

# Improving Opioid Use Disorder Treatment through Quality Assessment



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Harms associated with opioids and opioid use disorder (OUD) continue to affect millions of Americans. Despite falling rates of opioid prescriptions and increased national efforts to reduce opioid misuse, a projected 700,000 people will die from opioid overdose between 2016 and 2025.<sup>1</sup> Less than 35% of people with OUD receive any treatment, and fewer receive evidence-based medication treatment.

The path forward in the face of this stark reality has important implications for millions who currently suffer from or will yet develop OUD. Nearly two decades of legislative measures to expand access to OUD treatment have engendered rapid growth of independent addiction treatment programs—private outpatient or residential facilities that offer a disparate range of OUD treatment modalities—nationwide.<sup>2</sup> In 2018, the SUPPORT for Patients and Communities Act (SUPPORT Act) further incentivized expansion of these programs through additional coverage in Medicare and Medicaid. Now, rising overdose deaths amidst the COVID-19 pandemic underscore the need to leverage these policies to enable access in a dynamic public health environment.<sup>3</sup>

However, addiction treatment programs have developed without consistent oversight from medical regulatory bodies, resulting in heterogeneous care models that often misalign with current standards.<sup>4</sup> Federally funded programs must adhere to evidence-based practices, but have few tools to assess deficiencies or measure the impact of changes to existing practice patterns. The adoption of quality measurement frameworks specifically tailored to OUD treatment represents an important means of addressing this problem. Quality measurement has been used to address barriers like those that limit access to effective OUD care, including heterogeneous

practice patterns, treatment infrastructure deficits, and underutilization of evidence-based care. However, until recently, few quality measures specific to OUD treatment have been proposed.<sup>5</sup> Without established quality standards, efforts to align practice patterns in an ever-growing number of unique treatment settings are likely to falter.

Importantly, the SUPPORT Act has also directed attention to OUD care quality. In 2019, a SUPPORT Act–mandated technical expert panel convened by the National Quality Forum (NQF) identified several priority areas for OUD quality measurement.<sup>6</sup> Guided by the current national landscape of value-based payment systems and established quality measurement programs, the NQF concluded that continuity of care throughout OUD recovery; recognition of physical, psychiatric, and substance use comorbidities; and consideration of vulnerable populations are vital for developing sustainable improvements in OUD care. These efforts lay a foundation for improving OUD quality assessment and accountability; however, their success requires broad stakeholder engagement, implementation support, and technical assistance to integrate frameworks across a spectrum of small treatment programs to large health systems.

We propose four guiding principles for patient-centered quality measurement in a rapidly expanding, diverse OUD treatment environment.

## EMPHASIZE REWARD OVER PENALTY

Because the expansion of treatment services is central to combating the opioid public health crisis, care must be taken to ensure implementation of quality measurement programs does not dissuade healthcare organizations from providing OUD care because of perceived risk or inconvenience. Creating accountability structures that reward adherence to evidence-based practices, such as the provision of FDA-approved medications to treat OUD, while providing additional support for those falling short, can cultivate the development of treatment infrastructure in two ways. First, it incentivizes participation in federal funding programs among independent opioid treatment programs, preserving critical treatment access for patients otherwise vulnerable to steep out-of-

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pocket costs levied by many private facilities. Second, it promotes the integration of quality-driven OUD treatment into settings such as primary care, which can vastly increase access. Receiving OUD treatment in the context of primary care builds patient-provider continuity and removes the perceived stigma from receiving care in an addiction clinic or program. However, relatively few primary care clinicians currently prescribe medications to treat OUD, citing barriers such as licensing requirements, inadequate time, and lack of support.<sup>7</sup> Incentives such as additional compensation, telehealth-based coaching, enhanced case management supports, and smaller panel sizes could surmount these barriers and encourage the adoption of evidence-based OUD care.

### INCENTIVIZE INNOVATION TO SUPPORT VULNERABLE GROUPS

The NQF panel found that establishing robust metrics for OUD treatment is complicated by significant numbers of affected individuals in vulnerable groups, such as pregnant women, persons detained or experiencing homelessness, and Native Americans or other racial minorities. Novel OUD treatment initiatives for vulnerable patients already exist in non-traditional venues such as syringe exchange services, mobile clinics, and correctional facilities, but forums to accelerate innovation by leveraging best practices and lessons learned from these efforts are lacking. Quality measures can identify where and when novel program initiatives are yielding positive outcomes and generate standards and implementation frameworks for disseminating successful models to similar practice settings. For example, in a proposal to improve quality for emergency department buprenorphine treatment initiation, Samuels and colleagues designed patient-centric process measures relevant to the care environment, such as rapid treatment of withdrawal symptoms, provision of naloxone at discharge, and timely linkage to outpatient follow-up, rather than traditional measures such as retention in treatment and urine drug screening.<sup>8</sup> Stakeholders—including patients—from care environments, such as correctional health, shelter health, and tribal health, may develop frameworks reflecting goals tailored to each unique practice setting. Providing tools for local health organizations to evaluate and share successful programs enables agile “ground-up” innovation that complements slower large scale regulatory change.

### IDENTIFY GAPS IN TREATMENT INFRASTRUCTURE

While many proposed OUD quality measures focus on organizational processes and treatment outcomes, the COVID-19 pandemic has laid bare the need for measures that help health systems evaluate treatment infrastructure. The growth of telehealth-based addiction treatment provides an impetus for states to map regional access gaps and allocate resources proportional to need. At present, over 60% of rural US

counties lack a licensed buprenorphine prescriber.<sup>9</sup> Geographic data for these providers is publicly available, but it is unclear how states and health systems use this information. Because regional practice patterns contribute to gaps in evidence-based care, quality measurement programs may be more likely to succeed when incentives are responsive to specific barriers and needs. The OUD Cascade of Care, endorsed by the National Institute on Drug Abuse, proposes an adaptable framework for building these types of quality measurement programs.

### ENCOMPASS HOLISTIC, PATIENT-CENTERED CARE

Aligning community practice patterns through standardized quality measurement provides a critical opportunity to define what counts as success in OUD treatment. Many traditional outcomes, such as validation of non-prescription opioid abstinence through urine drug screens, may not reflect the goals of every individual. Many desire to use fewer drugs, or to use more safely, rather than commit to abstinence. Measures that assess quality-of-life outcomes, solicit patient feedback on treatment experience, encourage screening for co-occurring conditions, foster behavioral health support, and offer harm reduction strategies to avert overdose and other health complications reflect the multifarious goals of OUD treatment. Conversely, measures based on abstinence and adherence to patient visits alone are not evidence-based and may disincentivize programs serving vulnerable populations who face barriers to meeting those standards. At present, there is no widely-used tool to assess the effects of OUD treatment on patient-centered outcomes such as function, safety, mood, and engagement with healthcare and social services. Such an instrument could play a critical role in OUD quality assessment, particularly in large healthcare systems, where establishing patient-centered quality standards across a spectrum of care settings has historically been difficult.

As the OUD treatment landscape evolves, dynamic quality measurement tailored to unique clinical environments is required. With input from local stakeholders and commitment to develop quality standards reflecting a continuum of patient-centered treatment goals, we can improve the care we give to those in need.

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