Shatterproof Rating System for Addiction Treatment Programs

Measure Set for Feasibility Testing

April 2019

Shatterproof is leading a pilot project to develop a Rating System of Addiction Treatment Programs (Rating System). The Rating System is being piloted in five states in 2019. Shatterproof has led an iterative, multi-stakeholder process to develop a set of measures to inform the ratings. As a key step in this process, Shatterproof partnered with the National Quality Forum (NQF) to independently gather expert and public guidance to inform implementation of the Rating System measure set. **Following the NQF process, Shatterproof is pleased to share the measures below that reflect recommendations from the NQF facilitated process, including an expert panel, key informant interviews, public comments, and a landscape review** (See: Table 1, Column 'Measure Concepts Following NQF Process*, Revised Measure Set 5.0*'). In the table below, Shatterproof also sought to summarize inputs from the NQF process and explain any changes that have been made in response, or in some cases explain why suggestions are not being actioned now.

The measures will continue to be refined by Shatterproof and its analytics partner, Research Triangle Institute (RTI) - revising specifications and consolidating or removing measures - through feasibility testing in pilot states in May 2019. The data collection period for the Rating System will begin in August 2019. **Shatterproof would like to thank all of those involved in this process, outlined in Appendix A, and the numerous additional stakeholders that submitted comments and feedback**.

Background

In November 2017, Shatterproof, with guidance and support from the Shatterproof Substance Use Disorder Treatment Task Force (Appendix A) released the National Principles of Care for Substance Use Disorder Treatment © (the Principles). The Principles are core concepts from the Surgeon General's Report on addiction that are shown by rigorous research studies to improve patient outcomes; including reducing the risk of overdose and improving health, productivity, and criminal justice-related outcomes, and are applicable across addiction treatment settings.

Using the Principles as a framework, the Shatterproof Quality Measure Committee (Appendix A) undertook an iterative process to crosswalk potential quality measures that are already in use, as well as identify gaps. The group aggregated structure, process, and outcome measures previously used for substance use disorder (SUD) treatment or in related disciplines and identified potential new measures. The Committee then refined the measures based on input from different stakeholders, including key-informant interviews with payers and a series of provider focus groups. The focus groups were conducted by the Technical Assistance Collaborative with support from the Melville Charitable Trusts.

In October 2018, Shatterproof retained the National Quality Forum (NQF) to articulate considerations for measuring the quality of care for the purposes of rating SUD treatment programs, gather feedback on the measure set developed by the Shatterproof Quality measure Committee, provide guidance for adapting existing measures for use at the facility level, identify potential data implementation challenges and solutions, and outline recommendations for future phases of the Rating System. NQF facilitated a multi-part, process involving an independent landscape review, key-informant interviews, an in-person strategy session before the measure set was revised and posted for a public comment period. Over 350 comments to the measure set were received. Based on these comments,

the Expert Panel conducted a final review of the measure set and recommended that the measure concepts listed below move forward for feasibility testing (**See: Table 1, Column 'Measure Concepts Following NQF Process, *Revised Measure Set 5.0'***).

Overall, the Expert Panel and public commenters viewed the pilot and initial measure set as a critical "starting point" to improve the quality of SUD treatment across settings, increase alignment across measurement initiatives, address the diverse needs of different stakeholder groups, and destigmatize SUD. Where there was consistent agreement in inputs, and it was feasible for the pilot phase, the measure set was modified based on comments and ultimately expert insight.

Shatterproof has prepared this document to summarize inputs and changes to the measure set from beginning to end of the NQF process. The measures will continue to be refined (revising specifications and consolidating or removing measures) through feasibility testing which will occur in pilot states in May 2019.

KEY POINTS

- **SCORING MEASURES:** The 'scoring' of each measure, and determination of whether a core set of measures may be factored into a composite score to be used in the Rating System, will be made after data collection and analysis. Where there were specific questions or comments about measure scoring this is included in the table below.
- **FINALIZING MEASURES**: The measure set listed below will continue to be refined by Shatterproof and Research Triangle Institute and is subject to change based on findings from feasibility testing.
- **PUBLIC COMMENTS:** While every comment was reviewed and considered, not all were integrated into the measure set. Some suggestions were infeasible to implement during the pilot phase and will be considered for future phases, other feedback was conflicting. When possible, the experts deferred to keep measures with face-validity unchanged. A summary of comments by the public, expert panel, and key-informants is included in the table, as well as a response and changes to the measure set.

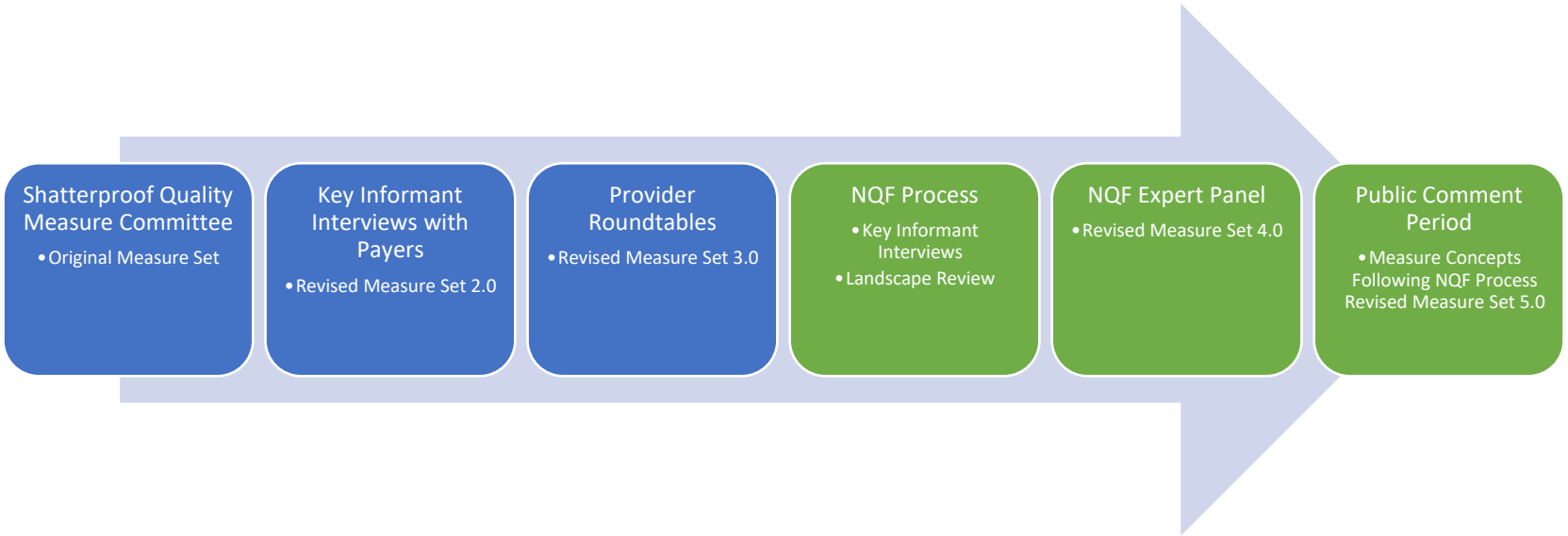

TABLE 1: COMMENTS, RESPONSE, & CHANGES TO MEASURE SET DURING NQF PROCESS

April 2019

Measures that went into NQF process ***Measure Set 3.0***	**Summary of Comments (Key Informants, Expert Panel, Public Comments)**	**Response and Explanation of Changes**	**#**	**Data Collection Method**	**Measure Concepts Following NQF Process** ***Revised Measure Set 5.0***
The mean number of days between contact and treatment	There was general sentiment by both public comments and Expert Panel that this measure may be duplicative of Measure 2C (which was added in *Measure Set 4.0* based on feedback from focus groups and the Expert Panel). Comments that this should be collected via Survey and inability to collect consistently via claims. There was consensus around the need for a solid measure of access but concern that 2A may not be captured consistently across providers. There was also concern that this may not be a reliable representation of quality given variation in demand, level of care, and confounding factors. As a result, there were some suggestions to display for transparency but not include in a weighted composite score, should one be developed.	Measure 2A will be informed by the Treatment Program Survey, not by claims. Both measure 2A and 2C will move forward to feasibility testing of Treatment Program Survey. This will inform the determination about next steps - likely removing the less feasible measure to get to a single rapid access measure that can be captured consistently. On systems issue point, there was support from the Expert Panel that this measure should not be used as part of a composite score during phase 1 (if a composite score is used at all), or stated differently, should not be a part of a core set. However, there was agreement that this is important for people to know when looking for treatment and that an access measure should be reported for transparency. If this measure is determined infeasible in the pilot, alternative mechanisms for capturing rapid access will be considered in future phases.	2a	Treatment Program Survey	Wait time for treatment: *The mean number of days between first contact or assessment and treatment.*[++]
Added in Measure Set 4.0	Feedback on this measure was neutral to positive. Feedback on the consumer experience of care questions in general included concern about subjectivity. There were suggestions to consider rewording to capture outside variables (e.g. travel, legal, medical, etc.) impacting access to treatment. There were also questions about who will field the consumer experience survey and how timely the responses will be.	Given this is a CAHPS ECHO question the wording has already been tested and it is suggested to not modify wording. In response to questions about timing, the specifics about "fielding the survey" will be determined following a pilot in NY State. The intention is that the survey will be available on a crowdsource platform. This will allow people to leave feedback	2b	Consumer Experience Survey	Access to treatment: *When you needed treatment right away, how often did you see someone from this treatment program as soon as you wanted?*

		on the program at any point in their treatment.			
Added in Measure Set 4.0	This measure was added in *Measure Set 4.0* and was posted for public comment. It was suggested that "same day access" should be interpreted as "same day capacity," since many patients do not choose same-day care. Similar to measure 2A, commenters recognize that there is good intention: whether providers have good-faith mechanisms to ensure same-day care when it is desired and possible. There was support for principle 2 criteria, especially to differentiate between baseline quality and high-quality, but a mixed response about whether the criteria should be uniformly applied. Specifically, there were some concerns on how this measure may vary in relevance when it comes to different levels of care. Several comments allude to a need for clarity about whether this is also assessing extended hours or accessibility outside standard business hours, in addition to same day access, and how this measure differs from 2a. There were some concerns regarding how capacity issues (caused by insurance barriers) may impact the ability of treatment programs to offer same day access, but less concern pertaining to this measure than there was with 2a, especially when viewed as same-day capacity. There was also conflicting/ mixed feedback about the relevance of "same day access" from different groups.	The following additional sub questions have been added to this measure: Do you use any of the following to assist clients: Please select all that apply: (1) We keep a running list of available beds and treatment slots and provide the consumer with the telephone number of other treatment providers with availability, (2) We call the other treatment facility and assist the consumer in setting up an appointment with the other facility, (3) We advise the consumer to check out the SAMHSA treatment locator, (4) Other [specify]. Both measure 2A and 2C will move forward to feasibility testing the Treatment Program Survey. This will inform the determination about next steps - likely removing the less feasible measure to get to a single rapid access measure that can be captured consistently. On systems issue point, there was support that this would not be used as part of a composite score during phase 1 (if a composite score is developed in the pilot at all), but that this is important for people to know when looking for treatment and that an access measure should be reported for transparency.	2c	Treatment Program Survey	Access to treatment: *Does your program offer same day access? Does your facility have the ability to admit clients after hours? If you do not have available beds or treatment slots, do you assist consumers in finding alternative treatment providers?" Do you use any of the following to assist clients: (1) We keep a running list of available beds and treatment slots and provide the consumer with the telephone number of other treatment providers with availability, (2) We call the other treatment facility and assist the consumer in setting up an appointment with the other facility, (3) We advise the consumer to check out the SAMHSA treatment locator, (4) Other [specify]* [#, ++]
Provider use of valid/reliable assessment instrument	Feedback on this measure was neutral with a desire for a list of valid and reliable assessment tools and an interest in how Shatterproof might expand upon surveying assessment tools used, to potentially identify a correlation between assessment tools used and patient placement in the correct level of care.	The measure will be retained, with modifications to include a list of potential assessment tools and an "other" option with a fill in the blank if a program uses a tool that is not listed. Shatterproof is considering assembling an expert committee to review additional tools submitted in phase one.	3a	Treatment Program Survey	*Does your program use a valid/reliable assessment instrument, if so, which one (e.g., ASAM, ASI, other)? Does the intake assessment collect information on the following: substance use, mental health status, physical health conditions, social relationships, risk of*

		Future phases of the Rating System may look at linking assessment to appropriate placement, but the primary goal in the first phase of the pilot is to set a "floor" for quality and communicate via the Rating System that conducting assessment at intake using a reliable and valid tool is the expectation. This may be an area in which the consumer portal of the Rating System offers educational materials for consumers explaining this in more detail.			*relapse (e.g., cravings), other?* [++]
Added in Measure Set 4.0	Suggestion to examine whether patients were given information about specific treatment types, and examples given included medications, counseling, recovery services. There was also some concern that the measure may be too broad as written. There were questions about when in treatment this would be administered.	The measure will be retained as written, as it is a well-vetted CAHPS measure to capture the concept of shared decision-making. The addition of asking about whether specific treatment modalities were offered or explained will be considered for future phases. In response to questions about timing, the intention is that the survey will be available on a crowdsource platform. This will allow people to leave feedback on the program at any point in their treatment.	3b	Consumer Experience Survey	*During your treatment, were you given information about different kinds of counseling or treatment that are available?*
Continuous engagement: The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of alcohol or other drug dependency (AOD) within 30 days of the initiation visit	This measure was modified to examine continuity of care after residential treatment (an NQF endorsed measured) prior to the public comment period. Public comments pointed to a desire to define which claims will be included in discharge and potentially listing which code sets are used and whether primary care visits are included in the measure concept.	The NQF-endorsed measure for continuity of care after residential treatment will be used. The value set for the metric includes a description of all the claims data and has been well-vetted through the NQF process. The measure applies to all discharges with an SUD code. An effort will be made to ensure claims going into this measure have a long enough lag period that all adjudicated claims can be included, including inpatient. The measure specifications at the treatment program level are being developed by Research Triangle Institute.	4a	Claims	Continuous engagement: *Continuity of care after residential treatment for substance use disorder.*

Continuous adjustments to treatment: Use of standardized tool or instrument to monitor individual's progress in achieving his or her care, treatment, or service goals. Results are used to inform goals and objectives of the plan for care as needed.	Feedback on this measure was neutral with consistent interest in the ability to assess outcomes related to treatment progress.	The measure will be retained as written with an effort undertaken to offer clarity on data collection and interpretation.	4b	Treatment Program Survey	Continuous adjustments to treatment (measurement-based care): *Does the program apply standardized assessments over time to determine treatment progress? If so, what outcomes are measured? How frequently are they measured? What instruments are used to measures outcomes?*
Ability to access EMR	Feedback received in public comment indicated the need for more specificity on this measure to dig deeper into assessing level of EMR functionality. It was also suggested to assess how well an EMR adheres to privacy restrictions. Several comments suggested assessment of whether a treatment program is connected to a HIE. The Expert Panel agreed information for this measure should be collected for the purpose of identifying areas where providers could use support in adoption of EMRs, but there was mixed feedback about whether the measure should be included in a core set that would be scored.	An effort will be made to word the question in a way that captures relevant functionality without being burdensome, and the measure will be tested during Treatment Program Survey feasibility testing across pilot states. There was mixed feedback about whether this measure should be included in a composite score, should a composite score be developed. This decision will be made after data collection as stated in 'Key Points' above.	5a	Treatment Program Survey	Program Uses an Electronic Medical Record: *Please select which of the following statements best describes your facility's highest level of Electronic Health System use (excluding billing)?*[++]
Documentation of Current Medications in the Medical Record	This measure was modified prior to public comment. Measure 5b was modified to capture provision of mental health practices while Measure 5c was added to examine physical health. Commenters on measure 5b shared an interest in focusing on outcomes - getting to the percent of patients treated onsite v. offsite and measuring provision of mental and physical health services in a tiered platform.	Final wording for this measure will be determined during the Treatment Program Survey feasibility testing process. Based on both public comments and expert feedback, the measure will likely be revised to provide flexibility in how providers meet this requirement by allowing referral to a provider that is not on-site, through an MOU. The language for this measure will be modified to better reflect the application of this measure to treatment centers that are part of large systems (and the process by which they may connect patients to	5b	Treatment Program Survey	Provision of Mental Health Treatment: *Does your program provide mental health treatment either onsite or via an MOU? Which of the following mental health professionals does your organization employ and for how many hours per year? (Expanded list of professional distinctions) Does your program have a memorandum of*

	The expert panel agreed on the need for specificity around the types of mental health services offered.	psychiatric care within the broader system).			*understanding with a mental health care practice(s)?*[++]
Added in Measure Set 4.0	Public comment was fairly neutral on this measure, though there was a shared interest in having this measure document receipt of permission or refusal to share information with other providers. There was a suggestion to add a question about screening and treating other specific conditions, such as Hepatitis C.	This measure will be revised to follow the structure of 5B (addressing provision of services onsite v. offsite). A list of services is being developed. The revised measure will likely focus less on coordination and more on whether providers ensure a patient's medical conditions are addressed, while remaining sensitive to/considering the fact that many individuals receiving SUD treatment are concerned about privacy and may not want their SUD provider to contact other providers.	5c	Treatment Program Survey	Connection to Medical Care Providers: *Does your program have physicians on staff? Does your program have a MOU with primary care practice(s)? Do you coordinate care with clients' other healthcare providers, when given permission to do so by the clients? Do you obtain a medical history? Do you document in the medical record which medications your patients are currently taking? Do you ask if the patient in currently receiving behavioral health treatment?* [++]
Evidence of appropriate behavioral interventions for individuals diagnosed with an SUD	Public comments on this measure related primarily to the issue of data validation. There were also numerous suggestions to expand the list of BH options included as examples. Suggested that specifying question about the number of patients that receive each therapy per year would not be feasible.	Wording for this measure will be finalized after the Treatment Program Survey feasibility testing process, and the final measure will likely include a dropdown list of therapies. Shatterproof acknowledges the fact that there is presently no way to validate this information, but as with several other measures, this is about setting a floor for quality. As the system develops it will get more sophisticated. Additionally, the NSSATs shows that not all providers offer these services. The question element that asked about the number of patients receiving each therapy was removed. In future phases it will be considered to ask about staff trainings in each of the modalities.	6a	Treatment Program Survey	Evidence of appropriate behavioral interventions for individuals diagnosed with an SUD: *Do you offer the following types of therapies? Do you offer them in a group and/or in 1:1 individual therapy sessions? Cognitive-behavioral therapy (CBT), contingency management, community reinforcement approach (CRA), motivational enhancement therapy (MET), the matrix model, twelve-step facilitation therapy (TSF), MultiSystemic Therapy (MST), Multi-Dimensional Family Therapy (MDFT), Brief Strategic Family*

					Therapy (BSFT), Functional Family Therapy (FFT), and behavioral couples therapy (BCT)).[++]
Overall rating of counseling and treatment	Some commenters felt this measure is subjective, like other patient-reported measures. Suggested allowing for breakdown of consumer rating into different elements (accommodations, clinical care, etc.)	This measure will be retained without changes. It is a well-vetted CAHPS measure and has been deemed as a valid and reliable measure of consumer experience of care. It will be moved to the end of the survey.	6b	Consumer Experience Survey	Overall rating of treatment program: *Using any number from 0 to 10, where 0 is the worst treatment program possible and 10 is the best treatment program possible, what number would you use to rate this treatment program?*
Added in Measure Set 4.0	Commenters expressed that this measure alone is not representative of therapeutic alliance, but felt there was face validity of the measure.	The question will be retained as it is a CAHPS question with face validity and content validity. Reference to therapeutic alliance will be removed.	6c	Consumer Experience Survey	*During your treatment, how often did the treatment staff show respect for what you had to say?*
Added in Measure Set 4.0	Commenters broadly supported tracking of accreditation and suggested adding a list to choose from and whether programs have ever lost their license.	The measure will be retained with the final wording being tested by Research Triangle Institute. There will be a drop-down list of accreditations included in the question.	6d	Treatment Program Survey	National accreditation: *Is the facility nationally accredited (or, has the facility ever lost its license and/or accreditation)?* [++]
Evidence of medication among patients with opioid use disorder (OUD)	Commenters questioned whether methadone data would be available on claims review. The expert panel suggested it would be useful to go beyond asking whether providers offer medications to understand actual prescribing practices. There was support for using this measure in conjunction with measure 7b and 7c to capture a fuller picture.	The measure concept will be remain as is.	7a	Claims	Evidence of OUD medication use among patients with OUD treated at this program: *Individuals with an OUD diagnosis that have medical or pharmacy claims for an FDA-approved medication specific to OUD treatment.*
Continuity of Pharmacotherapy for Opioid Use Disorder	Public comment raised questions related to how the issue of attribution will be handled for patients who receive treatment at more than one program. The expert panel feedback raised questions about the numerous factors that influence continuous treatment - availability of community providers and supports, provider infrastructure and treatment capacity of other providers, insurance restrictions routinely posed by medical necessity and utilization management practices, including narrow provider networks,	The measure concept will remain as is. The measure specifications are being expanded to examine continuity of pharmacotherapy at 30, 60, and 90 days in addition to 180 days. Research Triangle Institute is working to develop the measure specifications to account for the questions of attribution.	7b	Claims	Continuity of Pharmacotherapy for Opioid Use Disorder: *Percentage of adults 18-64 years of age treated at this program with pharmacotherapy for OUD who have at least 30, 60, 90, or 180 days of continuous treatment.*

	etc. Additionally, commenters and experts raised the issue of some clinics having higher noncompliance due to higher acuity and questioned whether the adaptation of the measure from the plan level to the program level will lead to same-cohort comparisons. Additionally, when shifting this from a systems to a program level measure it was suggested that the measure be examined at more frequent time durations.				
Availability of pharmacotherapies for SUD	Commenters expressed an interest in how data will be validated. Experts suggested adding language that gets to whether MAT is directly prescribed or offered via an MOU with a prescriber. Both public comment and expert panel feedback indicated a need to add naloxone and alter measure language accordingly (e.g. treat OR rescue).	This measure will be modified to include a drop-down selection inclusive of onsite and offsite availability of medications including naloxone.	7c	Treatment Program Survey	Availability of medications to treat substance use disorders. [++]
Populate Recovery Supports w NSSATS	Public comment related to assessing treatment program provision of recovery support services was positive, with numerous suggestions on additional services to be listed in the drop-down selection box. Examples include financial copay assistance for MAT therapy, enrollment in Medicaid for eligible populations and referral to food pantries to address food insecurity. Feedback pointed to a need to understand which services are provided onsite versus via an arrangement with outside service organizations.	This measure will be retained, and the list of services included in a drop-down menu may be expanded based on Research Triangle Institute's review of the suggested additions to the dropdown and feasibility testing. The final measure will capture whether services are provided onsite or via arrangements with external service providers.	8a	Treatment Program Survey	*Do you provide the following recovery support services or offer these services via connection to local community providers: Peer Recovery Support; Employment counseling or training for clients; Assistance in locating housing for clients; Transportation assistance to treatment; Child care for clients' children; Assistance with obtaining social services (for example, Medicaid, WIC, SSI, SSDI); Domestic violence (family or partner) services (physical, sexual, and emotional abuse); Legal aide*
Inclusion of family in treatment approach (Moved to Principle 8)	Public comment on this measure was positive, indicating a consensus on the importance of family involvement as a principle of effective treatment. Suggestions were made related to	This measure was modified in *Measure Set 4* to include friends as well as family.	8b	Consumer Experience Survey	Family Support: *Have staff in this treatment program talked with you about including your family or*

	wording, pointing out the importance of getting to the individual's broader support network, which may not always include family. Comments were made suggesting the target population for this measure should include the number of patients to consent to family involvement.	Assessing different mechanisms of family engagement will be considered for future phases.			*friends in your counseling or treatment?*
Readmissions (ED, hospital admissions, detoxification, residential treatment)	Feedback on this measure indicated concern that measuring admission to a higher-level of care may have unintended consequences, and there were suggestions to focus only on overdose events. Numerous suggestions to identify a range of time frames (e.g. 14 days, 30 days, 90 days, 180 days). Many commenters pointed to a need for the measure to be risk-adjusted to avoid unfairly penalizing programs with a heavy mental health burden or other high acuity population (i.e. There is a need for risk adjustment by type of substance and other client characteristics.)	The measure has been modified to only capture overdoses (poisoning) ED visits at 14, 30, 90, and 180 days.	O1	Claims	Overdose after treatment: *Admission to the ED or hospital for poisoning 14, 30, 90, and 180 days after discharge*
Amount helped by treatment	Some comments expressed a shared desire to capture more detail in understanding whether treatment improved the overall quality of life and helped individuals meet recovery goals, gain employment, return to school and/or improve their success with relationships. Recognition that this measure has face-validity and is widely used.	The question will be retained as it is a CAHPS question with face validity and content validity.	O2	Consumer Experience Survey	Amount helped by treatment: *How much have you been helped by the treatment you got here?*
Ability to manage symptoms	Feedback on this measure was generally positive.	The question will be retained as it is a CAHPS question with face validity and content validity.	O3	Consumer Experience Survey	Improvement in ability to function: *Compared to when you entered this treatment program, how would you rate your ability to deal with daily problems now?*
Added in Measure Set 4.0	Public feedback on this measure was very positive, with most commenters indicating patient narrative feedback both helps to provide a greater understanding of the foundation of a provider's rating, and is consistent with the way consumers currently rank other kinds of services, thus easy for patients to understand.	The question will be retained as it is a CAHPS question with face validity and content validity.	N1	Consumer Experience Survey	Patient Narrative Treatment Experience: *Please think about some treatment experiences at this program. What is the program doing right? What could be done to improve this program?*

Added in Measure Set 5.0	There were many comments about confounding factors that are outside of providers control, such as payment and policy issues.	We recognize that the onus of quality improvement in the addiction treatment space is not squarely on treatment programs, but rather that there must be systems level changes. In an effort to identify the key barriers to aligning processes and structures with evidence-base best practices, Shatterproof will add a question to the Treatment Program Survey to capture barriers faced by providers. The wording is being developed by Research Triangle Institute. The responses will not be displayed on the public facing Rating System, but will anonymously be shared with payers and state partners and help inform Shatterproof's work in other areas.	S1	Treatment Program Survey	This is an optional question. The information gathered from this question will not be displayed on the public facing Rating System. This information will be anonymized, and key themes will be shared with state and payer partners involved in the Rating System. This may inform the development of future technical assistance initiatives, policy changes, and advocacy work. Are there specific barriers that inhibit your ability to deliver treatment that comport with the processes and structures that are assessed in this survey? Please describe them and include key actions that would facilitate change.

Notes

[*]These insights reflect consolidated recommendations from a multistakeholder Expert Panel. The Expert Panel considered an Environmental Scan and feedback from the public, Key Informants, and fellow panelists.

[++]Shatterproof may revise wording based on feasibility testing

Appendix A: Key Participants

Shatterproof Substance Use Disorder Treatment Task Force

- Donald M. Berwick, President Emeritus and Senior Fellow, Institute for Healthcare Improvement.
- Michael Botticelli, Executive Director of the Grayken Center for Addiction Medicine at Boston Medical Center, and former Director of Office of National Drug Control Policy
- Jay Butler, President, Association of State and Territorial Health Officials, and Chief Medical Officer, Alaska Department of Health and Social Services.
- Suzanne Delbanco, Executive Director, Catalyst for Payment Reform.
- Charles Ingoglia, Senior Vice President, Public Policy and Practice Improvement at the National Council of Behavioral Health.
- *Dr. Thomas McLellan, PHD. Founder of Treatment Research Institute (TRI), former Deputy Director of the White House Office of National Drug Control Policy (ONDCP).
- *Gary Mendell, Founder and CEO of Shatterproof.
- Penny S. Mills, Executive Vice President/CEO, American Society of Addiction Medicine.
- John O'Brien, Senior Consultant at Technical Assistance Collaborative, Inc., former senior advisor for healthcare financing at the U.S. Department of Health and Human Services.
- Daniel Polsky, Executive Director of the Leonard Davis Institute of Health Economics.
- Betty Tai, Director, Center for the Clinical Trials Network, National Institute on Drug Abuse.

*Co-Chair.

Shatterproof Quality Measure Committee – The following experts on SUD treatment are working with Shatterproof to crosswalk existing quality measures with the Principles of Care and identify new measures to assess treatment quality as it relates to evidence-based best practices:

- Tami Mark, Senior Director, Behavioral Health and Criminal Justice, RTI International.
- Dennis McCarty, Professor, OHSU-PSU School of Public Health.
- Thomas McLellan, founder and chairman of the Treatment Research Institute, and former Deputy Director of the Office of National Drug Control Policy under President Obama.
- John O'Brien, Senior Consultant at Technical Assistance Collaborative, Inc., former senior advisor for healthcare financing at the U.S. Department of Health and Human Services.
- Daniel Polsky, Executive Director of the Leonard Davis Institute of Health Economics.

National Quality Forum Expert Panel

- Jennifer B. Atkins, MBA, Vice President, Network Solutions, Blue Cross Blue Shield Association

- Ellen Bouchery, MS, Principal Program Analyst, Mathematica Policy Researcher
- Teresita Camacho-Gonsalves, PhD, MA, Co-Director of Behavioral Health Team, Human Services Research Institute
- Vitka Eisen, EdD, MSW, President & CEO, HealthRight 360
- Miriam Komaromy, MD, FACP, DFASAM, Professor of Medicine, Director of Addiction and Community Health Worker Programs at the ECHO Institute, University of New Mexico Health Sciences Center
- Joseph Lee, MD, Medical Director, Hazelden Betty Ford Foundation Youth Consortium
- Tami Mark, PhD, MBA, Senior Director, Behavioral Health Financing and Quality Measurement, RTI International
- Tiffany McCaslin, MPP, Senior Policy Analyst, Public Policy, National Business Group on Health
- Thomas McLellan, PhD, Founder, Treatment Research Institute
- Kirk Moberg, MD, PhD, FASAM, FACP, FAAPL, CPE, Executive Medical Director, UnityPoint Health Illinois Institute for Addiction Recovery
- Douglas Nemecek, MD, MBA, Chief Medical Officer-Behavioral Health, and National Medical Officer-Coverage Policy and Trend Review, Cigna
- Andrey Ostrovsky, MD, Chief Medical Officer and Senior Vice President of Behavioral Health, Solera Health
- Justin Luke Riley, MBA, President & CEO, Young People in Recovery
- Patricia Santora, PhD, Public Health Analyst, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Service Administration (SAMHSA)
- Sarah Wattenberg, MSW, Director of Quality and Addiction Services, National Association for Behavioral Healthcare

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National Quality Forum Key Informants

- Deborah Agus, JD, Executive Director, Behavioral Health Leadership Institute
- Amy Sorensen-Alawad, MSPH/MPA, Assistant Director for Grants Policy and Administration, Bureau of Substance Addiction Services, Massachusetts Department of Public Health
- Trishia Allen, JD, Associate Attorney, NYS Office of Alcoholism and Substance Abuse Services
- Abigail Averbach, MSc, Assistant Commissioner and Director, Office of Population Health, Bureau of Substance Addiction Services, Massachusetts Department of Public Health
- Hermik Babakhanlou-Chase, MPH, Director, Office of Statistics and Evaluation, Bureau of Substance Addiction Services, Massachusetts Department of Public Health
- Angie Bergefurd, Assistant Director for Community Programs and Services, Ohio Department of Medicaid
- Jim Cremer, Deputy Director, Bureau of Substance Addiction Services, Massachusetts Department of Public Health
- Carmelita Cruz, JD, Senior Attorney, NYS Office of Alcoholism and Substance Abuse Services
- Robert DuPont, MD, President, Institute for Behavior and Health
- Edmund Dyke, MA, MAHA, Director of Grants and Development at Massachusetts Department of Public Health
- Leon Evans, MS, Retired President/CEO, Center for Healthcare Services

- Katherine Fillo, PhD, MPH, RN-BC, Director of Clinical Quality Improvement, Bureau of Health Care Safety and Quality, Massachusetts Department of Public Health
- Bryan Harter, MSW, MBA, Director, Quality Assurance and Licensing, Bureau of Substance Addiction Services, Massachusetts Department of Public Health
- Nilufer Isvan, PhD, Co-Director of Behavioral Health, Human Services Research Institute
- Robert Kent, JD, General Counsel, NYS Office of
- Alcoholism and Substance Abuse Services
- Sarah Melton, PharmD, Chair, One Care of Southwest Virginia
- Martin Rosenzweig, MD, Chief Medical Officer, Optum Behavioral
- Josh Sharfstein, MD, Vice Dean for Public Health Practice and Community Engagement, Johns Hopkins Bloomberg School of Public Health
- David Streem, MD, Section Head, Medical Director, and Endowed Chair in Alcohol and Drug Rehabilitation, Cleveland Clinic
- James Tassie, JD, Assistant Direct and Head of Policy, Ohio Department of Medicaid
- Marketa Wills, MD, Senior Medical Director, Wellcare Health Plans, Inc. of Kentucky

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- Danitza Valdivia, Administrative Manager

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- Samantha Arsenault, Director, National Treatment Quality Initiatives
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