cessation advice/counseling	Heart failure patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
4	Endorsed	Alcohol & Other Drug Use Disorder Treatment at Discharge	This rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Process	OUD Treatment	OUD Treatment Initiation	IQR; VBP
5		Alcohol and Drug Use Assessing Status After Discharge	Discharged patients who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected.	Process	OUD Treatment	OUD Treatment Continuity	IQR; VBP
6		Alcohol Problem Use Assessment & Brief Intervention for Home-Based Primary Care and Palliative Care Patients	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	OUD Treatment	Psychiatric or Dependence Comorbidity	
7		Alcohol Screening and Brief Intervention (ASBI) in the ER	Percentage of patients aged 15 to 34 seen in the ER for injury who were screened for hazardous alcohol use AND provided a brief intervention within 7 days of the ER visit if screened positive.	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
8	Endorsed	Alcohol Use Brief Intervention Provided or Offered	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included. These measures are 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).	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
9		All cause inpatient, residential re-admission	This measure is used to assess the rate of all-cause unplanned readmissions, 90 days following an initial episode of residential/inpatient SUD treatment and assesses the clinician's management of the patient's entire medical condition.	Process	OUD Treatment	OUD Treatment Continuity	
10		Ambulatory Post-Discharge Patient Follow-Up	Percentage of patients, regardless of age, who received anesthesia services in an ambulatory setting whose post-discharge status was assessed within 72 hours of discharge	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
11		Annual Monitoring for Individuals on Chronic Opioid Therapy	The proportion of patients age 18 years and older who are continuously enrolled in a Qualified Health Plan product and on chronic opioid therapy who have not received a drug test at least once during the measurement year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
12		Appropriate controlled substance prescribing (definitive diagnosis(es)) via adherence to Controlled Substance Agreements (CSA) or (OA's) with corrective action taken for pain and/or substance use disorder patients when violations occur.	1. Successful Reporting: a. Documentation of definitive pathology (e.g., imaging, surgical report, serology, provider referral for addiction/substance use disorder, etc.) to warrant chronic pain and/or buprenorphine/naloxone medication chronically. b. Provider must document signing of a Controlled Substance (CSA) or Opiate Agreement (OA) if more than two (2) Schedule II controlled substance prescriptions are provided to a patient in a 12-month period. Understandably, prescriptions may occur in the prior reporting year as well as in the current reporting year. c. For all patients violating existing CSA/OA, such violations are documented with correlative adjustments in treatment (e.g.: shorter duration prescriptions (2 week to 4 week), increased frequency of urine drug screens (quarterly to monthly), random pill counts, more frequent visits, etc.). 2. Numerator & Denominator. Numerator data are patients aged 18 and above with documented definitive pathology of ICD data below. Denominator data are all patients aged 18 and above with any combination of the ICD and HCPCS data defined in this section 3, below. 3. Measure explanation: Chronic Pain medication prescribed (prescribed for greater than one week or more than twice a year) only after a diagnosis and medical or surgical plan has been implemented. CSA or OA followed and, if actionable violation (i.e.: Urine Drug Screen inappropriate, pill counts off, multiple providers prescribing, polypharmacy, etc.) corrective action taken (i.e.: probation, escalated use of Urine Drug Screens, shorter prescriptions intervals, termination of controlled prescribing or similar actions) as result of the CSA/OA violation.	Outcome	Pain Management	Appropriate Opioid Analgesic Prescribing	
13		Appropriate Monitoring for Adverse Events of Opioid and Psychiatric Medications	This measure assesses whether established guidelines to monitor for common ADEs of opioid and psychiatric medications that are administered to patients during inpatient psychiatric facility admissions are being followed. The performance period for the measure is one year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
14		Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Patients receiving intravenous opioids via patient controlled analgesia who receive appropriate monitoring of their respiratory status (respiratory rate and pulse oximetry) and level of sedation	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
15		Appropriate Prescribing for First Fill of Opioids	The percentage of adults, 18 and older, who fill an initial prescription for opioid medications that does not comply with at least one of five separate measure components derived from the 2016 Centers for Disease Control (CDC) Guideline for prescribing of opioid medications that are measurable in secondary administrative claims data. Lower is better on this measure.	Composite	Pain Management	Appropriate Opioid Analgesic Prescribing	
16		Assessment and management of chronic pain: percentage of patients with chronic pain diagnosis with documentation of a pain assessment completed at initial visit using a standardized tool	This measure is used to assess the percentage of patients age 16 years and older with chronic pain diagnosis with documentation of a pain assessment completed at initial visit using a standardized tool that addresses pain intensity, location, pattern, mechanism of pain, current functional status and follow-up plan	Process	Pain Management	Pain Assessment	
17		Avoid Certain Opioid Analgesics in the Elderly© ActiveHealth	Percentage of patients 65 years or older who were prescribed certain opioid analgesics	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
18		Avoidance of Long-Acting (LA) or Extended-Release (ER) Opiate Prescriptions	Percentage of Adult Patients Who Were Prescribed an Opiate Who Were Not Prescribed a Long-Acting (LA) or Extended-Release (ER) Formulation	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
19		Avoidance of Opiate Prescriptions for Greater Than 3 Days Duration for Acute Pain	Percentage of Adult Patients Who Were Prescribed an Opiate for Whom the Prescription Duration Was Not Greater than 3 days for Acute Pain	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
20		Avoidance of Opiates for Low Back Pain or Migraines	Percentage of Patients with Low Back Pain and/or Migraines Who Were Not Prescribed an Opiate	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
21		Avoiding Use of CNS Depressants in Patients on Long-Term Opioids	The percentage of patients on long-term opioid prescriptions without a concurrent prescription for an CNS depressant	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
22		Back Pain: Initial Visit	Percentage of patients at least 18 years of age and younger than 80 with a diagnosis of back pain who have medical record documentation of all of the following on the date of the initial visit to the physician: 1. Pain assessment 2. Functional status 3. Patient history, including notation of presence or absence of “red flags” 4. Assessment of prior treatment and response, and 5. Employment status	Process	Pain Management	Pain Assessment	
23		Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use	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	OUD Treatment	OUD Screening	SSP; MIPS; APM

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
24	Endorsed	CAHPS Hospice Survey: Getting Help for Symptoms	Multi-item measure P1: Did your family member get as much help with pain as he or she needed P2: How often did your family member get the help he or she needed for trouble breathing P3: How often did your family member get the help he or she needed for trouble with constipation P4: How often did your family member receive the help he or she needed from the hospice team for feelings of anxiety or sadness	Outcome: PRO-PM	Pain Management	Pain Assessment	
25		Care for Older Adults Pain Assessment	Percent of plan members who had a pain screening or pain management plan at least once during the year. (This information about pain screening or pain management is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.)	Process	Pain Management	Pain Assessment	
26		Care for Older Adults: Advance Care Planning, Functional Status Assessment, Pain Screening	Care for Older Adults: The percentage of adults 65 years and older who received the following during the measurement year: • Advance Care Planning • Functional Status Assessment • Pain Screening	Outcome	Pain Management	QoL/Function	MIPS; APM
27		Change in Patient Reported Pain and Functional Status Following Spinal Cord Stimulator Implantation	Measurement of the change in patient reported quality of life following spinal cord stimular implantation for failed back surgery syndrome. Quality of life measurement on standardized scale includes pain, mobility, analgesic medication use, psychological well-being and activities of daily living.	Outcome: PRO-PM	Pain Management	Pain Score Change	
28		Chronic Opioid Therapy Follow up Evaluation	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 COT documented in the medical record.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APM;
29	Endorsed	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours.	Intermediate Outcome	Pain Management	Time to Pain Management	
30		Communication about Pain During the Hospital Stay	The following questions (or a subset of questions) would replace the current Pain Management measure in the HCAHPS Survey with a new measure(s). The following items were tested in early 2016. CMS is currently analyzing the results, as well as discussing these potential new pain management items with focus groups and hospital staff. Multi-item measure (composite): HP1: During this hospital stay, did you have any pain HP2: During this hospital stay, how often did hospital staff talk with you about how much pain you had HP3: During this hospital stay, how often did hospital staff talk with you about how to treat your pain	Outcome: PRO-PM	Pain Management	Pain Assessment	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
31		Communication about Treating Pain Post-Discharge	The following questions (or a subset of questions) would replace the current Pain Management measure in the HCAHPS Survey with a new measure(s). The following items were tested in early 2016. CMS is currently analyzing the results, as well as discussing these potential new pain management items with focus groups and hospital staff. Multi-item measure (composite): DP1: Before you left the hospital, did someone talk with you about how to treat pain after you got home DP2: Before you left the hospital, did hospital staff give you a prescription for medicine to treat pain DP3: Before giving you the prescription for pain medicine, did hospital staff describe possible side effects in a way you could understand	Outcome	Pain Management	Pain Assessment	
32		Concomitant Chronic Opioid Analgesic Therapy and Benzodiazepines Prescribing Rate	The number of patients prescribed an elevated dose (≥ 50 MME per day) of chronic opioid analgesic therapy (COAT) who have greater than 7 days of overlapping benzodiazepine therapy in the measurement year. The overlapping benzodiazepine therapy days must be from one prescription in order to meet the inclusion criteria.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
33	Endorsed	Concurrent Use of Opioids and Benzodiazepines (COB)	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	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP
34		Consideration of Non Pharmacologic Interventions	All patients 18 and older prescribed opiates for longer than six weeks duration with whom the clinician discussed nonpharmacologic interventions (e.g. graded exercise, cognitive/behavioral therapy, activity coaching at least once during COT documented in the medical record.	Process	Pain Management	Alternatives to Opioids	SSP; IQR; VBP
35		Constipation assessment following narcotic prescription in patients diagnosed with cancer	Percentage of patients for whom constipation was assessed at the time of narcotic prescription or the following visit	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
36		Continuity of Care after Detox	This measure is defined as the percent of individuals who receive a detoxification service and received another substance abuse service (other than detoxification or crisis care) within 14 days of discharge from detoxification.	Access	OUD Treatment	OUD Treatment Continuity	SSP; IQR; VBP
37	Endorsed	Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	Percentage of discharges from an inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which was followed by a treatment service for SUD. SUD treatment includes having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being administered or ordered 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	OUD Treatment	OUD Treatment Continuity	SSP; IQR; VBP

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
38	Endorsed	Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy) within 7 or 14 days after discharge. This measure is reported across all detoxification settings.	Process	OUD Treatment	OUD Treatment Continuity	SSP; IQR; VBP
39		Continuity of Pharmacotherapy for Alcohol Use Disorder	Percentage of adults 18-64 years of age with pharmacotherapy for alcohol use disorder (AUD) who have at least 180 days of treatment and a Proportion of Days Covered (PDC) of at least 0.8	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
40	Endorsed	Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)	Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment	Process	OUD Treatment	OUD Treatment Continuity	SSP; MIPS; APM
41		Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	Discussing Physical Activity: Percentage patients 65 years of age and older who reported: discussing their level of exercise or physical activity with a doctor or other health provider in the last 12 months. Advising Physical Activity: Percentage patients 65 years of age and older who reported receiving advice to start, increase, or maintain their level of exercise or physical activity from a doctor or other health provider in the last 12 months.	Process	Pain Management	Alternatives to Opioids	SSP; IQR; VBP
42		Counseling Regarding Pharmacological Treatment for Opioid Dependence	This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial and pharmacologic treatment options for opioid addiction within the 12 month reporting period.	Process	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APM; IQR; VBP
43		Counseling Regarding Psychosocial and Pharmacological Treatment Options for Alcohol Dependence	This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period.	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
44		Depression and Anxiety Assessment Prior to Spine-Related Therapies	Percentage of patients aged 18 years and older with documentation of depression and/or anxiety assessment through discussion with the patient including the use of a standardized assessment tool prior to index therapy(-ies) for treatment of spine-related pain symptoms.	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
45		Discharge Prescription of Naloxone after Opioid Poisoning or Overdose	Percentage of Opioid Poisoning or Overdose Patients Presenting to An Acute Care Facility Who Were Prescribed Naloxone at Discharge	Process	Harm Reduction	Opioid Reversal Drug Prescription	IQR; VBP
46		Documentation of Signed Opioid Treatment Agreement	All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during COT documented in the medical record.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
47		Emergency Department Use Due to Opioid Overdose	This is a claims-based measure that captures the rate of emergency department visits for opioid overdose events using ICD-9 or ICD-10 diagnosis codes. Events are measured per 1,000 person-years among Medicare beneficiaries greater than 18 years of age residing in the geography being measured. The measure is designed for use at both the county and state levels.	Outcome	Harm Reduction	Overdose	
48		Emergent care for improper medication administration, medication side effects	Percentage of home health quality episodes of care during which the patient required emergency medical treatment from a hospital emergency department related to improper medication administration or medication side effects.	Outcome	Harm Reduction	Overdose	
49		Evaluation of High Risk Pain Medications for MME	Percentage of patients aged 18 years and older prescribed and actively taking one or more high risk pain medications and evaluated for clinical appropriateness of morphine milligram equivalents (MME)	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APM
50		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with hip, leg or ankle (lower extremity except knee) injury.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with hip, leg, or ankle injuries treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: LEFS score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	
51		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in revalidation patients with knee injury pain.	The proportion of patients failing to achieve MCID of two (2) points or more improvement in the NPRS change score for patients with knee injuries treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline KOS score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
52		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in revalidation patients with low back pain.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with low back pain treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline MDQ score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	
53		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with arm, shoulder, or hand injury.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with arm, shoulder, or hand injury treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline DASH score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	
54		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with arm, shoulder, or hand injury.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with arm, shoulder, or hand injury treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline DASH score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
55		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with neck pain/injury.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with neck pain/injury treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline NDI score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	
56		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) to indicate functional improvement in knee rehabilitation of patients with knee injury measured via their validated Knee Outcome Survey (KOS) score, or equivalent instrument which has undergone peer reviewed published validation and demonstrates a peer reviewed published MCID.	The proportion of patients failing to achieve an MCID of ten (10) points or more improvement in the KOS change score for patients with knee injury patients treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline KOS score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a PT/OT performance measure at the eligible PT/OT or PT/OT group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	MIPS; APMs
57	Endorsed	Follow-Up After Hospitalization for Mental Illness	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness 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 • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
58	Endorsed	HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed	The proportion of patients, age greater than and equal to 1 year, admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.	Process	OUD Treatment	OUD Screening	IQR
59		HBIPS-6 Post discharge continuing care plan created	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. 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, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification 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-7 (Post Discharge Continuing Care Plan Transmitted).	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; IQR; VBP
60		HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge. 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, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-6: Post Discharge Continuing Care Plan Created) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
61	Endorsed	HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey	HCAHPS (NQF #0166) is a 32-item survey instrument that produces 11 publicly reported measures: 7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, 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). Please note: Beginning with patients discharged in January 2018, the three original Pain Management items were removed from the HCAHPS Survey and replaced by three new items that will comprise the new Communication About Pain measure. The original Pain Management measure will be publicly reported on the Hospital Compare Web site until December 2018. The new Communication About Pain measure will be publicly reported beginning in October 2020.	Outcome	Pain Management	Pain Assessment	
62	Endorsed	Health literacy measure derived from the health literacy domain of the C-CAT	0-100 measure of health literacy related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit	Outcome	Social Issues	Health Literacy	
63		Heel Pain Treatment Outcomes for Adults	DESCRIPTION: Percentage of patients aged 18 years and older with a diagnosis of heel pain who had two or more encounters in the past year.	Outcome: PRO-PM	Pain Management	Pain Score Change	
64		Heel Pain Treatment Outcomes for Pediatric Patients	Percentage of patients aged 6 to 18 years with a diagnosis of heel pain who experience a decrease in heel pain.	Outcome: PRO-PM	Pain Management	Pain Score Change	
65		High-Dose Chronic Opioid Analgesic Therapy Prescribing Rate	The percentage of enrollees prescribed chronic opioid analgesic therapy (COAT) that met or exceeded the daily dose recommendation upper limit of 90 Morphine Milligram Equivalence (MME) per day in the measurement year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
66		History and Physical Examination for Opioid Users	All patients 18 and older prescribed opiates for longer than six weeks duration who had a history and physical examination conducted at least once during COT documented in the medical record.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
67	Endorsed	Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.	Composite	Pain Management	Pain Assessment	
68		Hospital Harm – Opioid-Related Adverse Events	This electronic clinical quality measure (eCQM) assesses the proportion of inpatient admissions for patients age 18 years and older who suffer the harm of receiving an excess of hospital-administered opioids, defined as receiving a narcotic antagonist (naloxone). In the first 24 hours of the hospitalization, a hospital-administered opioid must be documented prior to receiving naloxone to be considered part of the numerator.	Outcome	Harm Reduction	Overdose	
69		Hospital Harm Performance Measure: Opioid Related Adverse Respiratory Events	This measure will assess opioid related adverse respiratory events (ORARE) in the hospital setting. The goal for this measure is to assess the rate at which naloxone is given for opioid related adverse respiratory events that occur in the hospital setting, using a valid method that reliably allows comparison across hospitals.	Outcome	Harm Reduction	Overdose	
70		Hospital-level risk-standardized Opioid extended use rate following THA and/or TKA (Opioid extended use)	This measure estimates the proportion of individuals without cancer who had any (1) opioid prescription filed between 90- and 180-days post TKA and/or THA. The target population is patients who are 65 years and older, are enrolled in fee-for-service (FFS) Medicare, and discharged from BWH and other PHS acute-care hospitals following THA/TKA.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
71		Identification of Major Co-Morbid Medical Conditions	Percentage of patients 18 years or older undergoing an elective surgical procedure who received general or spinal anesthesia AND who has documentation of a significant co-morbid condition(s) in their medical record within 30 days of operation date.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
72		Identification of Opioid Use Disorder among Patients Admitted to Inpatient Psychiatric Facilities	The measure assesses the percentage of patients admitted to an inpatient psychiatric facility who were screened and evaluated for opioid use disorder. The performance period for the measure is one year.	Process	OUD Treatment	OUD Screening	
73		Immediate Adult Post-Operative Pain Management	The percentage of patients 18 or older admitted to the PACU after an anesthetic with a maximum pain score <7/10 prior to anesthesia end time.	Outcome	Pain Management	Pain Score Change	
74	Endorsed	Improvement in Pain Interfering with Activity	Percentage of home health episodes of care during which the patient's frequency of pain when moving around improved.	Outcome	Pain Management	Pain Score Change	MIPS; APM

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
75		Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	Outcome	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
76		Index Opioid Prescription Prescribing Rate	The prescribing rate of index opioid prescriptions to enrollees during the measurement year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
77		Initial Opioid Prescribing at High Dosage	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions with an average daily morphine milligram equivalent (MME) of ≥50. (Excludes patients in hospice care and those with cancer.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APMs
78		Initial Opioid Prescribing for Long Duration	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for >7 cumulative days' supply.(Excludes patients in hospice care and those with cancer	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APMs
79		Initial Opioid Prescribing for Long-Acting or Extended-Release High Dosage	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for long-acting or extended-release opioids.(Excludes patients in hospice care and those with cancer	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APMs
80		Initial opioid prescription compliant with CDC recommendations	Composite score indicating compliance with five measurable CDC opioid prescribing guidelines. The denominator includes new opioid prescriptions in the measurement year. The numerator includes new opioid prescriptions that are compliant on all 5 CDC indicators. Higher is better on this measure.	Composite	Pain Management	Appropriate Opioid Analgesic Prescribing	
81	Endorsed	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	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	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APM; IQR, VBP

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
82	Endorsed	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Percentage of Medicaid beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	Process	OUD Treatment	OUD Treatment Initiation	SSP
83	Endorsed	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	Process	OUD Treatment	OUD Treatment Initiation	SSP
84		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Process	OUD Treatment	OUD Treatment Initiation	
85	Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (eCQM)	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported a. Percentage of patients who initiated treatment within 14 days of the diagnosis b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit	Process	OUD Treatment	OUD Treatment Initiation	SSP

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
86		Inpatient Assessment of Depression Symptoms	The purpose of this measure is to improve the monitoring of the severity of depression as a part of the treatment care plan by implementing the PHQ-9 in the inpatient setting. This process measure will serve as a complementary patient-reported outcome performance measure (PRO-PM) that would evaluate risk-adjusted symptom improvement in patients admitted to inpatient facilities.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
87		Intimate Partner (Domestic) Violence Screening	Percentage of female patients aged 15-40 years old who were screened for intimate partner (domestic) violence at any time during the reporting period.	Process	Social Issues	Violence	
88		IPF Alcohol Use Screening completed within one day of admission	Alcohol Use Screening completed within one day of patient's admission to the IPF. This is a companion measure to MUC XDFGC -- IPF Drug Use Screening completed within one day of admission.	Process	OUD Treatment	OUD Screening	
89		IPF Drug Use Screening completed within one day of admission	Drug Use Screening completed within one day of patient's admission to the IPF. This is a companion measure to MUC XDFGD -- IPF Alcohol Use Screening completed within one day of admission.	Process	OUD Treatment	OUD Screening	
90		IPF Suicide Risk Screening completed within one day of admission	Percentage of admissions to an IPF for which a detailed screening for risk of suicide was completed within one day of admission.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
91		IPF Violence Risk Screening completed within one day of admission	Percentage of admissions for which a detailed screening for risk of violent behavior was completed within one day of admission.	Process	Social Issues	Violence	
92		Kidney Stones: Opioid utilization after ureteroscopy	Percentage of patients who underwent ureteroscopy and are discharged on NSAIDS, Acetaminophen, or "Other" and who were not prescribed opioids for pain control	Process	Pain Management	Non-Opioid Pain Management	
93	Endorsed	MDS 3.0 Measure (#0676): Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)	This measure captures the percent of short stay residents, with at least one episode of moderate/severe pain or horrible/excruciating pain of any frequency, in the last 5 days.	Outcome	Pain Management	Pain Assessment	
94	Endorsed	MDS 3.0 Measure (#0677): Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)	This measure captures the percent of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last 5 days or (2) any very severe/horrible in the last 5 days.	Outcome	Pain Management	Pain Assessment	
95		Median Time to Pain Management for Long Bone Fracture	Median time from emergency department arrival to time of initial oral or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).	Process	Pain Management	Time to Pain Management	
96		Medication Prescribed For Acute Migraine Attack	Percentage of patients age 12 years and older with a diagnosis of migraine who were prescribed a guideline recommended medication for acute migraine attacks within the 12 month measurement period.	Process	Pain Management	Non-Opioid Pain Management	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
97		Medication Reconciliation at Admission	This measure assesses the percentage of inpatient psychiatric facility (IPF) hospitalizations with medication reconciliation completed within 24 hours of admission. The performance period for the measure is one year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
98	Endorsed	Medication Reconciliation Post-Discharge	The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
99		Mental Health Response at Twelve Months - Progress Toward Recovery	Patients age 18 and older with an initial score equivalent to ten or higher on the Patient Health Questionnaire (PHQ-9) OR equivalent to ten or higher on the Generalized Anxiety Disorder 7-Item (GAD-7), who demonstrate progress toward social goals at twelve months (+/- 60 days after an index visit) defined as an increase in score equivalent to 4 or higher on the PROMIS Satisfaction with Social Roles and Activities.	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
100		Multimodal Pain Management	Percentage of patients, regardless of age, undergoing selected elective surgical procedures that were managed with multimodal pain medicine.	Process	Pain Management	Non-Opioid Pain Management	
101		Narcotic Pain Medicine Management Following Elective Spine Procedure	Percentage of patients aged 18 years and older with documentation of narcotic use/requirements at baseline (initial encounter) and at 3 months following initial assessment and interventions for treatment of spine-related pain symptoms and documentation of follow-up plan.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
102		No or Reduced Criminal Justice Involvement	The percentage of Community Mental Health (CMH) assessed members with no or reduced criminal justice involvement	Outcome	Social Issues	Criminal Justice	
103	Endorsed	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Percentage of patients, regardless of age, with a diagnosis of cancer who are currently receiving chemotherapy or radiation therapy that have moderate or severe pain in the first two visits and for which there is a documented plan of care to address pain.	Process	Pain Management	Pain Care Plan	MIPS; APMs
104	Endorsed	Oncology: Medical and Radiation - Plan of Care for Moderate to Severe Pain	Percentage of patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having moderate to severe pain with a plan of care to address pain documented on or before the date of the second visit with a clinician	Process	Pain Management	Pain Care Plan	MIPS; APMs
105	Endorsed	Oncology: Medical and Radiation Pain Intensity Quantified (eCQM)	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Process	Pain Management	Pain Assessment	
106		Opioid Monitoring	The purpose of this measure is to improve the monitoring, based on evidence-based guidelines, of IPF patients prescribed opioids for increased risk of opioid use disorder (OUD) and substance use by conducting urine drug testing (UDT) and prescription drug monitoring program (PDMP) review.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
107		Opioid Screening	The purpose of this measure is to improve the universal screening of patients admitted to the IPF to identify opioid use by conducting a urine drug screen (UDS) and prescription drug monitoring program (PDMP) review.	Process	OUD Treatment	OUD Screening	
108		Opioid Therapy Follow-up Evaluation	All patients 18 and older prescribed opiates for longer than 6 weeks duration who had a follow-up evaluation conducted at least every 3 months during Opioid Therapy documented in the medical record	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
109		Opioid-Related Symptom Distress Scale	The Opioid-Related Symptom Distress Scale (ORSDS) is a 4-point scale that evaluates 3 symptom distress dimensions (frequency, severity, bothersomeness) for 12 symptoms.	Outcome	Pain Management	Appropriate Opioid Analgesic Prescribing	
110		Opioids: Hospital-level risk-standardized medication side effect rate following THA and/or TKA (Opioid-induced respiratory depression)	This measure estimates a risk-standardized opioid-related respiratory depression rate associated with elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA). The outcome is defined as any incidence of opioid-induced respiratory depression occurring from the date of index admission to discharge from the hospital. The target population is patients who are 65 years and older, are enrolled in fee-for-service (FFS) Medicare, and hospitalized in nonfederal acute-care hospitals.	Outcome	Harm Reduction	Overdose	
111		Osteoarthritis (OA): Function and Pain Assessment	Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain	Process	Pain Management	QoL/Function	
112		Outcome of High Risk Pain Medications Prescribed in Last 6 Months	Percentage of patients aged 18 years and older prescribed and actively taking one or more high risk medications in the last 6 months meeting the following criteria: • Evaluation of polypharmacy AND • Reduction to the high risk medication where clinically appropriate (e.g., change pain medication, number of medications, dosage and/or frequency prescribed)	Outcome	Pain Management	Appropriate Opioid Analgesic Prescribing	
113		Overuse of barbiturate and opioid containing medications for primary headache disorders	Percentage of patients age 12 years and older with a diagnosis of primary headache who were prescribed opioid or barbiturate containing medications assessed for medication overuse headache within the 12-month measurement period, and if identified as overusing opioid or barbiturate containing medication, treated or referred for treatment.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
114		Overuse Of Opioid Containing Medications For Primary Headache Disorders	Percentage of patients aged 12 years and older diagnosed with primary headache disorder and taking 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 Management	Appropriate Opioid Analgesic Prescribing	
115	Endorsed	Pain Assessment	The percentage of hospice patients who screened positive for pain and who received a comprehensive assessment of pain within 1 day of screening.	Process	Pain Management	Pain Assessment	
116		Pain Assessment and Follow-Up	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Process	Pain Management	Pain Assessment	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
117		Pain Assessment and Follow-Up for Patients with Dementia	Percentage of patients with dementia who underwent documented screening for pain symptoms at every visit and if screening was positive also had documentation of a follow-up plan.	Process	Pain Management	Pain Assessment	
118		Pain Assessment and Follow-up Reporting Measure	Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before August 1, 2017 and once before February 1, 2018. Based on NQF #0420. 1) Facilities must report one of the following conditions for each eligible patient: a) Pain assessment using a standardized tool is documented as positive and a follow-up plan is documented b) Pain assessment documented as positive, a follow-up plan is not documented, and the facility possesses documentation that the patient is not eligible c) Pain assessment documented as positive using a standardized tool, a follow-up plan is not documented, and no reason is given d) Pain assessment using a standardized tool is documented as negative, and no follow-up plan required e) No documentation of pain assessment, and the facility possesses documentation the patient is not eligible for a pain assessment using a standardized tool f) No documentation of pain assessment, and no reason is given 2) Conditions covering the first six months of the performance period must be reported in CROWNWeb before August 1, 2017, and the conditions covering the second six months of the performance period must be reported in CROWNWeb before February 1, 2018.	Process	Pain Management	Pain Assessment	
119		Pain Assessment Conducted	Percentage of home health episodes of care in which the patient was assessed for pain, using a standardized pain assessment tool, at start/resumption of care.	Process	Pain Management	Pain Assessment	
120		Pain Assessments and Target Setting for Patients with Osteoarthritis	Percentage of patients 18 years of age and older with a diagnosis of osteoarthritis (OA) for whom a score from one of a select list of validated pain interference or global health assessment tools was recorded at least twice during the measurement period and for whom a target was documented and linked to the initial assessment.	Process	Pain Management	Pain Care Plan	
121	Endorsed	Pain Brought Under Control Within 48 Hours	Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours	Outcome	Pain Management	Time to Pain Management	
122		Pain Brought Under Control within the first three visits	Percent of patients 18 and older who report being uncomfortable because of pain at the initial palliative care assessment who report pain was brought to a comfortable level (e.g. “Comfortable? Yes/No”, “mild” or pain score < 4) within the first three visits	Outcome	Pain Management	Time to Pain Management	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
123		Pain Interference Response utilizing PROMIS	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	Outcome: PRO-PM	Pain Management	Pain Score Change	
124		Pain Interventions Implemented during All Episodes of Care	Percentage of all home health episodes of care during which pain interventions were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	Process	Pain Management	Pain Care Plan	
125		Pain Interventions Implemented During Long Term Episodes Of Care	Percentage of long term home health episodes of care during which pain interventions were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	Process	Pain Management	Pain Care Plan	
126		Pain Interventions Implemented During Short Term Episodes Of Care	Percentage of short term home health episodes of care during which pain interventions were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	Process	Pain Management	Pain Care Plan	
127		Pain Interventions In Plan Of Care	Percentage of home health episodes of care in which the physician-ordered plan of care includes intervention(s) to monitor and mitigate pain.	Process	Pain Management	Pain Care Plan	
128	Endorsed	Pain Screening	The percentage of hospice patients who were screened for pain during the initial nursing assessment.	Process	Pain Management	Pain Assessment	
129		Pain, Function and General Health Postoperative Improvement	Performance Measure #1 - Change in the calculated score of a validated general health, function, and/or pain score using a standard patient reported outcome survey from before to after surgery. Performance Measure #2 - The overall percentage of patients that improve their general health, function, and/or pain scores beyond a minimum threshold for each postoperative interval. Instructions: Patients who undergo a surgical procedure are asked to complete an outcomes survey both preoperatively and following surgery. Rationale: Understanding a patient's mental and general physical improvement, functional improvement, and improvement in pain levels as a result of surgery is an important aspect of clinical care. The general health scores, functional scores, and pain scores that are calculated can be used to improve a specific patient's care plan or can be analyzed retrospectively to modify overall treatment methodologies. Doctors have the option of collecting a postoperative outcomes survey at different intervals following surgery to account for different surgery types and physician follow-up patterns.	Outcome: PRO-PM	Pain Management	Pain Score Change	
130		Patient Acceptable Symptom State Outcomes	Percentage of patients 18 years or older who completed a baseline and, within the CY(calendar year) reporting period of Jan. 1, 20xx - Dec.31, 20xx, a follow-up Patient Acceptable Symptoms State (PASS) assessment that showed a statistically significant improvement in comparison to initial assessment or who had already reported a score in which there is no room for statistical improvement. The use of Patient Reported Outcomes (PROs) in clinical research is well documented.	Outcome	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
131		Patient Queried about Pain and Pain Interference with Function	All visits for patients diagnosed with a muscular dystrophy (MD) where the patient was queried about pain and pain interference with function using a validated and reliable instrument.	Process	Pain Management	QoL/Function	
132		Patient Reported Pain in Cancer Following Chemotherapy	The PRO-PM will assess clinically meaningful change in pain following completion of chemotherapy administered with curative intent to adult patients with breast cancer, colon cancer, and non-small cell lung cancer (NSCLC).	Outcome: PRO-PM	Pain Management	Pain Score Change	
133		Patient Satisfaction With Spine Care	Percentage of patients aged 18 years and older undergoing spine intervention(s) who completed 3-month follow-up (patient-reported) satisfaction with care assessment. Satisfaction will be reported as % of patients reporting satisfaction with procedure. This measure will be calculated with 2 performance rates: 1) Rate 1: Patient population with Follow-up/Patient population with baseline 2) Rate 2: Patient population with improvement in satisfaction with care status after Follow-up/Patient population with Follow-up. Overall Rate = Rate 2	Outcome	Pain Management	Pain Score Change	
134		Patient-Reported Experience with Anesthesia	Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care and who reported a positive experience. This measure will consist of two performance rates: AQI48a: Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care AQI48b: Percentage of patients, aged 18 and older, who completed a survey on their patient experience and satisfaction with anesthesia care who report a positive experience with anesthesia care NOTE: The measure requires that a valid survey, as defined in the numerator, be sent to patients between discharge from the facility and within 30 days of facility discharge. To report AQI 48b, a minimum number of 20 surveys with the mandatory question completed must be reported.	Outcome: PRO-PM	Pain Management	Pain Assessment	
135		Patient-Reported Pain and/or Function Improvement after ACLR Surgery	Percentage of patients 13 years of age and older who obtained at least a 10% improvement in knee pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary anterior cruciate ligament reconstruction (ALCR) surgery. PROMs include any validated measures of knee-related measures of pain and/or function, such as KOOS-Pain, KOOS-ADL, KOOS-PS, and KOOS-JR.	Outcome: PRO-PM	Pain Management	QoL/Function	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
136		Patient-Reported Pain and/or Function Improvement after APM Surgery	Percentage of patients 13 years of age and older who obtained at least a 10% improvement in knee pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary arthroscopic partial meniscectomy (APM) surgery. PROMs include any validated measures of knee-related pain and/or function, such as KOOS-Pain, KOOS-ADL, KOOS-PS, and KOOS-JR.	Outcome: PRO-PM	Pain Management	QoL/Function	
137		Patient-Reported Pain and/or Function Improvement after Total Hip Arthroplasty	Percentage of patients 18 years of age and older who obtained at least a 10% improvement in hip pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary total hip arthroplasty (THA) surgery. PROMs include any validated measures of hip-related pain and/or function, such as HOOS-Pain, HOOS-ADL, HOOS-PS, and HOOS-JR.	Outcome: PRO-PM	Pain Management	QoL/Function	
138		Patient-Reported Pain and/or Function Improvement after Total Knee Arthroplasty	Percentage of patients 18 years of age and older who obtained at least a 10% improvement in knee pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary total knee arthroplasty (TKA) surgery. PROMs include any validated measures of knee-related measures of pain and/or function, such as KOOS-Pain, KOOS-ADL, KOOS-PS, and KOOS-JR.	Outcome: PRO-PM	Pain Management	QoL/Function	
139		Patient-Reported Pain and/or Function Improvement after Total Shoulder Arthroplasty	Percentage of patients 18 years of age and older who obtained at least a 10% improvement in shoulder pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary total shoulder arthroplasty (TSA) surgery. PROMs include any validated measures of shoulder-related pain and/or function, such as PSS-Pain and PSS-Function.	Outcome: PRO-PM	Pain Management	QoL/Function	
140	Endorsed	Patients Treated with an Opioid who are Given a Bowel Regimen	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
141		Percent days abstinent from alcohol	This measure was developed by staff of the Butler Center for Research (BCR), the research and clinical data analytic arm of the Hazelden Betty Ford Foundation, a national nonprofit alcohol/drug treatment provider. The BCR has been and is currently responsible for collection, analysis and reporting of post-treatment outcomes data for patients attending HBFF treatment programs. This outcomes measurement and reporting takes place on a rolling basis as part of routine healthcare operations. The BCR has designed our own outcomes surveys, which are administered by phone by BCR callers roughly 1, 6 and 12 months after patients discharge. Many of the questions on these surveys ask patients to self-report on substance use since leaving treatment. One of these questions asks patients to indicate the total number of days since treatment that they have drank at least 1 drink containing alcohol. The answer to this question is used to determine PDA from alcohol: among individuals who have recently attended alcohol addiction treatment at a HBFF program, the average percentage of days since treatment discharge that they have abstained from drinking alcohol. The measure we submit here pertains to the 6 month follow up survey; administered roughly 6 months after discharge. Hence, the measure is percent days abstinent (PDA) from alcohol at 6 months post-treatment (the mean or average for the sample of patients).	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
142		Percent of Chronic Opioid Analgesic Therapy Enrollees Receiving Opioids from Multiple Providers	The percent of patients receiving chronic opioid analgesic therapy (COAT) from a chronic opioid prescriber who received opioid prescriptions from 2 or more additional prescribers during the time span in which they received COAT.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
143		Percent of Medicaid beneficiaries receiving buprenorphine who have a documented diagnosis of opioid use disorder (OUD).	The purpose of this measure is to assess the percentage of Medicaid beneficiaries receiving buprenorphine (alone or in combination with naloxone) who have a DSM-5 diagnosis of opioid use disorder.	Process	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APM; IQR; VBP
144		Percent of patients meeting SCB thresholds for back or neck pain	Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in back or neck pain following a spine surgical intervention (cervical or lumbar)	Outcome	Pain Management	Pain Score Change	
145		Percent of patients meeting SCB thresholds for leg or arm pain	Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in leg or arm pain following a spine surgical intervention (cervical or lumbar)	Outcome	Pain Management	Pain Score Change	
146		Percent of patients meeting SCB thresholds for pain-related disability (ODI/NDI)	Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in pain-related disability following a spine surgical intervention (cervical or lumbar)	Outcome	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
147		Percent of patients prescribed a medication for alcohol use disorder (AUD)	This measure will be used to assess the extent to which clinicians prescribe medications to treat AUD to their patients.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
148		Percent of patients prescribed a medication for opioid use disorder (OUD)	This measure will be used to assess the extent to which clinicians make medications available to their patients with an OUD.	Process	OUD Treatment	OUD Treatment Initiation	
149		Percent of Patients with Chronic Opioid Analgesic Therapy	The percent of patients receiving chronic opioid analgesic therapy (COAT) prescribed at least one opioid by the healthcare provider.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
150	Endorsed	Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)	This measure reports the percentage of short-stay residents or patients with a 14-day PPS assessment during a selected quarter (3 months) who have reported almost constant or frequent pain and at least one episode of moderate to severe pain, or any severe or horrible pain, in the 5 days prior to the 14-day PPS assessment.	Outcome	Pain Management	Pain Assessment	
151		Percent of Skilled Nursing Facility Residents Who Self-Report Moderate to Severe Pain	This measure reports the percentage of skilled nursing facility residents who have reported daily pain with at least one episode of moderate to severe pain, or severe or horrible pain of any frequency in the 5 days prior to the assessment.	Outcome	Pain Management	Pain Assessment	
152		Perioperative Pain Plan	Percentage of patients with signed documentation that a perioperative pain plan using a multimodal, narcotic sparing technique was discussed	Process	Pain Management	Pain Care Plan	
153		Pharmacologic Management of Migraine Headaches	Percent of members ages 19-65 diagnosed with migraine who received first-line migraine specific therapy prior to receiving opiate or butalbital containing rescue medications.	Process	Pain Management	Non-Opioid Pain Management	
154		Plan Of Care Or Referral For Possible Medication Overuse Headache	Percentage of patients diagnosed with medication overuse headache (MOH) within the past 3 months or who screened positive for possible MOH (measure 6a) who had a medication overuse plan of care created or who were referred for this purpose.	Process	Pain Management	Pain Care Plan	
155		Post-operative opioid management following oculoplastic surgery	Percentage of patients aged 18 years and older who underwent oculoplastic 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	Pain Management	Appropriate Opioid Analgesic Prescribing	
156		Potential Opioid Overuse	Percentage of patients aged 18 years or older who receive opioid therapy for 90 days or longer and are prescribed a 90 milligram or larger morphine equivalent daily dose	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
157		Pregnancy test in women with a suspected toxicologic exposure	Percentage of women of childbearing age (12-60 years) who are seen by a medical toxicologist in the emergency department or inpatient setting with a suspected toxicologic exposure, who receive a pregnancy test prior to emergency department discharge or within 24 hours of hospital admission.	Process	OUD Treatment	OUD Screening	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
158		Preoperative Assessment for Opioid Dependence Risk	Percentage of patients, aged 18 years and older, who undergo preoperative assessment of opioid dependence risk prior to elective surgery and care team is notified.	Process	OUD Treatment	OUD Screening	
159		Preoperative Screening for Anesthetic Risk Factors	Percentage of Percentage of patients, regardless of age, undergoing a surgical, therapeutic or diagnostic procedures under anesthesia in an operating/procedure room during the performance period and who have a documented use of a pre-operative assessment of two or more anesthetic risk factors prior to the start of anesthesia and the procedure did not result in an impairment of anesthesia or the patient did not experience a decrease in the effectiveness of anesthesia. Risk factor assessment must include at least two of the following: • Symptoms of Gastroesophageal Reflux Disease • History of Glaucoma or elevated eye pressures • Post-operative Nausea and Vomiting risk factors • Alcohol and recreational drug use • Herbal supplements and antibiotic impairment of anesthesia	Process	OUD Treatment	OUD Screening	
160		Prescribing Rate of 700 Cumulative MME or Greater During an Initial Opioid Prescribing Episode	The percentage of opioid prescriptions prescribed during the initial index opioid prescribing episode which expose a patient to 700 cumulative Morphine Milligram Equivalence (MME) or more. The prescriber of the prescription that meets or exceeds the 700 cumulative MME threshold does not need to be the prescriber of previous prescriptions in the initial opioid prescribing episode.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
161		Prescribing Rate of an Index Opioid Prescription Greater than the Recommended Dose	The percentage of index opioid prescriptions prescribed in the measurement year that exceed the recommended 100 or 200 Morphine Milligram Equivalence (MME) dose limit. · The 100 MME dose limits applies to prescribers identified as a primary care or non-surgical medical specialists. · The 200 MME dose limit applies to prescribers identified as surgical specialists, including Obstetricians and Gynecologists.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
162		Presence of screening for psychiatric disorder	This measure assesses the extent to which patients with an SUD diagnosis, receiving addiction treatment, are formally assessed for a psychiatric diagnosis.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS, APM
163		Presence of screening for tobacco use disorder	This measure assesses the extent to which patients with an SUD diagnosis, receiving addiction treatment, are screened for a tobacco use disorder diagnosis.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS, APM
164		Pre-surgical screening for depression	Percentage of patients, regardless of age, undergoing surgical, therapeutic or diagnostic procedures under anesthesia where the patient a received a formal pre-surgical screening for depression 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	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
165		Preventative Care and Screening: Tobacco Screening and Cessation Intervention	Percentage of patients age 18 or older who are active tobacco users who receive tobacco screening AND are offered cessation counseling at least 2 months prior to elective surgical procedure in order to delay the procedure until smoking cessation is possibly achieved.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
166	Endorsed	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)	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	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
167	Endorsed	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	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	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
168		Primary care visit follow-up	This measure identifies the proportion of individuals who have a primary care visit after an SUD treatment encounter, and assesses the extent to which clinicians assure comprehensive patient care.	Process	OUD Treatment	OUD Treatment Continuity	SSP; MIPS, APM
169		Psychiatric disorder diagnosis presence	This measure will assess the extent to which patients with an SUD diagnosis, receiving addiction treatment, have a documented psychiatric diagnosis or an explicit entry of “no mental disorder diagnosis” or “mental disorder diagnosis deferred."	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS, APM
170		Quality Of Life Assessment For Patients With Primary Headache Disorders	Percentage of patients with a diagnosis of primary headache disorder whose health related quality of life (HRQoL) was assessed with a tool(s) during at least two visits during the 12 month measurement period AND whose health related quality of life score stayed the same or improved	Outcome: PRO-PM	Pain Management	QoL/Function	
171		Quality of Life for Patients with Neurotology Disorders	Percentage of neurotology patients whose most recent Quality of Life scores were maintained or improved during the measurement period.	Outcome: PRO-PM	Pain Management	QoL/Function	
172		Quality of Life-Mental Health Outcomes	Percentage of patients 18 years of age and older who completed a baseline and, within the CY(calendar year) reporting period of Jan. 1, 20xx - Dec.31, 20xx, follow-up quality of life (QoL) patient-reported outcomes assessment (VR-12, SF-12, SF-36, PROMIS Global 10 or equivalent Computer Adaptive Test (CAT) assessment if available) which yielded a mental component score that showed a statistically significant improvement in comparison to initial assessment or who had already reported a score in which there is no room for statistical improvement. The use of Patient Reported Outcomes (PROs) in clinical research is well documented. In addition, the AAOS Quality Outcomes Work Group recommends that QoL PROs in the clinical setting can lead to improved care.	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
173		Quality-of-Life Assessment for Spine Intervention	Percentage of patients aged 18 years and older undergoing index spine intervention(s) who completed baseline and 3-month follow-up (patient-reported) quality-of-life assessment, with an improvement in the quality of life status from baseline. This measure will be calculated with 2 performance rates: 1) Rate 1: Patient population with Follow-up/Patient population with baseline 2) Rate 2: Patient population with improvement in quality of life status after Follow-up/Patient population with Follow-up. Overall Rate = Rate 2	Outcome: PRO-PM	Pain Management	QoL/Function	
174		Query of Prescription Drug Monitoring Program (PDMP)	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	Pain Management	Appropriate Opioid Analgesic Prescribing	
175		Querying about Pain and Pain Interference with Function	Percentage of patient visits for patient age 18 years and older with a diagnosis of distal symmetric polyneuropathy who was queried about pain and pain interference with function using a valid and reliable instrument.	Process	Pain Management	QoL/Function	
176		Reduction in Patient Reported Pain Following Medial Branch Radiofrequency Ablation	Measurement of reduction in pain as reported by patients aged 18 years and older following medial branch radiofrequency ablation	Outcome: PRO-PM	Pain Management	Pain Score Change	
177		Risky Behavior Assessment or Counseling by Age 13 Years	The percentage of children with documentation of a risk assessment or counseling for risky behaviors by 13 years of age. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, Risk Assessment or Counseling for Sexual Activity.	Process	OUD Treatment	OUD Screening	
178		Risky Behavior Assessment or Counseling by Age 18 Years	The percentage of children with documentation of a risk assessment or counseling for risky behaviors by 18 years of age. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, Risk Assessment or Counseling for Sexual Activity.	Process	OUD Treatment	OUD Screening	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
179		Safe Opioid Prescribing Practices	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	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APMs; IQR; VBP
180	Endorsed	Safe Use of Opioids – Concurrent Prescribing	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	Pain Management	Appropriate Opioid Analgesic Prescribing	
181		Safe Use of Opioids at Time of Care Transitions	Proportion of patients ages 18 years and older who are treated in a hospital care setting who depart with a new opioid prescription not present on arrival and whose level of risk for opioid-related adverse drug events (ADEs) has been assessed and documented. NOTE: This is the draft description of the measure. The final description is dependent on questions we will consider through development and with the expert workgroup (EWG). See Stratification, Risk Adjustment, Clinical Recommendation Statement, Definition, Initial Population, and Denominator Exclusions.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
182		Screening and monitoring for psychosocial problems among children and youth	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.	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
183		Screening for Clinical Depression	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
184		Screening for risk of opioid misuse/overuse	Percentage of patients aged 12 years or older who were screened for the potential risk of opioid misuse/overuse	Process	OUD Treatment	OUD Screening	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
185		Spine/Extremity Pain Assessment	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized back or neck pain tool(s) AND/OR leg or arm pain tool(s) at baseline and 3 months following initial assessment and intervention(s) for treatment of spine-related pain symptoms with at least 10% improvement in the pain status from the baseline and documentation of follow-up plan. This measure will be calculated with 2 performance rates: 1. Rate 1: Patient population with Follow-up/Patient population with baseline 2. Rate 2: Patient population with improvement in pain status after Follow-up/Patient population with Follow-up. Overall Rate = Rate 2	Outcome	Pain Management	Pain Assessment	
186		Stabilization in Anxiety Level	Percentage of home health episodes of care during which the patient's anxiety became less frequent or stayed the same as at admission.	Outcome	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
187		Standardized functional assessment	Percentage of individuals who have documentation of assessment of function (physical, mental, and social functioning) using a standardized assessment instrument at two points in time.	Process	OUD Treatment	OUD Screening	
188		SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
189		SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.	Process	OUD Treatment	OUD Treatment Initiation	IQR; VBP

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
190		SUB-4 Alcohol & Drug Use: Assessing Status After Discharge	Hospitalized patients age 18 years and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected. 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).	Process	OUD Treatment	OUD Treatment Continuity	
191		Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period	This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial and pharmacologic treatment options for opioid addiction within the 12 month reporting period.	Process	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APMs
192		Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence	Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS; APMs
193	Endorsed	Substance Use Screening and Intervention Composite	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results	Composite	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APMs
194		SUD diagnosis documentation in addiction treatment	This measure will assess the extent to which clinicians document an SUD diagnosis for the patients they are treating, regardless of treatment setting.	Process	OUD Treatment	OUD Treatment Continuity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
195		Surgical Phases of Care Patient-Reported Outcome Composite Measure	Composite measure consisting of 12 items intended to measure the constructs of Surgeon Communication Before Surgery, Surgical Goals of Care, Satisfaction with Information, and Postoperative Care Coordination from the patient's perspective. Of these 12 items, 9 originate from the CAHPS Surgical Care Survey (S-CAHPS). Specifically, these 9 items are questions 3, 9, 11, 17, 26, 27, 31, 33, and 34 from the original S-CAHPS survey. Three (3) additional items are included to appropriately measure Goals of Care; these questions ask whether the surgeon discussed what the patient hoped to gain from surgery, whether the surgeon discussed how surgery would affect their daily activities, and what life might look like for the patient in the long-term. Please see the attachment for all 12 items in full.	Outcome: PRO-PM	Pain Management	Pain Care Plan	
196		Time from first face-to-face treatment encounter to buprenorphine dosing	Number of hours opioid dependent, non-pregnant adults aged 18 or older have to wait between their first face-to-face treatment encounter and receiving their first dose of buprenorphine medication (i.e. medication induction).	Process	OUD Treatment	OUD Treatment Initiation	
197	Endorsed	Use of High-Risk Medications in the Elderly	Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. 1) Percentage of patients who were ordered at least one high-risk medication. 2) Percentage of patients who were ordered at least two of the same high-risk medication	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
198		Use of Neuraxial Techniques and/or Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA)	Percentage of patients, regardless of age, that undergo primary total knee arthroplasty for whom neuraxial anesthesia and/or a peripheral nerve block is performed	Process	Pain Management	Non-Opioid Pain Management	
199	Endorsed	Use of Opioids at High Dosage in Persons Without Cancer	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	Pain Management	Appropriate Opioid Analgesic Prescribing	
200		Use of Opioids at High Dosage in Persons Without Cancer Following Elective Primary THA and/or TKA	This measure estimates the proportion 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 following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA). The target population is patients who are 65 years and older, are enrolled in fee-for-service (FFS) Medicare, and hospitalized in Partners HealthCare (PHS) hospitals.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
201	Endorsed	Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer	The rate (XX of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120 mg 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	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
202	Endorsed	Use of Opioids from Multiple Providers in Persons Without Cancer	The rate (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	Pain Management	Appropriate Opioid Analgesic Prescribing	
203	Endorsed	Use of pharmacotherapy for opioid use disorder (OUD)	The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered 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	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APM; IQR; VBP
204		Ventral Hernia Repair: Pain and Functional Status Assessment	Percentage of patients aged 18 years and older who have undergone ventral hernia repair and who completed baseline and 30 day follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline.	Outcome: PRO-PM	Pain Management	QoL/Function	
205		Verify Opioid Treatment Agreement	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	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
206		7-day follow-up after withdrawal management	This measure assesses the extent to which patients initiate treatment within 7 days after receiving withdrawal management services. Because this measure focuses solely on how patients are engaged in addiction treatment post-withdrawal management, this measure will exclude patients engaged in methadone maintenance treatment, patients engaged in office-based opioid treatment that utilizes partial agonist maintenance pharmacotherapy, and patients who enter treatment via intensive outpatient placement with no inpatient/ residential or outpatient withdrawal management services. Thus, a patient who never received withdrawal management services, e.g., because they were not clinically indicated, or because the patient underwent induction onto agonist maintenance pharmacotherapy without undergoing any phase of "withdrawal management," would not be identified via this measure. The purpose of the continuity measure is to assess treatment system contact and engagement beyond the initial follow-up contact within 7 days. Continuity refers to the provision of timely and complementary services within a shared management plan. Disease-specific literature emphasizes the need for care plans to ensure consistency across these treatment locations and providers. Nursing and mental health literature goes further, emphasizing the importance of consistent implementation, especially when patients cross organizational boundaries. However, flexibility in adapting to changes in an individual's needs is equally important, especially in mental health and addiction care.	Process	OUD Treatment	OUD Treatment Initiation	
207		Risk of Chronic Opioid Use.	The percentage of members 18 years and older who have a new episode of opioid use that puts them at risk for continued use. Two rates are reported: 1. The percentage of members whose new episode of opioid use lasts at least 15 days in a 30-day period. 2. The percentage of members whose new episode of opioid use lasts at least 31 days in a 62-day period.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
1		Activity counseling for back pain	Percentage of patients 18 to 65 years of age who were counseled to remain active and exercise or were referred to physical therapy	Process	Pain Management	Alternatives to Opioids	
2		Acute Medication Prescribed for Cluster Headache	Percentage of patients age 18 years old and older with a diagnosis of cluster headache (CH) who were prescribed a guideline recommended acute medication for cluster headache within the 12-month measurement period.	Process	Pain Management	Alternatives to Opioids	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
3		Adult smoking cessation advice/counseling	Heart failure patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
4	Endorsed	Alcohol & Other Drug Use Disorder Treatment at Discharge	This rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Process	OUD Treatment	OUD Treatment Initiation	IQR; VBP
5		Alcohol and Drug Use Assessing Status After Discharge	Discharged patients who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected.	Process	OUD Treatment	OUD Treatment Continuity	IQR; VBP
6		Alcohol Problem Use Assessment & Brief Intervention for Home-Based Primary Care and Palliative Care Patients	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	OUD Treatment	Psychiatric or Dependence Comorbidity	
7		Alcohol Screening and Brief Intervention (ASBI) in the ER	Percentage of patients aged 15 to 34 seen in the ER for injury who were screened for hazardous alcohol use AND provided a brief intervention within 7 days of the ER visit if screened positive.	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
8	Endorsed	Alcohol Use Brief Intervention Provided or Offered	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included. These measures are 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).	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
9		All cause inpatient, residential re-admission	This measure is used to assess the rate of all-cause unplanned readmissions, 90 days following an initial episode of residential/inpatient SUD treatment and assesses the clinician's management of the patient's entire medical condition.	Process	OUD Treatment	OUD Treatment Continuity	
10		Ambulatory Post-Discharge Patient Follow-Up	Percentage of patients, regardless of age, who received anesthesia services in an ambulatory setting whose post-discharge status was assessed within 72 hours of discharge	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
11		Annual Monitoring for Individuals on Chronic Opioid Therapy	The proportion of patients age 18 years and older who are continuously enrolled in a Qualified Health Plan product and on chronic opioid therapy who have not received a drug test at least once during the measurement year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
12		Appropriate controlled substance prescribing (definitive diagnosis(es)) via adherence to Controlled Substance Agreements (CSA) or (OA's) with corrective action taken for pain and/or substance use disorder patients when violations occur.	1) Successful Reporting: a. Documentation of definitive pathology (e.g., imaging, surgical report, serology, provider referral for addiction/substance use disorder, etc.) to warrant chronic pain and/or buprenorphine/naloxone medication chronically. b. Provider must document signing of a Controlled Substance (CSA) or Opiate Agreement (OA) if more than two (2) Schedule II controlled substance prescriptions are provided to a patient in a 12-month period. Understandably, prescriptions may occur in the prior reporting year as well as in the current reporting year. c. For all patients violating existing CSA/OA, such violations are documented with correlative adjustments in treatment (e.g.: shorter duration prescriptions (2 week to 4 week), increased frequency of urine drug screens (quarterly to monthly), random pill counts, more frequent visits, etc.). 2) Numerator & Denominator. Numerator data are patients aged 18 and above with documented definitive pathology of ICD data below. Denominator data are all patients aged 18 and above with any combination of the ICD and HCPCS data defined in this section 3, below. 3) Measure explanation: Chronic Pain medication prescribed (prescribed for greater than one week or more than twice a year) only after a diagnosis and medical or surgical plan has been implemented. CSA or OA followed and, if actionable violation (i.e.: Urine Drug Screen inappropriate, pill counts off, multiple providers prescribing, polypharmacy, etc.) corrective action taken (i.e.: probation, escalated use of Urine Drug Screens, shorter prescriptions intervals, termination of controlled prescribing or similar actions) as result of the CSA/OA violation.	Outcome	Pain Management	Appropriate Opioid Analgesic Prescribing	
13		Appropriate Monitoring for Adverse Events of Opioid and Psychiatric Medications	This measure assesses whether established guidelines to monitor for common ADEs of opioid and psychiatric medications that are administered to patients during inpatient psychiatric facility admissions are being followed. The performance period for the measure is one year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
14		Appropriate Monitoring of patients receiving an Opioid via an IV Patient Controlled Analgesia Device	Patients receiving intravenous opioids via patient controlled analgesia who receive appropriate monitoring of their respiratory status (respiratory rate and pulse oximetry) and level of sedation	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
15		Appropriate Prescribing for First Fill of Opioids	The percentage of adults, 18 and older, who fill an initial prescription for opioid medications that does not comply with at least one of five separate measure components derived from the 2016 Centers for Disease Control (CDC) Guideline for prescribing of opioid medications that are measurable in secondary administrative claims data. Lower is better on this measure.	Composite	Pain Management	Appropriate Opioid Analgesic Prescribing	
16		Assessment and management of chronic pain: percentage of patients with chronic pain diagnosis with documentation of a pain assessment completed at initial visit using a standardized tool	This measure is used to assess the percentage of patients age 16 years and older with chronic pain diagnosis with documentation of a pain assessment completed at initial visit using a standardized tool that addresses pain intensity, location, pattern, mechanism of pain, current functional status and follow-up plan	Process	Pain Management	Pain Assessment	
17		Avoid Certain Opioid Analgesics in the Elderly © ActiveHealth	Percentage of patients 65 years or older who were prescribed certain opioid analgesics	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
18		Avoidance of Long-Acting (LA) or Extended-Release (ER) Opiate Prescriptions	Percentage of Adult Patients Who Were Prescribed an Opiate Who Were Not Prescribed a Long-Acting (LA) or Extended-Release (ER) Formulation	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
19		Avoidance of Opiate Prescriptions for Greater Than 3 Days Duration for Acute Pain	Percentage of Adult Patients Who Were Prescribed an Opiate for Whom the Prescription Duration Was Not Greater than 3 days for Acute Pain	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
20		Avoidance of Opiates for Low Back Pain or Migraines	Percentage of Patients with Low Back Pain and/or Migraines Who Were Not Prescribed an Opiate	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
21		Avoiding Use of CNS Depressants in Patients on Long-Term Opioids	The percentage of patients on long-term opioid prescriptions without a concurrent prescription for an CNS depressant	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
22		Back Pain: Initial Visit	Percentage of patients at least 18 years of age and younger than 80 with a diagnosis of back pain who have medical record documentation of all of the following on the date of the initial visit to the physician: 6. Pain assessment 7. Functional status 8. Patient history, including notation of presence or absence of “red flags” 9. Assessment of prior treatment and response, and 10. Employment status	Process	Pain Management	Pain Assessment	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
23		Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use	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	OUD Treatment	OUD Screening	SSP; MIPS; APM
24	Endorsed	CAHPS Hospice Survey: Getting Help for Symptoms	Multi-item measure P1: Did your family member get as much help with pain as he or she needed P2: How often did your family member get the help he or she needed for trouble breathing P3: How often did your family member get the help he or she needed for trouble with constipation P4: How often did your family member receive the help he or she needed from the hospice team for feelings of anxiety or sadness	Outcome: PRO-PM	Pain Management	Pain Assessment	
25		Care for Older Adults Pain Assessment	Percent of plan members who had a pain screening or pain management plan at least once during the year. (This information about pain screening or pain management is collected for Medicare Special Needs Plans only. These plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who live in an institution such as a nursing home.)	Process	Pain Management	Pain Assessment	
26		Care for Older Adults: Advance Care Planning, Functional Status Assessment, Pain Screening	Care for Older Adults: The percentage of adults 65 years and older who received the following during the measurement year: • Advance Care Planning • Functional Status Assessment • Pain Screening	Outcome	Pain Management	QoL/Function	MIPS; APM
27		Change in Patient Reported Pain and Functional Status Following Spinal Cord Stimulator Implantation	Measurement of the change in patient reported quality of life following spinal cord stimular implantation for failed back surgery syndrome. Quality of life measurement on standardized scale includes pain, mobility, analgesic medication use, psychological well-being and activities of daily living.	Outcome: PRO-PM	Pain Management	Pain Score Change	
28		Chronic Opioid Therapy Follow up Evaluation	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 COT documented in the medical record.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APM;
29	Endorsed	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours.	Intermediate Outcome	Pain Management	Time to Pain Management	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
30		Communication about Pain During the Hospital Stay	The following questions (or a subset of questions) would replace the current Pain Management measure in the HCAHPS Survey with a new measure(s). The following items were tested in early 2016. CMS is currently analyzing the results, as well as discussing these potential new pain management items with focus groups and hospital staff. Multi-item measure (composite): HP1: During this hospital stay, did you have any pain HP2: During this hospital stay, how often did hospital staff talk with you about how much pain you had HP3: During this hospital stay, how often did hospital staff talk with you about how to treat your pain	Outcome: PRO-PM	Pain Management	Pain Assessment	
31		Communication about Treating Pain Post-Discharge	The following questions (or a subset of questions) would replace the current Pain Management measure in the HCAHPS Survey with a new measure(s). The following items were tested in early 2016. CMS is currently analyzing the results, as well as discussing these potential new pain management items with focus groups and hospital staff. Multi-item measure (composite): DP1: Before you left the hospital, did someone talk with you about how to treat pain after you got home DP2: Before you left the hospital, did hospital staff give you a prescription for medicine to treat pain DP3: Before giving you the prescription for pain medicine, did hospital staff describe possible side effects in a way you could understand	Outcome	Pain Management	Pain Assessment	
32		Concomitant Chronic Opioid Analgesic Therapy and Benzodiazepines Prescribing Rate	The number of patients prescribed an elevated dose (≥ 50 MME per day) of chronic opioid analgesic therapy (COAT) who have greater than 7 days of overlapping benzodiazepine therapy in the measurement year. The overlapping benzodiazepine therapy days must be from one prescription in order to meet the inclusion criteria.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
33	Endorsed	Concurrent Use of Opioids and Benzodiazepines (COB)	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	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP
34		Consideration of Non Pharmacologic Interventions	All patients 18 and older prescribed opiates for longer than six weeks duration with whom the clinician discussed nonpharmacologic interventions (e.g. graded exercise, cognitive/behavioral therapy, activity coaching at least once during COT documented in the medical record.	Process	Pain Management	Alternatives to Opioids	SSP; IQR; VBP
35		Constipation assessment following narcotic prescription in patients diagnosed with cancer	Percentage of patients for whom constipation was assessed at the time of narcotic prescription or the following visit	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
36		Continuity of Care after Detox	This measure is defined as the percent of individuals who receive a detoxification service and received another substance abuse service (other than detoxification or crisis care) within 14 days of discharge from detoxification.	Access	OUD Treatment	OUD Treatment Continuity	SSP; IQR; VBP

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
37	Endorsed	Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	Percentage of discharges from an inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which was followed by a treatment service for SUD. SUD treatment includes having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being administered or ordered 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	OUD Treatment	OUD Treatment Continuity	SSP; IQR; VBP
38	Endorsed	Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy) within 7 or 14 days after discharge. This measure is reported across all detoxification settings.	Process	OUD Treatment	OUD Treatment Continuity	SSP; IQR; VBP
39		Continuity of Pharmacotherapy for Alcohol Use Disorder	Percentage of adults 18-64 years of age with pharmacotherapy for alcohol use disorder (AUD) who have at least 180 days of treatment and a Proportion of Days Covered (PDC) of at least 0.8	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
40	Endorsed	Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)	Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment	Process	OUD Treatment	OUD Treatment Continuity	SSP; MIPS; APM
41		Counseling on physical activity in older adults - a. Discussing Physical Activity, b. Advising Physical Activity	Discussing Physical Activity: Percentage patients 65 years of age and older who reported: discussing their level of exercise or physical activity with a doctor or other health provider in the last 12 months. Advising Physical Activity: Percentage patients 65 years of age and older who reported receiving advice to start, increase, or maintain their level of exercise or physical activity from a doctor or other health provider in the last 12 months.	Process	Pain Management	Alternatives to Opioids	SSP; IQR; VBP
42		Counseling Regarding Pharmacological Treatment for Opioid Dependence	This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial and pharmacologic treatment options for opioid addiction within the 12 month reporting period.	Process	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APM; IQR; VBP
43		Counseling Regarding Psychosocial and Pharmacological Treatment Options for Alcohol Dependence	This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period.	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	
44		Depression and Anxiety Assessment Prior to Spine-Related Therapies	Percentage of patients aged 18 years and older with documentation of depression and/or anxiety assessment through discussion with the patient including the use of a standardized assessment tool prior to index therapy(-ies) for treatment of spine-related pain symptoms.	Process	OUD Treatment	Psychiatric or Dependence Comorbidity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
45		Discharge Prescription of Naloxone after Opioid Poisoning or Overdose	Percentage of Opioid Poisoning or Overdose Patients Presenting to An Acute Care Facility Who Were Prescribed Naloxone at Discharge	Process	Harm Reduction	Opioid Reversal Drug Prescription	IQR; VBP
46		Documentation of Signed Opioid Treatment Agreement	All patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during COT documented in the medical record.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
47		Emergency Department Use Due to Opioid Overdose	This is a claims-based measure that captures the rate of emergency department visits for opioid overdose events using ICD-9 or ICD-10 diagnosis codes. Events are measured per 1,000 person-years among Medicare beneficiaries greater than 18 years of age residing in the geography being measured. The measure is designed for use at both the county and state levels.	Outcome	Harm Reduction	Overdose	
48		Emergent care for improper medication administration, medication side effects	Percentage of home health quality episodes of care during which the patient required emergency medical treatment from a hospital emergency department related to improper medication administration or medication side effects.	Outcome	Harm Reduction	Overdose	
49		Evaluation of High Risk Pain Medications for MME	Percentage of patients aged 18 years and older prescribed and actively taking one or more high risk pain medications and evaluated for clinical appropriateness of morphine milligram equivalents (MME)	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APM
50		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with hip, leg or ankle (lower extremity except knee) injury.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with hip, leg, or ankle injuries treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: LEFS score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
51		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in revalidation patients with knee injury pain.	The proportion of patients failing to achieve MCID of two (2) points or more improvement in the NPRS change score for patients with knee injuries treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline KOS score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	
52		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in revalidation patients with low back pain.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with low back pain treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline MDQ score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	
53		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with arm, shoulder, or hand injury.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with arm, shoulder, or hand injury treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline DASH score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
54		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with arm, shoulder, or hand injury.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with arm, shoulder, or hand injury treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline DASH score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	
55		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) in in improvement in pain score, measured via the Numeric Pain Rating Scale (NPRS), in rehabilitation patients with neck pain/injury.	The proportion of patients failing to achieve an MCID of two (2) points or more improvement in the NPRS change score for patients with neck pain/injury treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline NDI score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a physical or occupational therapy performance measure at the eligible physical or occupational therapist or physical or occupational therapy group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
56		Failure to Progress (FTP): Proportion of patients failing to achieve a Minimal Clinically Important Difference (MCID) to indicate functional improvement in knee rehabilitation of patients with knee injury measured via their validated Knee Outcome Survey (KOS) score, or equivalent instrument which has undergone peer reviewed published validation and demonstrates a peer reviewed published MCID.	The proportion of patients failing to achieve an MCID of ten (10) points or more improvement in the KOS change score for patients with knee injury patients treated during the observation period will be reported. Additionally, a risk-adjusted MCID proportional difference will be determined by calculating the difference between the risk model predicted and observed MCID proportion will reported for each physical therapist or physical therapy group. The risk adjustment will be calculated using a logistic regression model using: baseline KOS score, baseline pain score, age, sex, payer, and symptom duration (time from surgery or injury to baseline physical therapy visit). These measures will serve as a PT/OT performance measure at the eligible PT/OT or PT/OT group level.	Outcome: PRO-PM	Pain Management	Pain Score Change	MIPS; APMs
57	Endorsed	Follow-Up After Hospitalization for Mental Illness	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness 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 • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
58	Endorsed	HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed	The proportion of patients, age greater than and equal to 1 year, admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.	Process	OUD Treatment	OUD Screening	IQR

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
59		HBIPS-6 Post discharge continuing care plan created	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a post discharge continuing care plan created. 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, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification 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-7 (Post Discharge Continuing Care Plan Transmitted).	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; IQR; VBP
60		HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	The proportion of patients discharged from a hospital-based inpatient psychiatric setting with a complete post discharge continuing care plan, all the components of which are transmitted to the next level of care provider upon discharge. 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, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification and HBIPS-6: Post Discharge Continuing Care Plan Created) that are used in The Joint Commission's accreditation process. Note that this is a paired measure with HBIPS-6 (Post Discharge Continuing Care Plan Created).	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
61	Endorsed	HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey	HCAHPS (NQF #0166) is a 32-item survey instrument that produces 11 publicly reported measures: 7 multi-item measures (communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, 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). Please note: Beginning with patients discharged in January 2018, the three original Pain Management items were removed from the HCAHPS Survey and replaced by three new items that will comprise the new Communication About Pain measure. The original Pain Management measure will be publicly reported on the Hospital Compare Web site until December 2018. The new Communication About Pain measure will be publicly reported beginning in October 2020.	Outcome	Pain Management	Pain Assessment	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
62	Endorsed	Health literacy measure derived from the health literacy domain of the C-CAT	0-100 measure of health literacy related to patient-centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit	Outcome	Social Issues	Health Literacy	
63		Heel Pain Treatment Outcomes for Adults	DESCRIPTION: Percentage of patients aged 18 years and older with a diagnosis of heel pain who had two or more encounters in the past year.	Outcome: PRO-PM	Pain Management	Pain Score Change	
64		Heel Pain Treatment Outcomes for Pediatric Patients	Percentage of patients aged 6 to 18 years with a diagnosis of heel pain who experience a decrease in heel pain.	Outcome: PRO-PM	Pain Management	Pain Score Change	
65		High-Dose Chronic Opioid Analgesic Therapy Prescribing Rate	The percentage of enrollees prescribed chronic opioid analgesic therapy (COAT) that met or exceeded the daily dose recommendation upper limit of 90 Morphine Milligram Equivalence (MME) per day in the measurement year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
66		History and Physical Examination for Opioid Users	All patients 18 and older prescribed opiates for longer than six weeks duration who had a history and physical examination conducted at least once during COT documented in the medical record.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
67	Endorsed	Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	The Hospice Comprehensive Assessment Measure assesses the percentage of hospice stays in which patients who received a comprehensive patient assessment at hospice admission. The measure focuses on hospice patients age 18 years and older. A total of seven individual NQF endorsed component quality will provide the source data for this comprehensive assessment measure, including NQF #1634, NQF #1637, NQF #1639, NQF #1638, NQF #1617, NQF #1641, and NQF #1647. These seven measures are currently implemented in the CMS HQRP. These seven measures focus on care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation, including patient preferences regarding life-sustaining treatments, care for spiritual and existential concerns, and management of pain, dyspnea, and bowels.	Composite	Pain Management	Pain Assessment	
68		Hospital Harm – Opioid-Related Adverse Events	This electronic clinical quality measure (eCQM) assesses the proportion of inpatient admissions for patients age 18 years and older who suffer the harm of receiving an excess of hospital-administered opioids, defined as receiving a narcotic antagonist (naloxone). In the first 24 hours of the hospitalization, a hospital-administered opioid must be documented prior to receiving naloxone to be considered part of the numerator.	Outcome	Harm Reduction	Overdose	
69		Hospital Harm Performance Measure: Opioid Related Adverse Respiratory Events	This measure will assess opioid related adverse respiratory events (ORARE) in the hospital setting. The goal for this measure is to assess the rate at which naloxone is given for opioid related adverse respiratory events that occur in the hospital setting, using a valid method that reliably allows comparison across hospitals.	Outcome	Harm Reduction	Overdose	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
70		Hospital-level risk-standardized Opioid extended use rate following THA and/or TKA (Opioid extended use)	This measure estimates the proportion of individuals without cancer who had any (1) opioid prescription filed between 90- and 180-days post TKA and/or THA. The target population is patients who are 65 years and older, are enrolled in fee-for-service (FFS) Medicare, and discharged from BWH and other PHS acute-care hospitals following THA/TKA.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
71		Identification of Major Co-Morbid Medical Conditions	Percentage of patients 18 years or older undergoing an elective surgical procedure who received general or spinal anesthesia AND who has documentation of a significant co-morbid condition(s) in their medical record within 30 days of operation date.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
72		Identification of Opioid Use Disorder among Patients Admitted to Inpatient Psychiatric Facilities	The measure assesses the percentage of patients admitted to an inpatient psychiatric facility who were screened and evaluated for opioid use disorder. The performance period for the measure is one year.	Process	OUD Treatment	OUD Screening	
73		Immediate Adult Post-Operative Pain Management	The percentage of patients 18 or older admitted to the PACU after an anesthetic with a maximum pain score <7/10 prior to anesthesia end time.	Outcome	Pain Management	Pain Score Change	
74	Endorsed	Improvement in Pain Interfering with Activity	Percentage of home health episodes of care during which the patient's frequency of pain when moving around improved.	Outcome	Pain Management	Pain Score Change	MIPS; APM
75		Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	Outcome	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
76		Index Opioid Prescription Prescribing Rate	The prescribing rate of index opioid prescriptions to enrollees during the measurement year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
77		Initial Opioid Prescribing at High Dosage	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions with an average daily morphine milligram equivalent (MME) of ≥50. (Excludes patients in hospice care and those with cancer.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APMs
78		Initial Opioid Prescribing for Long Duration	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for >7 cumulative days' supply.(Excludes patients in hospice care and those with cancer	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APMs
79		Initial Opioid Prescribing for Long-Acting or Extended-Release High Dosage	The percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for long-acting or extended-release opioids.(Excludes patients in hospice care and those with cancer	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APMs
80		Initial opioid prescription compliant with CDC recommendations	Composite score indicating compliance with five measurable CDC opioid prescribing guidelines. The denominator includes new opioid prescriptions in the measurement year. The numerator includes new opioid prescriptions that are compliant on all 5 CDC indicators. Higher is better on this measure.	Composite	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
81	Endorsed	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	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	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APM; IQR, VBP
82	Endorsed	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Percentage of Medicaid beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	Process	OUD Treatment	OUD Treatment Initiation	SSP
83	Endorsed	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	Process	OUD Treatment	OUD Treatment Initiation	SSP

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
84		Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Process	OUD Treatment	OUD Treatment Initiation	
85	Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (eCQM)	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported a. Percentage of patients who initiated treatment within 14 days of the diagnosis b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit	Process	OUD Treatment	OUD Treatment Initiation	SSP
86		Inpatient Assessment of Depression Symptoms	The purpose of this measure is to improve the monitoring of the severity of depression as a part of the treatment care plan by implementing the PHQ-9 in the inpatient setting. This process measure will serve as a complementary patient-reported outcome performance measure (PRO-PM) that would evaluate risk-adjusted symptom improvement in patients admitted to inpatient facilities.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
87		Intimate Partner (Domestic) Violence Screening	Percentage of female patients aged 15-40 years old who were screened for intimate partner (domestic) violence at any time during the reporting period.	Process	Social Issues	Violence	
88		IPF Alcohol Use Screening completed within one day of admission	Alcohol Use Screening completed within one day of patient's admission to the IPF. This is a companion measure to MUC XDFGC -- IPF Drug Use Screening completed within one day of admission.	Process	OUD Treatment	OUD Screening	
89		IPF Drug Use Screening completed within one day of admission	Drug Use Screening completed within one day of patient's admission to the IPF. This is a companion measure to MUC XDFGD -- IPF Alcohol Use Screening completed within one day of admission.	Process	OUD Treatment	OUD Screening	
90		IPF Suicide Risk Screening completed within one day of admission	Percentage of admissions to an IPF for which a detailed screening for risk of suicide was completed within one day of admission.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
91		IPF Violence Risk Screening completed within one day of admission	Percentage of admissions for which a detailed screening for risk of violent behavior was completed within one day of admission.	Process	Social Issues	Violence	
92		Kidney Stones: Opioid utilization after ureteroscopy	Percentage of patients who underwent ureteroscopy and are discharged on NSAIDS, Acetaminophen, or "Other" and who were not prescribed opioids for pain control	Process	Pain Management	Non-Opioid Pain Management	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
93	Endorsed	MDS 3.0 Measure (#0676): Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)	This measure captures the percent of short stay residents, with at least one episode of moderate/severe pain or horrible/excruciating pain of any frequency, in the last 5 days.	Outcome	Pain Management	Pain Assessment	
94	Endorsed	MDS 3.0 Measure (#0677): Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)	This measure captures the percent of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last 5 days or (2) any very severe/horrible in the last 5 days.	Outcome	Pain Management	Pain Assessment	
95		Median Time to Pain Management for Long Bone Fracture	Median time from emergency department arrival to time of initial oral or parenteral pain medication administration for emergency department patients with a principal diagnosis of long bone fracture (LBF).	Process	Pain Management	Time to Pain Management	
96		Medication Prescribed For Acute Migraine Attack	Percentage of patients age 12 years and older with a diagnosis of migraine who were prescribed a guideline recommended medication for acute migraine attacks within the 12 month measurement period.	Process	Pain Management	Non-Opioid Pain Management	
97		Medication Reconciliation at Admission	This measure assesses the percentage of inpatient psychiatric facility (IPF) hospitalizations with medication reconciliation completed within 24 hours of admission. The performance period for the measure is one year.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
98	Endorsed	Medication Reconciliation Post-Discharge	The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
99		Mental Health Response at Twelve Months - Progress Toward Recovery	Patients age 18 and older with an initial score equivalent to ten or higher on the Patient Health Questionnaire (PHQ-9) OR equivalent to ten or higher on the Generalized Anxiety Disorder 7-Item (GAD-7), who demonstrate progress toward social goals at twelve months (+/- 60 days after an index visit) defined as an increase in score equivalent to 4 or higher on the PROMIS Satisfaction with Social Roles and Activities.	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
100		Multimodal Pain Management	Percentage of patients, regardless of age, undergoing selected elective surgical procedures that were managed with multimodal pain medicine.	Process	Pain Management	Non-Opioid Pain Management	
101		Narcotic Pain Medicine Management Following Elective Spine Procedure	Percentage of patients aged 18 years and older with documentation of narcotic use/requirements at baseline (initial encounter) and at 3 months following initial assessment and interventions for treatment of spine-related pain symptoms and documentation of follow-up plan.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
102		No or Reduced Criminal Justice Involvement	The percentage of Community Mental Health (CMH) assessed members with no or reduced criminal justice involvement	Outcome	Social Issues	Criminal Justice	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
103	Endorsed	Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)	Percentage of patients, regardless of age, with a diagnosis of cancer who are currently receiving chemotherapy or radiation therapy that have moderate or severe pain in the first two visits and for which there is a documented plan of care to address pain.	Process	Pain Management	Pain Care Plan	MIPS; APMs
104	Endorsed	Oncology: Medical and Radiation - Plan of Care for Moderate to Severe Pain	Percentage of patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having moderate to severe pain with a plan of care to address pain documented on or before the date of the second visit with a clinician	Process	Pain Management	Pain Care Plan	MIPS; APMs
105	Endorsed	Oncology: Medical and Radiation Pain Intensity Quantified (eCQM)	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Process	Pain Management	Pain Assessment	
106		Opioid Monitoring	The purpose of this measure is to improve the monitoring, based on evidence-based guidelines, of IPF patients prescribed opioids for increased risk of opioid use disorder (OUD) and substance use by conducting urine drug testing (UDT) and prescription drug monitoring program (PDMP) review.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
107		Opioid Screening	The purpose of this measure is to improve the universal screening of patients admitted to the IPF to identify opioid use by conducting a urine drug screen (UDS) and prescription drug monitoring program (PDMP) review.	Process	OUD Treatment	OUD Screening	
108		Opioid Therapy Follow-up Evaluation	All patients 18 and older prescribed opiates for longer than 6 weeks duration who had a follow-up evaluation conducted at least every 3 months during Opioid Therapy documented in the medical record	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
109		Opioid-Related Symptom Distress Scale	The Opioid-Related Symptom Distress Scale (ORSDS) is a 4-point scale that evaluates 3 symptom distress dimensions (frequency, severity, bothersomeness) for 12 symptoms.	Outcome	Pain Management	Appropriate Opioid Analgesic Prescribing	
110		Opioids: Hospital-level risk-standardized medication side effect rate following THA and/or TKA (Opioid-induced respiratory depression)	This measure estimates a risk-standardized opioid-related respiratory depression rate associated with elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA). The outcome is defined as any incidence of opioid-induced respiratory depression occurring from the date of index admission to discharge from the hospital. The target population is patients who are 65 years and older, are enrolled in fee-for-service (FFS) Medicare, and hospitalized in nonfederal acute-care hospitals.	Outcome	Harm Reduction	Overdose	
111		Osteoarthritis (OA): Function and Pain Assessment	Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain	Process	Pain Management	QoL/Function	
112		Outcome of High Risk Pain Medications Prescribed in Last 6 Months	Percentage of patients aged 18 years and older prescribed and actively taking one or more high risk medications in the last 6 months meeting the following criteria: • Evaluation of polypharmacy AND • Reduction to the high risk medication where clinically appropriate (e.g., change pain medication, number of medications, dosage and/or frequency prescribed)	Outcome	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
113		Overuse of barbiturate and opioid containing medications for primary headache disorders	Percentage of patients age 12 years and older with a diagnosis of primary headache who were prescribed opioid or barbiturate containing medications assessed for medication overuse headache within the 12-month measurement period, and if identified as overusing opioid or barbiturate containing medication, treated or referred for treatment.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
114		Overuse Of Opioid Containing Medications For Primary Headache Disorders	Percentage of patients aged 12 years and older diagnosed with primary headache disorder and taking 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 Management	Appropriate Opioid Analgesic Prescribing	
115	Endorsed	Pain Assessment	The percentage of hospice patients who screened positive for pain and who received a comprehensive assessment of pain within 1 day of screening.	Process	Pain Management	Pain Assessment	
116		Pain Assessment and Follow-Up	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Process	Pain Management	Pain Assessment	
117		Pain Assessment and Follow-Up for Patients with Dementia	Percentage of patients with dementia who underwent documented screening for pain symptoms at every visit and if screening was positive also had documentation of a follow-up plan.	Process	Pain Management	Pain Assessment	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
118		Pain Assessment and Follow-up Reporting Measure	Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before August 1, 2017 and once before February 1, 2018. Based on NQF #0420. 1. Facilities must report one of the following conditions for each eligible patient: a. Pain assessment using a standardized tool is documented as positive and a follow-up plan is documented b. Pain assessment documented as positive, a follow-up plan is not documented, and the facility possesses documentation that the patient is not eligible c. Pain assessment documented as positive using a standardized tool, a follow-up plan is not documented, and no reason is given d. Pain assessment using a standardized tool is documented as negative, and no follow-up plan required e. No documentation of pain assessment, and the facility possesses documentation the patient is not eligible for a pain assessment using a standardized tool f. No documentation of pain assessment, and no reason is given 2. Conditions covering the first six months of the performance period must be reported in CROWNWeb before August 1, 2017, and the conditions covering the second six months of the performance period must be reported in CROWNWeb before February 1, 2018.	Process	Pain Management	Pain Assessment	
119		Pain Assessment Conducted	Percentage of home health episodes of care in which the patient was assessed for pain, using a standardized pain assessment tool, at start/resumption of care.	Process	Pain Management	Pain Assessment	
120		Pain Assessments and Target Setting for Patients with Osteoarthritis	Percentage of patients 18 years of age and older with a diagnosis of osteoarthritis (OA) for whom a score from one of a select list of validated pain interference or global health assessment tools was recorded at least twice during the measurement period and for whom a target was documented and linked to the initial assessment.	Process	Pain Management	Pain Care Plan	
121	Endorsed	Pain Brought Under Control Within 48 Hours	Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours	Outcome	Pain Management	Time to Pain Management	
122		Pain Brought Under Control within the first three visits	Percent of patients 18 and older who report being uncomfortable because of pain at the initial palliative care assessment who report pain was brought to a comfortable level (e.g. “Comfortable? Yes/No”, “mild” or pain score < 4) within the first three visits	Outcome	Pain Management	Time to Pain Management	
123		Pain Interference Response utilizing PROMIS	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	Outcome: PRO-PM	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
124		Pain Interventions Implemented during All Episodes of Care	Percentage of all home health episodes of care during which pain interventions were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	Process	Pain Management	Pain Care Plan	
125		Pain Interventions Implemented During Long Term Episodes Of Care	Percentage of long term home health episodes of care during which pain interventions were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	Process	Pain Management	Pain Care Plan	
126		Pain Interventions Implemented During Short Term Episodes Of Care	Percentage of short term home health episodes of care during which pain interventions were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	Process	Pain Management	Pain Care Plan	
127		Pain Interventions In Plan Of Care	Percentage of home health episodes of care in which the physician-ordered plan of care includes intervention(s) to monitor and mitigate pain.	Process	Pain Management	Pain Care Plan	
128	Endorsed	Pain Screening	The percentage of hospice patients who were screened for pain during the initial nursing assessment.	Process	Pain Management	Pain Assessment	
129		Pain, Function and General Health Postoperative Improvement	Performance Measure #1 - Change in the calculated score of a validated general health, function, and/or pain score using a standard patient reported outcome survey from before to after surgery. Performance Measure #2 - The overall percentage of patients that improve their general health, function, and/or pain scores beyond a minimum threshold for each postoperative interval. Instructions: Patients who undergo a surgical procedure are asked to complete an outcomes survey both preoperatively and following surgery. Rationale: Understanding a patient's mental and general physical improvement, functional improvement, and improvement in pain levels as a result of surgery is an important aspect of clinical care. The general health scores, functional scores, and pain scores that are calculated can be used to improve a specific patient's care plan or can be analyzed retrospectively to modify overall treatment methodologies. Doctors have the option of collecting a postoperative outcomes survey at different intervals following surgery to account for different surgery types and physician follow-up patterns.	Outcome: PRO-PM	Pain Management	Pain Score Change	
130		Patient Acceptable Symptom State Outcomes	Percentage of patients 18 years or older who completed a baseline and, within the CY(calendar year) reporting period of Jan. 1, 20xx - Dec.31, 20xx, a follow-up Patient Acceptable Symptoms State (PASS) assessment that showed a statistically significant improvement in comparison to initial assessment or who had already reported a score in which there is no room for statistical improvement. The use of Patient Reported Outcomes (PROs) in clinical research is well documented.	Outcome	Pain Management	Pain Score Change	
131		Patient Queried about Pain and Pain Interference with Function	All visits for patients diagnosed with a muscular dystrophy (MD) where the patient was queried about pain and pain interference with function using a validated and reliable instrument*.	Process	Pain Management	QoL/Function	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
132		Patient Reported Pain in Cancer Following Chemotherapy	The PRO-PM will assess clinically meaningful change in pain following completion of chemotherapy administered with curative intent to adult patients with breast cancer, colon cancer, and non-small cell lung cancer (NSCLC).	Outcome: PRO-PM	Pain Management	Pain Score Change	
133		Patient Satisfaction With Spine Care	Percentage of patients aged 18 years and older undergoing spine intervention(s) who completed 3-month follow-up (patient-reported) satisfaction with care assessment. Satisfaction will be reported as % of patients reporting satisfaction with procedure. This measure will be calculated with 2 performance rates: 1) Rate 1: Patient population with Follow-up/Patient population with baseline 2) Rate 2: Patient population with improvement in satisfaction with care status after Follow-up/Patient population with Follow-up. Overall Rate = Rate 2	Outcome	Pain Management	Pain Score Change	
134		Patient-Reported Experience with Anesthesia	Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care and who reported a positive experience. This measure will consist of two performance rates: AQI48a: Percentage of patients, aged 18 and older, who were surveyed on their patient experience and satisfaction with anesthesia care AQI48b: Percentage of patients, aged 18 and older, who completed a survey on their patient experience and satisfaction with anesthesia care who report a positive experience with anesthesia care NOTE: The measure requires that a valid survey, as defined in the numerator, be sent to patients between discharge from the facility and within 30 days of facility discharge. To report AQI 48b, a minimum number of 20 surveys with the mandatory question completed must be reported.	Outcome: PRO-PM	Pain Management	Pain Assessment	
135		Patient-Reported Pain and/or Function Improvement after ACLR Surgery	Percentage of patients 13 years of age and older who obtained at least a 10% improvement in knee pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary anterior cruciate ligament reconstruction (ALCR) surgery. PROMs include any validated measures of knee-related measures of pain and/or function, such as KOOS-Pain, KOOS-ADL, KOOS-PS, and KOOS-JR.	Outcome: PRO-PM	Pain Management	QoL/Function	
136		Patient-Reported Pain and/or Function Improvement after APM Surgery	Percentage of patients 13 years of age and older who obtained at least a 10% improvement in knee pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary arthroscopic partial meniscectomy (APM) surgery. PROMs include any validated measures of knee-related pain and/or function, such as KOOS-Pain, KOOS-ADL, KOOS-PS, and KOOS-JR.	Outcome: PRO-PM	Pain Management	QoL/Function	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
137		Patient-Reported Pain and/or Function Improvement after Total Hip Arthroplasty	Percentage of patients 18 years of age and older who obtained at least a 10% improvement in hip pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary total hip arthroplasty (THA) surgery. PROMs include any validated measures of hip-related pain and/or function, such as HOOS-Pain, HOOS-ADL, HOOS-PS, and HOOS-JR.	Outcome: PRO-PM	Pain Management	QoL/Function	
138		Patient-Reported Pain and/or Function Improvement after Total Knee Arthroplasty	Percentage of patients 18 years of age and older who obtained at least a 10% improvement in knee pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary total knee arthroplasty (TKA) surgery. PROMs include any validated measures of knee-related measures of pain and/or function, such as KOOS-Pain, KOOS-ADL, KOOS-PS, and KOOS-JR.	Outcome: PRO-PM	Pain Management	QoL/Function	
139		Patient-Reported Pain and/or Function Improvement after Total Shoulder Arthroplasty	Percentage of patients 18 years of age and older who obtained at least a 10% improvement in shoulder pain and/or function as measured by validated patient-reported outcome measures (PROMs) completed up to 90 days prior to and 9 to 15 months after undergoing primary total shoulder arthroplasty (TSA) surgery. PROMs include any validated measures of shoulder-related pain and/or function, such as PSS-Pain and PSS-Function.	Outcome: PRO-PM	Pain Management	QoL/Function	
140	Endorsed	Patients Treated with an Opioid who are Given a Bowel Regimen	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
141		Percent days abstinent from alcohol	This measure was developed by staff of the Butler Center for Research (BCR), the research and clinical data analytic arm of the Hazelden Betty Ford Foundation, a national nonprofit alcohol/drug treatment provider. The BCR has been and is currently responsible for collection, analysis and reporting of post-treatment outcomes data for patients attending HBFF treatment programs. This outcomes measurement and reporting takes place on a rolling basis as part of routine healthcare operations. The BCR has designed our own outcomes surveys, which are administered by phone by BCR callers roughly 1, 6 and 12 months after patients discharge. Many of the questions on these surveys ask patients to self-report on substance use since leaving treatment. One of these questions asks patients to indicate the total number of days since treatment that they have drank at least 1 drink containing alcohol. The answer to this question is used to determine PDA from alcohol: among individuals who have recently attended alcohol addiction treatment at a HBFF program, the average percentage of days since treatment discharge that they have abstained from drinking alcohol. The measure we submit here pertains to the 6 month follow up survey; administered roughly 6 months after discharge. Hence, the measure is percent days abstinent (PDA) from alcohol at 6 months post-treatment (the mean or average for the sample of patients).	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
142		Percent of Chronic Opioid Analgesic Therapy Enrollees Receiving Opioids from Multiple Providers	The percent of patients receiving chronic opioid analgesic therapy (COAT) from a chronic opioid prescriber who received opioid prescriptions from 2 or more additional prescribers during the time span in which they received COAT.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
143		Percent of Medicaid beneficiaries receiving buprenorphine who have a documented diagnosis of opioid use disorder (OUD).	The purpose of this measure is to assess the percentage of Medicaid beneficiaries receiving buprenorphine (alone or in combination with naloxone) who have a DSM-5 diagnosis of opioid use disorder.	Process	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APM; IQR; VBP
144		Percent of patients meeting SCB thresholds for back or neck pain	Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in back or neck pain following a spine surgical intervention (cervical or lumbar)	Outcome	Pain Management	Pain Score Change	
145		Percent of patients meeting SCB thresholds for leg or arm pain	Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in leg or arm pain following a spine surgical intervention (cervical or lumbar)	Outcome	Pain Management	Pain Score Change	
146		Percent of patients meeting SCB thresholds for pain-related disability (ODI/NDI)	Calculation of the percent of patients who meet the substantial clinical benefit (SCB) thresholds for improvement in pain-related disability following a spine surgical intervention (cervical or lumbar)	Outcome	Pain Management	Pain Score Change	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
147		Percent of patients prescribed a medication for alcohol use disorder (AUD)	This measure will be used to assess the extent to which clinicians prescribe medications to treat AUD to their patients.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
148		Percent of patients prescribed a medication for opioid use disorder (OUD)	This measure will be used to assess the extent to which clinicians make medications available to their patients with an OUD.	Process	OUD Treatment	OUD Treatment Initiation	
149		Percent of Patients with Chronic Opioid Analgesic Therapy	The percent of patients receiving chronic opioid analgesic therapy (COAT) prescribed at least one opioid by the healthcare provider.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
150	Endorsed	Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)	This measure reports the percentage of short-stay residents or patients with a 14-day PPS assessment during a selected quarter (3 months) who have reported almost constant or frequent pain and at least one episode of moderate to severe pain, or any severe or horrible pain, in the 5 days prior to the 14-day PPS assessment.	Outcome	Pain Management	Pain Assessment	
151		Percent of Skilled Nursing Facility Residents Who Self-Report Moderate to Severe Pain	This measure reports the percentage of skilled nursing facility residents who have reported daily pain with at least one episode of moderate to severe pain, or severe or horrible pain of any frequency in the 5 days prior to the assessment.	Outcome	Pain Management	Pain Assessment	
152		Perioperative Pain Plan	Percentage of patients with signed documentation that a perioperative pain plan using a multimodal, narcotic sparing technique was discussed	Process	Pain Management	Pain Care Plan	
153		Pharmacologic Management of Migraine Headaches	Percent of members ages 19-65 diagnosed with migraine who received first-line migraine specific therapy prior to receiving opiate or butalbital containing rescue medications.	Process	Pain Management	Non-Opioid Pain Management	
154		Plan Of Care Or Referral For Possible Medication Overuse Headache	Percentage of patients diagnosed with medication overuse headache (MOH) within the past 3 months or who screened positive for possible MOH (measure 6a) who had a medication overuse plan of care created or who were referred for this purpose.	Process	Pain Management	Pain Care Plan	
155		Post-operative opioid management following oculoplastic surgery	Percentage of patients aged 18 years and older who underwent oculoplastic 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	Pain Management	Appropriate Opioid Analgesic Prescribing	
156		Potential Opioid Overuse	Percentage of patients aged 18 years or older who receive opioid therapy for 90 days or longer and are prescribed a 90 milligram or larger morphine equivalent daily dose	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
157		Pregnancy test in women with a suspected toxicologic exposure	Percentage of women of childbearing age (12-60 years) who are seen by a medical toxicologist in the emergency department or inpatient setting with a suspected toxicologic exposure, who receive a pregnancy test prior to emergency department discharge or within 24 hours of hospital admission.	Process	OUD Treatment	OUD Screening	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
158		Preoperative Assessment for Opioid Dependence Risk	Percentage of patients, aged 18 years and older, who undergo preoperative assessment of opioid dependence risk prior to elective surgery and care team is notified.	Process	OUD Treatment	OUD Screening	
159		Preoperative Screening for Anesthetic Risk Factors	Percentage of Percentage of patients, regardless of age, undergoing a surgical, therapeutic or diagnostic procedures under anesthesia in an operating/procedure room during the performance period and who have a documented use of a pre-operative assessment of two or more anesthetic risk factors prior to the start of anesthesia and the procedure did not result in an impairment of anesthesia or the patient did not experience a decrease in the effectiveness of anesthesia. Risk factor assessment must include at least two of the following: • Symptoms of Gastroesophageal Reflux Disease • History of Glaucoma or elevated eye pressures • Post-operative Nausea and Vomiting risk factors • Alcohol and recreational drug use • Herbal supplements and antibiotic impairment of anesthesia	Process	OUD Treatment	OUD Screening	
160		Prescribing Rate of 700 Cumulative MME or Greater During an Initial Opioid Prescribing Episode	The percentage of opioid prescriptions prescribed during the initial index opioid prescribing episode which expose a patient to 700 cumulative Morphine Milligram Equivalence (MME) or more. The prescriber of the prescription that meets or exceeds the 700 cumulative MME threshold does not need to be the prescriber of previous prescriptions in the initial opioid prescribing episode.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
161		Prescribing Rate of an Index Opioid Prescription Greater than the Recommended Dose	The percentage of index opioid prescriptions prescribed in the measurement year that exceed the recommended 100 or 200 Morphine Milligram Equivalence (MME) dose limit. · The 100 MME dose limits applies to prescribers identified as a primary care or non-surgical medical specialists. · The 200 MME dose limit applies to prescribers identified as surgical specialists, including Obstetricians and Gynecologists.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
162		Presence of screening for psychiatric disorder	This measure assesses the extent to which patients with an SUD diagnosis, receiving addiction treatment, are formally assessed for a psychiatric diagnosis.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS, APM
163		Presence of screening for tobacco use disorder	This measure assesses the extent to which patients with an SUD diagnosis, receiving addiction treatment, are screened for a tobacco use disorder diagnosis.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS, APM
164		Pre-surgical screening for depression	Percentage of patients, regardless of age, undergoing surgical, therapeutic or diagnostic procedures under anesthesia where the patient a received a formal pre-surgical screening for depression 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	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
165		Preventative Care and Screening: Tobacco Screening and Cessation Intervention	Percentage of patients age 18 or older who are active tobacco users who receive tobacco screening AND are offered cessation counseling at least 2 months prior to elective surgical procedure in order to delay the procedure until smoking cessation is possibly achieved.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
166	Endorsed	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eCQM)	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	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
167	Endorsed	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	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	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
168		Primary care visit follow-up	This measure identifies the proportion of individuals who have a primary care visit after an SUD treatment encounter, and assesses the extent to which clinicians assure comprehensive patient care.	Process	OUD Treatment	OUD Treatment Continuity	SSP; MIPS, APM
169		Psychiatric disorder diagnosis presence	This measure will assess the extent to which patients with an SUD diagnosis, receiving addiction treatment, have a documented psychiatric diagnosis or an explicit entry of “no mental disorder diagnosis” or “mental disorder diagnosis deferred."	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS, APM
170		Quality Of Life Assessment For Patients With Primary Headache Disorders	Percentage of patients with a diagnosis of primary headache disorder whose health related quality of life (HRQoL) was assessed with a tool(s) during at least two visits during the 12 month measurement period AND whose health related quality of life score stayed the same or improved	Outcome: PRO-PM	Pain Management	QoL/Function	
171		Quality of Life for Patients with Neurotology Disorders	Percentage of neurotology patients whose most recent Quality of Life scores were maintained or improved during the measurement period.	Outcome: PRO-PM	Pain Management	QoL/Function	
172		Quality of Life-Mental Health Outcomes	Percentage of patients 18 years of age and older who completed a baseline and, within the CY(calendar year) reporting period of Jan. 1, 20xx - Dec.31, 20xx, follow-up quality of life (QoL) patient-reported outcomes assessment (VR-12, SF-12, SF-36, PROMIS Global 10 or equivalent Computer Adaptive Test (CAT) assessment if available) which yielded a mental component score that showed a statistically significant improvement in comparison to initial assessment or who had already reported a score in which there is no room for statistical improvement. The use of Patient Reported Outcomes (PROs) in clinical research is well documented. In addition, the AAOS Quality Outcomes Work Group recommends that QoL PROs in the clinical setting can lead to improved care.	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
173		Quality-of-Life Assessment for Spine Intervention	Percentage of patients aged 18 years and older undergoing index spine intervention(s) who completed baseline and 3-month follow-up (patient-reported) quality-of-life assessment, with an improvement in the quality of life status from baseline. This measure will be calculated with 2 performance rates: 1) Rate 1: Patient population with Follow-up/Patient population with baseline 2) Rate 2: Patient population with improvement in quality of life status after Follow-up/Patient population with Follow-up. Overall Rate = Rate 2	Outcome: PRO-PM	Pain Management	QoL/Function	
174		Query of Prescription Drug Monitoring Program (PDMP)	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	Pain Management	Appropriate Opioid Analgesic Prescribing	
175		Querying about Pain and Pain Interference with Function	Percentage of patient visits for patient age 18 years and older with a diagnosis of distal symmetric polyneuropathy who was queried about pain and pain interference with function using a valid and reliable instrument.	Process	Pain Management	QoL/Function	
176		Reduction in Patient Reported Pain Following Medial Branch Radiofrequency Ablation	Measurement of reduction in pain as reported by patients aged 18 years and older following medial branch radiofrequency ablation	Outcome: PRO-PM	Pain Management	Pain Score Change	
177		Risky Behavior Assessment or Counseling by Age 13 Years	The percentage of children with documentation of a risk assessment or counseling for risky behaviors by 13 years of age. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, Risk Assessment or Counseling for Sexual Activity.	Process	OUD Treatment	OUD Screening	
178		Risky Behavior Assessment or Counseling by Age 18 Years	The percentage of children with documentation of a risk assessment or counseling for risky behaviors by 18 years of age. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, Risk Assessment or Counseling for Sexual Activity.	Process	OUD Treatment	OUD Screening	
179		Safe Opioid Prescribing Practices	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	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APMs; IQR; VBP

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
180	Endorsed	Safe Use of Opioids – Concurrent Prescribing	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	Pain Management	Appropriate Opioid Analgesic Prescribing	
181		Safe Use of Opioids at Time of Care Transitions	Proportion of patients ages 18 years and older who are treated in a hospital care setting who depart with a new opioid prescription not present on arrival and whose level of risk for opioid-related adverse drug events (ADEs) has been assessed and documented. NOTE: This is the draft description of the measure. The final description is dependent on questions we will consider through development and with the expert workgroup (EWG). See Stratification, Risk Adjustment, Clinical Recommendation Statement, Definition, Initial Population, and Denominator Exclusions.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
182		Screening and monitoring for psychosocial problems among children and youth	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.	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
183		Screening for Clinical Depression	Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
184		Screening for risk of opioid misuse/overuse	Percentage of patients aged 12 years or older who were screened for the potential risk of opioid misuse/overuse	Process	OUD Treatment	OUD Screening	
185		Spine/Extremity Pain Assessment	Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized back or neck pain tool(s) AND/OR leg or arm pain tool(s) at baseline and 3 months following initial assessment and intervention(s) for treatment of spine-related pain symptoms with at least 10% improvement in the pain status from the baseline and documentation of follow-up plan. This measure will be calculated with 2 performance rates: 1) Rate 1: Patient population with Follow-up/Patient population with baseline 2) Rate 2: Patient population with improvement in pain status after Follow-up/Patient population with Follow-up. Overall Rate = Rate 2	Outcome	Pain Management	Pain Assessment	
186		Stabilization in Anxiety Level	Percentage of home health episodes of care during which the patient's anxiety became less frequent or stayed the same as at admission.	Outcome	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
187		Standardized functional assessment	Percentage of individuals who have documentation of assessment of function (physical, mental, and social functioning) using a standardized assessment instrument at two points in time.	Process	OUD Treatment	OUD Screening	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
188		SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
189		SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.	Process	OUD Treatment	OUD Treatment Initiation	IQR; VBP
190		SUB-4 Alcohol & Drug Use: Assessing Status After Discharge	Hospitalized patients age 18 years and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected. 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).	Process	OUD Treatment	OUD Treatment Continuity	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
191		Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period	This measure is used to assess the percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial and pharmacologic treatment options for opioid addiction within the 12 month reporting period.	Process	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APMs
192		Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence	Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS; APMs
193	Endorsed	Substance Use Screening and Intervention Composite	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results	Composite	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APMs
194		SUD diagnosis documentation in addiction treatment	This measure will assess the extent to which clinicians document an SUD diagnosis for the patients they are treating, regardless of treatment setting.	Process	OUD Treatment	OUD Treatment Continuity	
195		Surgical Phases of Care Patient-Reported Outcome Composite Measure	Composite measure consisting of 12 items intended to measure the constructs of Surgeon Communication Before Surgery, Surgical Goals of Care, Satisfaction with Information, and Postoperative Care Coordination from the patient's perspective. Of these 12 items, 9 originate from the CAHPS Surgical Care Survey (S-CAHPS). Specifically, these 9 items are questions 3, 9, 11, 17, 26, 27, 31, 33, and 34 from the original S-CAHPS survey. Three (3) additional items are included to appropriately measure Goals of Care; these questions ask whether the surgeon discussed what the patient hoped to gain from surgery, whether the surgeon discussed how surgery would affect their daily activities, and what life might look like for the patient in the long-term. Please see the attachment for all 12 items in full.	Outcome: PRO-PM	Pain Management	Pain Care Plan	
196		Time from first face-to-face treatment encounter to buprenorphine dosing	Number of hours opioid dependent, non-pregnant adults aged 18 or older have to wait between their first face-to-face treatment encounter and receiving their first dose of buprenorphine medication (i.e. medication induction).	Process	OUD Treatment	OUD Treatment Initiation	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
197	Endorsed	Use of High-Risk Medications in the Elderly	Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are submitted. 3) Percentage of patients who were ordered at least one high-risk medication. 4) Percentage of patients who were ordered at least two of the same high-risk medication	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
198		Use of Neuraxial Techniques and/or Peripheral Nerve Blocks for Total Knee Arthroplasty (TKA)	Percentage of patients, regardless of age, that undergo primary total knee arthroplasty for whom neuraxial anesthesia and/or a peripheral nerve block is performed	Process	Pain Management	Non-Opioid Pain Management	
199	Endorsed	Use of Opioids at High Dosage in Persons Without Cancer	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	Pain Management	Appropriate Opioid Analgesic Prescribing	
200		Use of Opioids at High Dosage in Persons Without Cancer Following Elective Primary THA and/or TKA	This measure estimates the proportion 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 following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA). The target population is patients who are 65 years and older, are enrolled in fee-for-service (FFS) Medicare, and hospitalized in Partners HealthCare (PHS) hospitals.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
201	Endorsed	Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer	The rate (XX of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120 mg 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	Pain Management	Appropriate Opioid Analgesic Prescribing	
202	Endorsed	Use of Opioids from Multiple Providers in Persons Without Cancer	The rate (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	Pain Management	Appropriate Opioid Analgesic Prescribing	
203	Endorsed	Use of pharmacotherapy for opioid use disorder (OUD)	The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered 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	OUD Treatment	OUD Treatment Initiation	SSP; MIPS; APM; IQR; VBP
204		Ventral Hernia Repair: Pain and Functional Status Assessment	Percentage of patients aged 18 years and older who have undergone ventral hernia repair and who completed baseline and 30 day follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline.	Outcome: PRO-PM	Pain Management	QoL/Function	

#	NQF-Endorsed	Measure Title	Description	Measure Type	Domain	Subdomain	Relevant Federal Programs for Measure Type
205		Verify Opioid Treatment Agreement	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	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP
206		7-day follow-up after withdrawal management	This measure assesses the extent to which patients initiate treatment within 7 days after receiving withdrawal management services. Because this measure focuses solely on how patients are engaged in addiction treatment post-withdrawal management, this measure will exclude patients engaged in methadone maintenance treatment, patients engaged in office-based opioid treatment that utilizes partial agonist maintenance pharmacotherapy, and patients who enter treatment via intensive outpatient placement with no inpatient/ residential or outpatient withdrawal management services. Thus, a patient who never received withdrawal management services, e.g., because they were not clinically indicated, or because the patient underwent induction onto agonist maintenance pharmacotherapy without undergoing any phase of “withdrawal management,” would not be identified via this measure. The purpose of the continuity measure is to assess treatment system contact and engagement beyond the initial follow-up contact within 7 days. Continuity refers to the provision of timely and complementary services within a shared management plan. Disease-specific literature emphasizes the need for care plans to ensure consistency across these treatment locations and providers. Nursing and mental health literature goes further, emphasizing the importance of consistent implementation, especially when patients cross organizational boundaries. However, flexibility in adapting to changes in an individual's needs is equally important, especially in mental health and addiction care.	Process	OUD Treatment	OUD Treatment Initiation	
207		Risk of Chronic Opioid Use.	The percentage of members 18 years and older who have a new episode of opioid use that puts them at risk for continued use. Two rates are reported: 1. The percentage of members whose new episode of opioid use lasts at least 15 days in a 30-day period. 2. The percentage of members whose new episode of opioid use lasts at least 31 days in a 62-day period.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

Appendix D: Measure Concept Inventory from Opioid TEP Environmental Scan

SSP – Shared Savings Program
MIPS – Merit-based Incentive Payment System
APMs – Alternative Payment Models
IQR – In-Patient Quality Reporting Program
VBP – Value-based Purchasing Program

Note that the "Relevant Federal Programs for Measure Type" column indicates that based on Opioid TEP discussions, the TEP regards this measure or an appropriately specified version of the measure to be appropriate for consideration in the indicated program.

#	Measure Description	Measure Type	Domain	Subdomain	Appropriate Federal Programs for Measure Type
1	Average inpatient daily MMEs administered during hospitalization	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
2	Behavioral health integration in medical care instrument	Process	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS; APM
3	Clinical Opiate Withdrawal Scale	Process	OUD Treatment	OUD Treatment Continuity	
4	Continuity of Pharmacotherapy for Opioid Use	Process	OUD Treatment	OUD Treatment Continuity	SSP; MIPS; APM
5	Current Opioid Misuse Measure is a 17-item survey useful in assessing prescription opioid use in SUD treatment settings	Process	OUD Treatment	OUD Screening	
6	Daily MMEs prescribed at discharge	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
7	Days' supply of initial opioid prescription for acute pain.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
8	Discharges from opioid use	Process	OUD Treatment	OUD Treatment Continuity	
9	Extended-release opioid prescriptions as a proportion of all initial opioid prescriptions for acute pain.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
10	Extended-release opioid prescriptions as a proportion of all initial opioid prescriptions for chronic pain.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
11	Hospital-level risk standardized opioid extended use following elective THA and/or TKA	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
12	Hospital-level risk standardized opioid respiratory depression following elective THA and/or TKA	Outcome	Harm Reduction	Overdose	
13	Improvement or maintenance of functioning for all patients seen for mental health and substance use care	Outcome	OUD Treatment	OUD Treatment Continuity	MIPS; APM
14	Improvement or maintenance of symptoms for patients with opioid misuse	Outcome	OUD Treatment	OUD Treatment Continuity	SSP
15	Morphine milligram equivalent (MME) of initial opioid prescription for chronic pain.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
16	Neonatal Infant Pain Scale	Process	Pain Management	Pain Assessment	
17	Neonatal Pain Agitation and sedation Scale	Process	Pain Management	Pain Assessment	
18	Number of opioid prescribers for single patient	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
19	Number of opioid prescriptions per 1,000 office visits	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	Measure Description	Measure Type	Domain	Subdomain	Appropriate Federal Programs for Measure Type
20	Number of pills prescribed at discharge	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
21	OD death synthetic opioids	Outcome	Harm Reduction	Overdose	
22	Opioid administration among the headache/migraine patients who visited ED	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
23	Opioid burden	Outcome	Social Issues	Opioid Burden	
24	Opioid covered-days prescribed to the patients who were discharged from ED	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
25	Overdose deaths any opioid	Outcome	Harm Reduction	Overdose	
26	Pain measure for children in inpatient; pain reduction by 30% within 120 minutes of complaint	Outcome: PRO-PM	Pain Management	Time to Pain Management	
27	Patient experience of care for all patients seen with mental health and substance use care	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	
28	Percentage of hospitalized patients with OUD on medication management	Process	OUD Treatment	OUD Treatment Initiation	
29	Percentage of opioid prescriptions for acute pain with less than 7 day supply	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
30	Percentage of opioid prescriptions with partial fill instructions	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
31	Percentage of opioid-naïve patients prescribed C-II & C-III opioid on emergency department discharge	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
32	Percentage of patients administered long-acting opioid during hospital stay	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
33	Percentage of Patients Prescribed Chronic Opioid with Risk and Plan Documented	Process	Pain Management	Pain Care Plan	SSP; MIPS; APM; IQR; VBP
34	Percentage of patients prescribed long-acting opioid at hospital discharge	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
35	Percentage of patients prescribed opioid	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
36	Percentage of patients prescribed opioid at discharge	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
37	Percentage of patients prescribed opioid more than 3 month after surgery	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
38	Percentage of patients prescribed opioid with daily MME > 90 among those who were prescribed	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
39	Percentage of patients that received more than 50 MME during at least one day of their hospitalization	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
40	Percentage of patients treated for opioid overdose in emergency department	Process	Harm Reduction	Overdose	
41	Percentage of patients with documented Opioid Risk Tool assessment among those on chronic opioids	Process	OUD Treatment	OUD Screening	

#	Measure Description	Measure Type	Domain	Subdomain	Appropriate Federal Programs for Measure Type
42	Percentage of patients with Naloxone on medication list while they received opioid with daily MME > 90	Process	Harm Reduction	Opioid Reversal Drug Prescription	SSP; MIPS; APMs; IQR; VBP
43	Percentage of patients with office visits within prior 3 months among chronic opioid users	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
44	Percentage of patients with OUD discharged with naloxone	Process	Harm Reduction	Opioid Reversal Drug Prescription	SSP; MIPS; APMs; IQR; VBP
45	Percentage of patients with urine drug toxicology among chronic opioid users	Process	OUD Treatment	OUD Screening	
46	Percentage of prescribers who have written for 1+ prescription of buprenorphine/nlx	Process	OUD Treatment	OUD Treatment Initiation	
47	Percentage of prescribers with a suboxone waiver	Process	OUD Treatment	OUD Treatment Initiation	
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	OUD Treatment	OUD Screening	
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	Pain Management	Appropriate Opioid Analgesic Prescribing	
50	Quantity of opioid prescribed to the patients who were discharged from ED	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
51	Rapid Recovery Progression Measure: 6-item	Intermediate Outcome	OUD Treatment	OUD Treatment Continuity	
52	Rate of NY Office of Alcoholism and Substance Abuse Services (OUD treatment program) use	Process	OUD Treatment	OUD Treatment Initiation	
53	Recovery Progression Measure: 36-item	Intermediate Outcome	OUD Treatment	OUD Treatment Continuity	SSP; MIPS; APM
54	Subjective Opiate Withdrawal Scale	Process	OUD Treatment	OUD Treatment Continuity	
55	The percentage of patients on long-term opioid therapy the clinician counseled on the risks and benefits of opioids at least annually.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
56	The percentage of patients on long-term opioid therapy who had a follow-up visit at least quarterly.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
57	The percentage of patients on long-term opioid therapy who had at least quarterly pain and functional assessments.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	SSP; MIPS; APM
58	The percentage of patients on long-term opioid therapy who had documentation that a PDMP was checked at least quarterly.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	

#	Measure Description	Measure Type	Domain	Subdomain	Appropriate Federal Programs for Measure Type
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	Harm Reduction	Opioid Reversal Drug Prescription	SSP; MIPS; APMs; IQR; VBP
60	The percentage of patients on long-term opioid therapy with documentation that a urine drug test was performed at least annually.	Process	OUD Treatment	OUD Treatment Continuity	
61	The percentage of patients with a follow-up visit within 4 weeks of starting an opioid for chronic pain.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
62	The percentage of patients with a new opioid prescription for acute pain for a three days' supply or less	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
63	The percentage of patients with a new opioid prescription for an immediate-release opioid.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
64	The percentage of patients with a new opioid prescription for chronic pain with documentation that a PDMP was checked prior to prescribing.	Process	Pain Management	Appropriate Opioid Analgesic Prescribing	
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	Pain Management	Appropriate Opioid Analgesic Prescribing	
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	Pain Management	Non-Opioid Pain Management	SSP; MIPS; APMs; IQR; VBP
67	PROMIS Pain Interference instruments	Outcome: PRO-PM	Pain Management	Pain Assessment	
68	PROMIS Physical Function - Short Form	Outcome: PRO-PM	Pain Management	QoL/Function	SSP; MIPS; APM; IQR; VBP
69	PROMIS Pain Intensity Scale	Outcome: PRO-PM	Pain Management	Pain Assessment	
70	PROMIS Emotional Distress-Depression Short Form	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS; APM; IQR; VBP
71	PROMIS Emotional Distress-Anxiety Short Form	Outcome: PRO-PM	OUD Treatment	Psychiatric and/or Other Illness Comorbidity	SSP; MIPS; APM; IQR; VBP

Appendix E: Measure Set for the Shatterproof Quality Measurement System for Addiction Treatment Facilities

With support from the advocacy group Shatterproof, NQF convened a TEP to put forth the following list of measure concepts for the evaluation of substance use disorder treatment facilities Note that this list has been adapted to summarize the concepts on the Shatterproof measure set list posted on NQF's website and includes modifications from the measure refinement process led by Shatterproof. The measures will be collected at the facility level, or brick and mortar location, and reported to the public through the Shatterproof "ATLAS" website.

1. Access: Ability to offer same day or walk-in appointments in the outpatient setting (treatment facility survey)
2. Access: Patient-reported experience (patient experience survey)
3. Access: Ability to optimize resources, refer patients, and support them if necessary level of care is not immediately available (treatment facility survey)
4. Use of a valid assessment tool, including to identify patient-specific symptom severity, circumstances, and comorbidities (treatment facility survey)
5. Continuity of care indicators after residential treatment discharge (claims)
6. Long-term care and follow up: tracks patient progress on all important dimensions through the use of reliable tools and tests and modifies treatment plans as needed (treatment facility survey)
7. Use of electronic health records and the level of integration (treatment facility survey)
8. Availability and coordination of mental health (treatment facility survey)
9. Staff composition, physicians, primary care (treatment facility survey)
10. Types of evidence-based SUD therapies available (cognitive behavioral therapy, contingency management, community reinforcement approach, matrix model, motivational enhancement therapy, twelve-step facilitation therapy, family behavior therapy, mindfulness-based relapse prevention) (treatment facility survey)
11. Patient overall rating of program from 0-10
12. Staff respect for patients (patient experience survey)
13. National accreditation (treatment facility survey)
14. Access to FDA-approved opioid use disorder medication (claims)
15. Continuity of medications for opioid use disorder up to 180 days (claims)
16. Availability of medication for opioid use disorder (treatment facility survey)
17. Availability of recovery support services, such as peer recovery, employment counseling/training, housing, transportation, child care, assistance obtaining social services, legal aid, domestic violence aid (treatment facility survey)
18. Family support (patient experience survey)
19. Overdose after treatment (claims)
20. How much has treatment helped (patient experience survey)
21. Improvement in ability to function (patient experience survey)
22. Patient narrative on experience, what could be done to enhance program (patient experience survey)

Appendix F: Opioid Crisis Indicators Evident in State Dashboards*

- Total overdose deaths (by toxic substance)
- Emergency room visits related to overdoses
- Prescription opioid misuse; heroin use; OUD rates
- Opioid prescriptions
- Opioid treatment capacity
- Hospitalization rates
- Neonatal exposure rates
- Comorbidity rates
- Naloxone save counts
- Peer recovery availability indicators

*State website sources: Minnesota, Rhode Island, Washington, Pennsylvania, Missouri

Appendix G: Public Comments on Draft Report