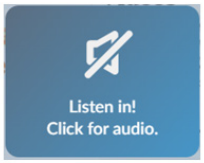
Pioneers in Quality
Expert to Expert Webinar Series

2023 Annual Updates for 2024 Reporting Year CMS506 Safe Use of Opioids - Concurrent Prescribing

January 11, 2024

Webinar Audio – Information & Tips



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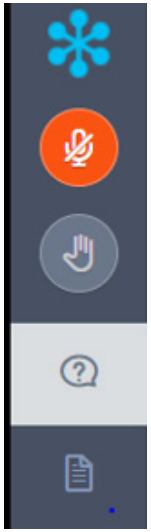

Welcome!

But first things first…

"Get Started with eCQMs"

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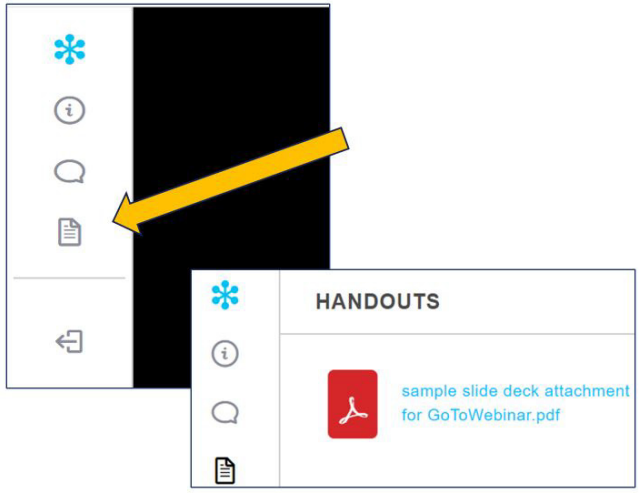

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Learning Objectives:

- Navigate to the measure specifications, value sets, measure flow diagrams and technical release notes
- Apply concepts learned about the logic and intent for the Safe Use of Opioids - Concurrent Prescribing eCQM
- Prepare to implement the Safe Use of Opioids - Concurrent Prescribing eCQM for the 2024 eCQM reporting period
- Identify common issues and questions regarding the Safe Use of Opioids - Concurrent Prescribing eCQM

Topics Not Covered in Today's Webinar

- Basic eCQM concepts
- Topics related to chart abstracted measures
- Process improvement efforts related to this measure
- eCQM validation

Disclosure Statement

These staff and speakers have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with, or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content.

- Erin Buchanan, MPH, Analyst, Mathematica
- Susan Funk, MPH, LSSGB, Associate Project Director, Engagement in Quality Improvement Programs (EQIP)
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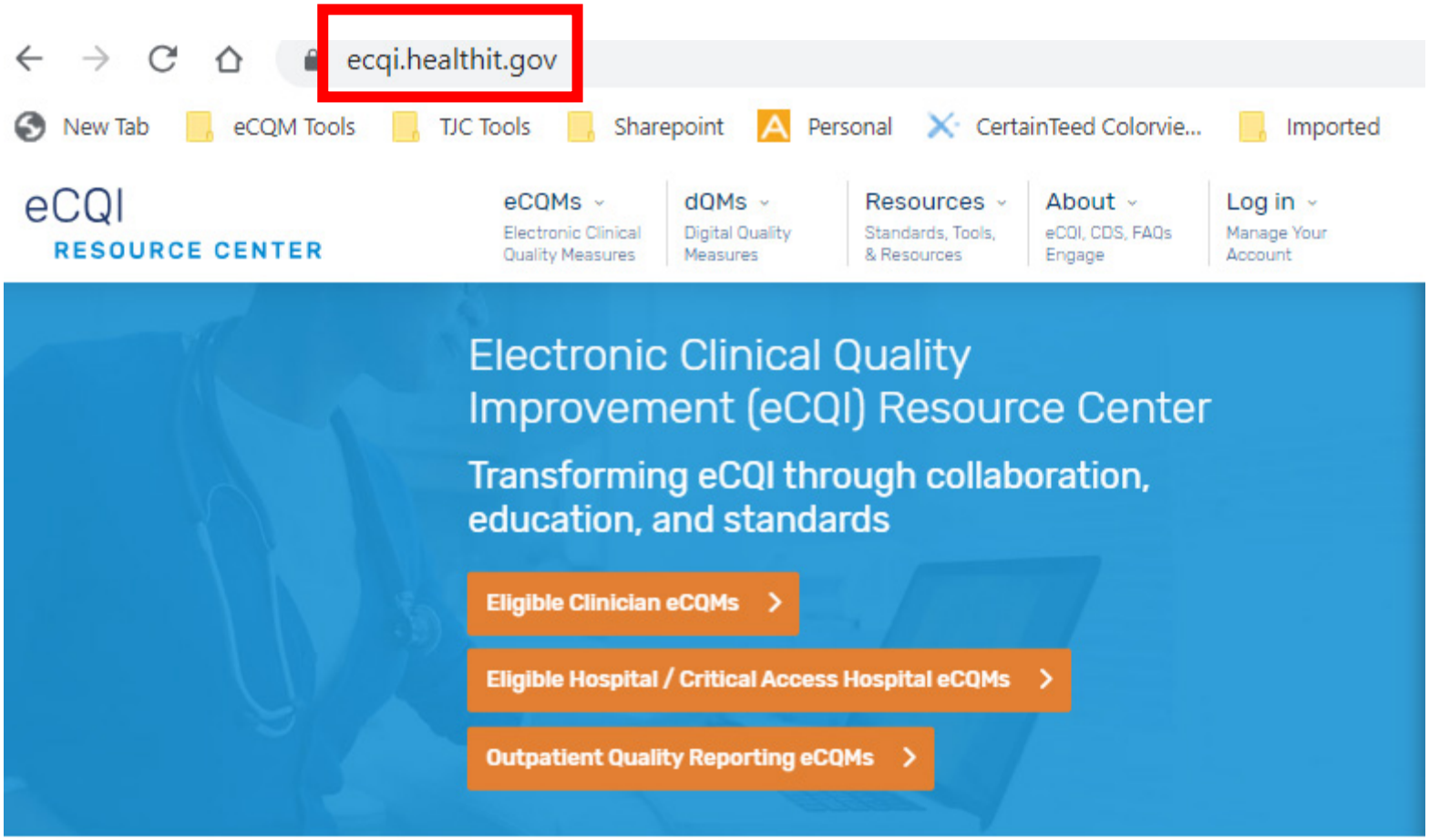
Pioneers in Quality Expert to Expert Webinar Agenda: Safe Use of Opioids—Concurrent Prescribing eCQM

- Review changes made to the Safe Use of Opioids - Concurrent Prescribing eCQM
- Review the measure flow/algorithm
- Review FAQs
- Facilitated Audience Q&A Segment

eCQI Resource Center Website Demo



Overview of Safe Use of Opioids—Concurrent Prescribing (CMS506v6)

Measure rationale

- Unintended opioid overdose fatalities are a major public health concern (Rudd et al. 2016).
- Concurrent prescriptions of opioids or of opioids and benzodiazepines place patients at a greater risk of unintentional overdose due to the increased risk of respiratory depression (Dowell et al. 2016); eliminating concurrent use of opioids and benzodiazepines could reduce the risk of emergency room and inpatient visits related to opioid overdose by 15% (Sun et al. 2017).
- 2022 CDC Guideline for Prescribing Opioids for Chronic Pain recommends avoiding concurrently prescribing two or more opioids OR opioids and benzodiazepines whenever possible.

CDC = Centers for Disease Control and Prevention.

Measure intent

1. Encourage providers to identify patients with concurrent prescriptions of opioids or opioids and benzodiazepines.
2. Discourage providers from prescribing two or more opioids or opioids and benzodiazepines concurrently.

Measure component changes between 2023 and 2024 reporting

Measure components	2023 reporting period (CMS506v5)	2024 reporting period (CMS506v6)
Denominator/ initial patient population	Inpatient hospitalizations (inpatient stay less than or equal to 120 days) that end during the measurement period, where the patient is 18 years of age and older at the start of the encounter and prescribed one or more new or continuing opioid or benzodiazepine at discharge	**No change except in value set**
Numerator	Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge	**No change except in value set**

Measure component changes between 2023 and 2024 reporting (continued)

Measure components	2023 reporting period (CMS506v5)	2024 reporting period (CMS506v6)
Denominator exclusions	Inpatient hospitalizations where patients have cancer that begins prior to or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay	Inpatient hospitalizations where patients have cancer that begins prior to or during the encounter **or are ordered** or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the **hospitalization or in an emergency department encounter or observation stay immediately prior to hospitalization**, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay.

Updates to Measure Value Sets and Logic: 2024 Reporting Period

Initial population – no changes

Inpatient hospitalizations (inpatient stay of less than or equal to 120 days) that end during the measurement period, where the patient is 18 years old or older at the start of the encounter and is prescribed a new or continuing opioid or benzodiazepine at discharge

Initial population

/*Captures encounters of patients with an opioid(s), benzodiazepine, or a combination of these medications at discharge*/

"Inpatient Encounters with an Opioid or Benzodiazepine at Discharge"

Inpatient Encounters– no changes

Inpatient hospitalizations (inpatient stay of less than or equal to 120 days) that end during the measurement period, where the patient is 18 years old or older at the start of the encounter and is prescribed a new or continuing opioid or benzodiazepine at discharge

Inpatient Encounters with an Opioid or Benzodiazepine at Discharge

"**Inpatient Encounter with Age Greater Than or Equal to 18**"
InpatientEncounter

with (["Medication, Discharge": "**Schedule II & III Opioid Medications**"]

union ["Medication, Discharge": "Schedule IV Benzodiazepines"])
OpioidOrBenzodiazepineDischargeMedication

such that OpioidOrBenzodiazepineDischargeMedication.authorDatetime during InpatientEncounter.relevantPeriod

Inpatient Encounter with Age Greater than 18 – no changes

Inpatient hospitalizations (inpatient stay of less than or equal to 120 days) that end during the measurement period, where the patient is 18 years old or older at the start of the encounter and is prescribed a new or continuing opioid or benzodiazepine at discharge

Inpatient encounter with Age Greater Than or Equal to 18

Global.'InpatientEncounter' InpatientHospitalEncounter

Where AgeInYearsAt (date from start of InpatientHospitalEncounter.relevantPeriod) >= 18

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Denominator – No changes

Initial Population

Denominator

“Initial Population"

Denominator exclusions (1) – New to 2024

Inpatient hospitalizations where patients have cancer that begins before or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay.

Denominator exclusions

/*Excludes encounters of patients with cancer or who are receiving palliative or hospice care at the time of the encounter **or who are discharged to another inpatient care facility or expire during the inpatient stay***/

"Inpatient Encounters with an Opioid or Benzodiazepine at Discharge" InpatientEncounter

where exists (["Diagnosis": "All Primary and Secondary Cancer"] Cancer

where Cancer.prevalencePeriod overlaps InpatientEncounter.relevantPeriod)

or exists (~~**"Inpatient Encounters with an Opioid or Benzodiazepine at Discharge“ InpatientEncounter**~~

Where exists InpatientEncounter.diagnoses Diagnosis

where Diagnosis.code in "All Primary and Secondary Cancer"

*Strikethrough text has been removed.

Denominator exclusions (2) – No changes

Inpatient hospitalizations where patients have cancer that begins before or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay.

Denominator exclusions (continued)

```
or exists ( "Intervention Palliative or Hospice Care" PalliativeOrHospiceCare
    where Coalesce(start of
    Global."NormalizeInterval"(PalliativeOrHospiceCare.relevantDatetime,
    PalliativeOrHospiceCare.relevantPeriod),
PalliativeOrHospiceCare.authorDatetime)during
Global."HospitalizationWithObservation"
( InpatientEncounter ))
```

Denominator exclusions (3) – New to 2024

Inpatient hospitalizations where patients have cancer that begins before or during the encounter or are receiving palliative or hospice care (including comfort measures, terminal care, and dying care) during the encounter, patients discharged to another inpatient care facility, and patients who expire during the inpatient stay.

Denominator exclusions (continued)

or exists ~~**"Inpatient Encounters with an Opioid or Benzodiazepine at Discharge"**~~
InpatientEncounter
where InpatientEncounter.dischargeDisposition in "Discharge To Acute Care Facility"
or InpatientEncounter.dischargeDisposition in "Hospice Care Referral or Admission"
or InpatientEncounter.dischargeDisposition in "Patient Expired")

*Strikethrough text has been removed.

Numerator logic – No changes (1)

Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge

- Numerator

/*Encounters of patients prescribed two or more opioids or an opioid and benzodiazepine at discharge.*/

“Inpatient Encounters with an Opioid or Benzodiazepine at Discharge" InpatientEncounter

where (Count(["Medication, Discharge": "Schedule II & III Opioid Medications"] Opioids

where Opioids.authorDatetime during InpatientEncounter.relevantPeriod

return distinct Opioids.code)>= 2))

Numerator logic – No changes (2)

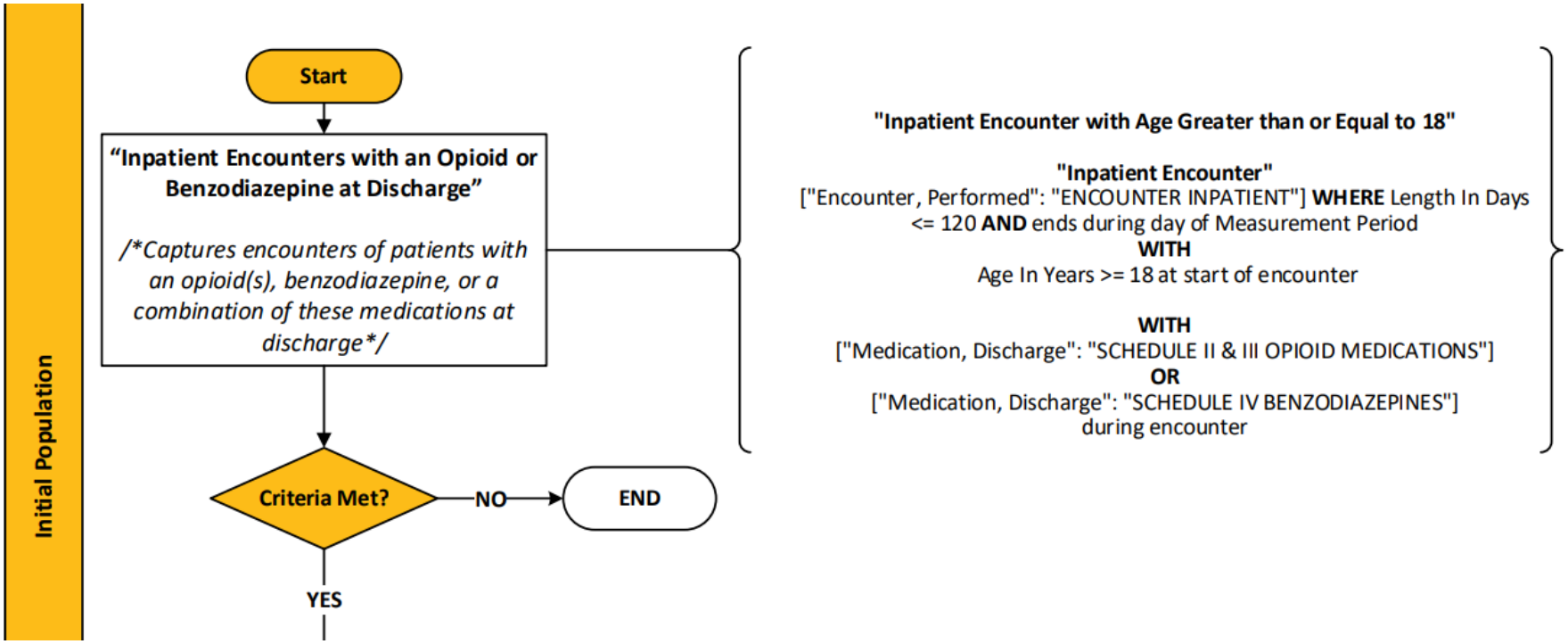
Inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge

- **Numerator**

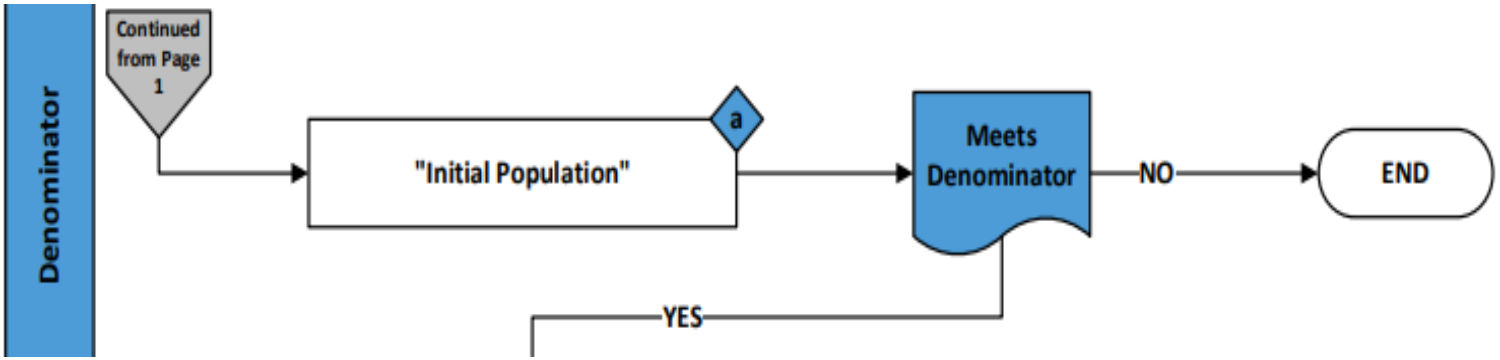
union ("Inpatient Encounters with an Opioid or Benzodiazepine at Discharge" InpatientEncounter
with ["Medication, Discharge": "Schedule II & III Opioid Medications"] OpioidsDischarge
such that OpioidsDischarge.authorDatetime during InpatientEncounter.relevantPeriod
with ["Medication, Discharge": "Schedule IV Benzodiazepines"] BenzodiazepinesDischarge
such that BenzodiazepinesDischarge.authorDatetime during InpatientEncounter.relevantPeriod

Flow Diagram

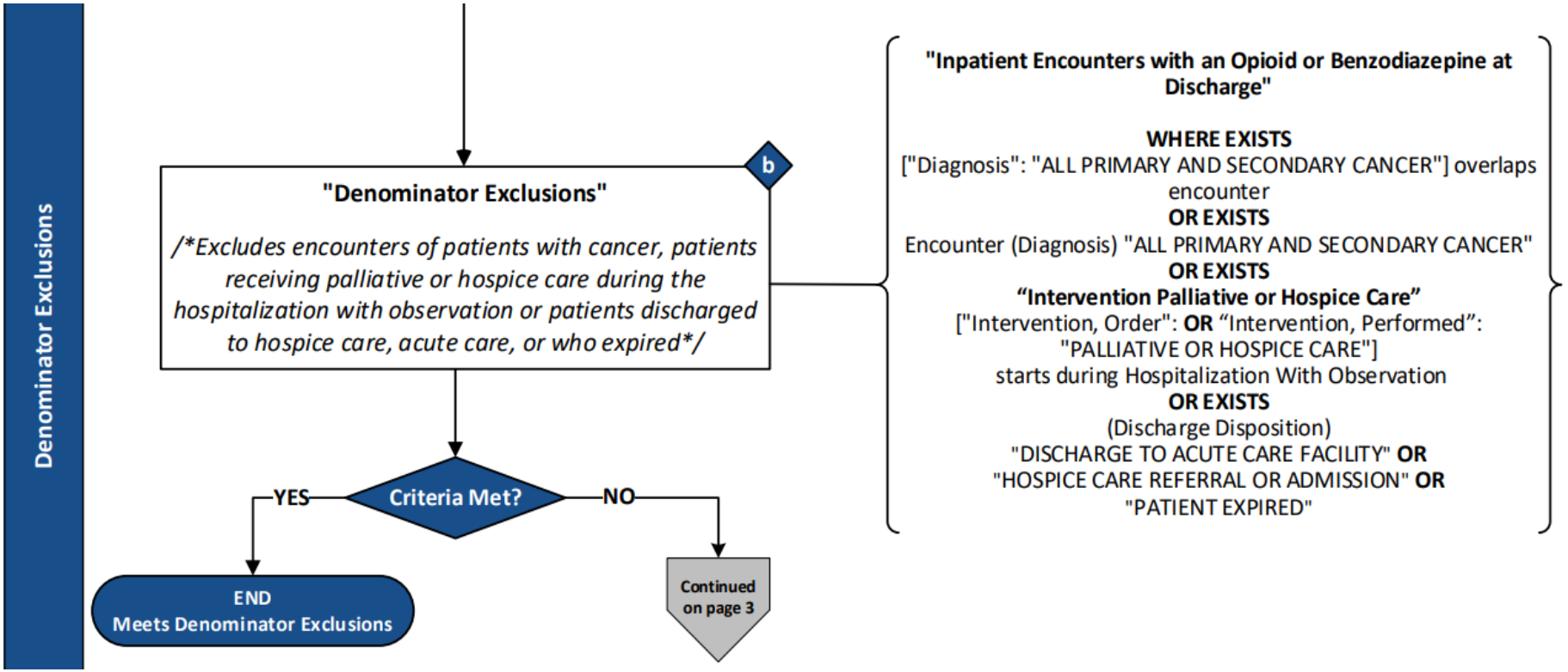
Flow diagram: Initial Population



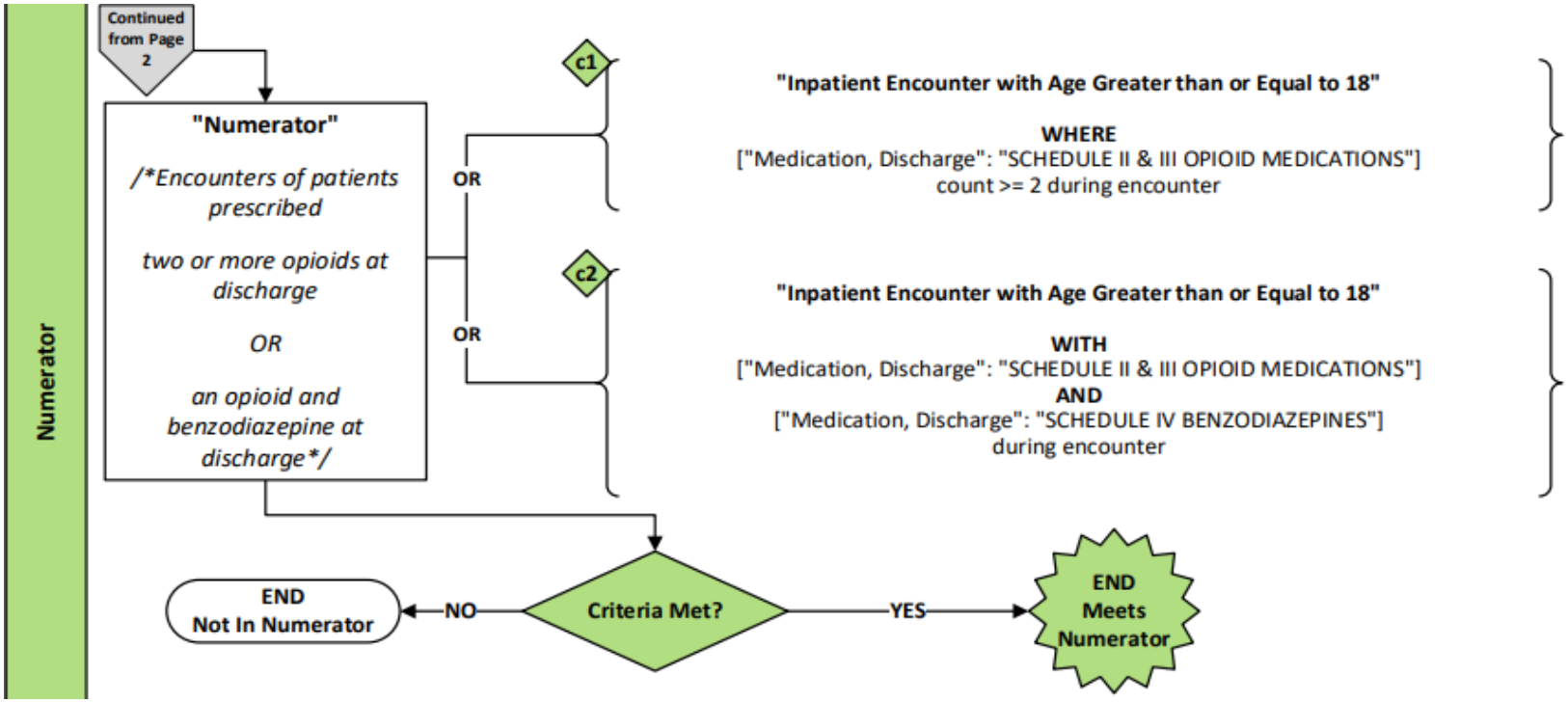
Flow diagram: Denominator



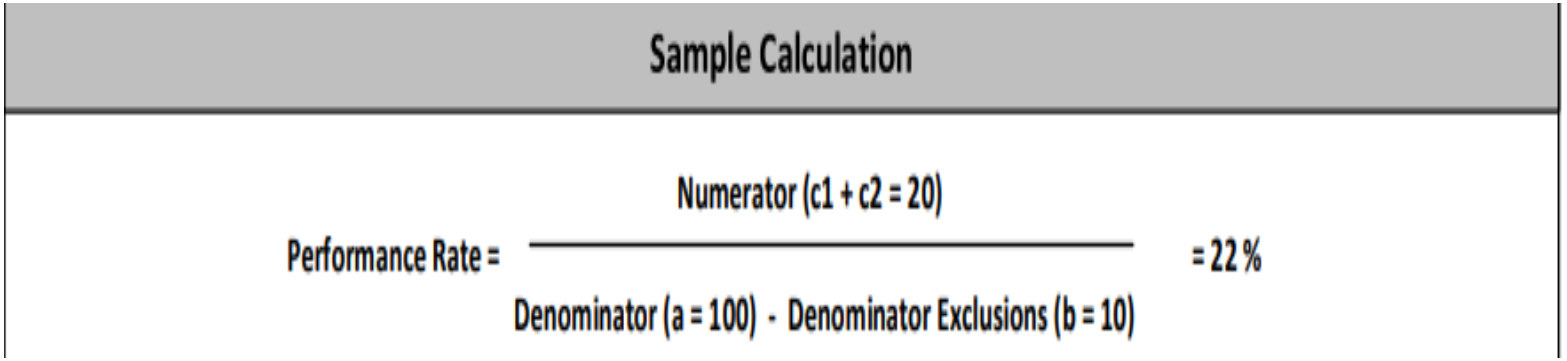
Flow diagram: Denominator Exclusions



Flow diagram: Numerator



Flow diagram: sample calculation



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Measure considerations

- Measure is not expected to have a zero rate

1. Based on clinical judgment, clinical appropriateness, or both, concurrent prescribing of two unique opioids or an opioid and benzodiazepine may be medically appropriate

- Differentiation between initial population and numerator

1. Initial population

   Inpatient hospitalizations with discharge medications of:

   A new or continuing **opioid** *OR*

   A new or continuing **benzodiazepine**

2. Numerator: Inpatient hospitalizations with discharge medications of: **Two or more** new or continuing **distinct opioids** O*R* A new or continuing **opioid AND benzodiazepine**

Frequently Asked Questions

What are considered distinct opioids for the numerator?

- Medications must have different RXNorm codes
- RXNorm codes distinguish one exact medication from another, for example:
- 12 HR oxycodone hydrochloride 10 mg extended release oral tablet (RxNorm 1049502)
- 12 HR oxycodone hydrochloride 15 mg extended release oral tablet (RxNorm 1049543)
- RXNorm codes do not distinguish prescription by dosing instructions.

What acute facility transfers count as exclusions?

- "Discharge To Acute Care Facility" (2.16.840.1.113883.3.117.1.7.1.87) includes:
  - Community hospitals
  - Tertiary referral hospitals
  - Acute care hospitals
- Does NOT include long-term acute care facilities

Is there a CMS benchmark for this measure?

- No benchmarks for this measure currently
- Hospitals will likely not score zero on the measure
  - For some patients, it may be medically appropriate to prescribe concurrent opioids or an opioid and benzodiazepine, despite the risk of respiratory depression

Resources

Additional Resources

eCQI Resource Center – EH Measures:
https://ecqi.healthit.gov/eligible-hospital/critical-access-hospital-ecqms

Teach Me Clinical Quality Language (CQL) Video Series
https://ecqi.healthit.gov/cql?qt-tabs_cql=2

- Coalesce
- Normalize Interval
- Time Zone Considerations
- Latest, LatestOf, Earliest, EarliestOf, HasStart, HasEnd

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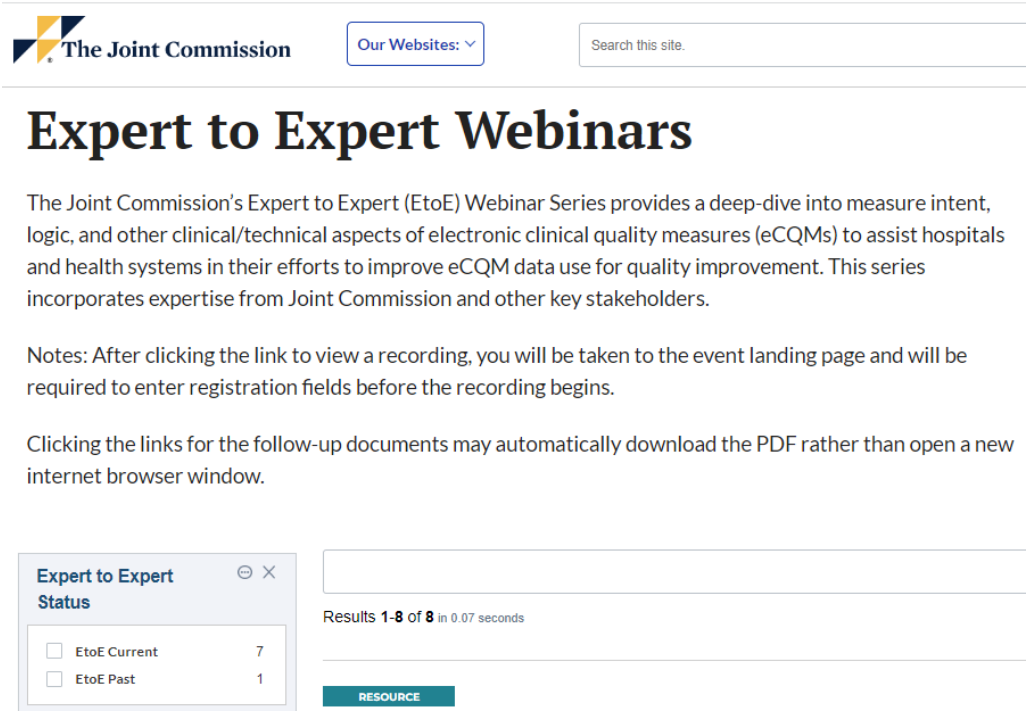

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Pioneers in Quality Expert to Expert Series: 2024 Annual Update Webinar for Safe Use of Opioids eCQM

Broadcast date: January 11, 2024

00:00:03

Welcome everyone and thank you for joining us today for our Expert to Expert Series Webinar 2024 Annual Updates for the Safe Use of Opioids - Concurrent Prescribing eCQM.

Before we start, just a few comments about today's webinar platform. Audio is by Voice Over Internet Protocol only. Click the button that reads "Listen in! "Click for audio," then use your computer speakers or headphones to listen. There are no dial-in lines. Participants are connected in listen-only mode. Feedback or dropped audio are common for live streaming events. Refresh your screen or rejoin the event if this occurs. We will not be recognizing the Raise a Hand or the Chat features. To ask a question, click on the Question Mark icon in the audience toolbar. A panel will open for you to type your question and submit. The slides are designed to follow Americans with Disabilities Act rules.

We would like to welcome you to our webinar. Before we get started, we do want to explain that this webinar is fairly technical in nature, and requires a baseline understanding of eCQMs. Participant feedback from previous webinars indicated that the content may have been too technical for individuals that are new to eCQMs. So, if you are new, we recommend that you visit the eCQI Resource Center at the hyperlink listed on this slide. You will find a collection of resources to help you get started with eCQMs.

If you'd like to follow along and take notes, you can access the slides now within your viewer toolbar. To access the slides, click on the icon that looks like a document. Select the file name, and the document will open in a new window. You can print or download and save the slides. Slides will also be available several weeks after the session at the link listed on this slide.

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not use your own link to join, you can still obtain CE credit if you meet these three criteria. If you did not pre-register, do so now so you can be eligible when the session concludes. After you complete the online evaluation survey, you will be redirected to a page from which you can print or download and save a PDF certificate. You will also receive an automated email after you complete the survey that includes the same certificate link. For more information on The Joint Commission's Continuing Education policies, visit the link at the bottom of this slide.

The learning objectives for this session are: Navigate to the measure specifications, value sets, measure flow diagrams, and technical release notes; apply concepts learned about the logic and intent for the Safe Use of Opioids - Concurrent Prescribing eCQM; prepare to implement the safe use of Opioids - Concurrent Prescribing eCQM for the 2024 eCQM Reporting Period, and identify common issues and questions regarding the Safe Use of Opioids - Concurrent Prescribing eCQM.

This webinar does not cover these topics: Basic eCQM concepts, topics related to chart abstracted measures, process improvement efforts related to this measure, and eCQM validation.

These staff and speakers have disclosed that they do not have any financial conflicts of interest. For example: Financial arrangements, affiliations with, or ownership of, organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content. Erin Buchanan, Susan Funk, Melissa Breth, and Susan Yendro.

00:05:13

The agenda for today's discussion follows Review the measure flow and algorithm, review changes made to the Safe Use of Opioids - Concurrent Prescribing eCQM, review Frequently Asked Questions, and then we will have a facilitated audience Q&A segment.

Before we get started, we would like to highlight some of the resources available on the CMS eCQI Resource Center. The eCQI Resource Center provides a centralized location for news, information, tools, and standards related to eCQMs The majority of the tools and resources referenced within the eCQI Resource Center are openly available for stakeholder use and provide a foundation for the development, testing, certification, implementation, reporting, and continuous evaluation of eCQMs.

We will now share a demo that illustrates navigation to the eCQI Resource Center. This video will demonstrate how to navigate the eCQI Resource Center website to locate the measure specifications, value sets, and technical release notes for all measures in the CMS program.

Here's a landing page for the eCQI Resource Center. Note the web address of eCQI.healthit.gov. Click on the orange horizontal rectangle for Eligible Hospital/Critical Access Hospital eCQMs. Here you can select the Reporting Period that you are interested in. For the purposes of this demo, I will select 2024. Click Apply Filters, and you will see multiple resources listed.

Click on the EH/CAH eCQM tab. Here you will see a list of the 12 eCQMs available for eligible hospital and Critical Access Hospitals. Let's select the Cesarean Birth eCQM, which is also referred to as PC-02 for short or CMS334. Here you will see all the measure information for this particular measure. We're going to click on the Specifications and Data Elements tab. Here you can find the HTML file, the measure package zip file, and the technical release notes for this measure. The value sets are also listed here.

We will take a quick look at the HTML document, which is also referred to as the Human Readable. By clicking on the file name, the HTML file opens. This is where you find all details related to the measure. The top portion of the document highlighted in gray is referred to as the metadata or header information. Here you will find relevant data for the measure, including the version number of the measure, the Measure Steward, the Measure Developer, additional information like related to the rationale, the Clinical Recommendation Statement. And here you see all the references that were used when building the eCQM measure. Scrolling through all the references, you will find additional guidance for implementing the measure. And down at the bottom of the metadata you will find definitions for each of the population criteria. Beyond the metadata, you will find the definitions for the Population Criteria. And then further down you will see the Definitions that are used making up the logic. Continuing to scroll, you will see all the functions that are used by the measure. Then we get into the terminology. Notice these first couple of lines are the direct reference codes that are used by the measure and then the value sets are listed here. Then we get into the QDM data elements, the Supplemental Data Elements, and if this is a risk adjusted measure, that information would be listed here. This is your source of truth for all of the measure details. I went through this very quickly, but wanted you to be aware of how to locate this document and to have a basic understanding of its contents.

00:10:08

So back to the eCQI Resource Center, the next item is the zip file. Click on this link and then click to open the zip file. Here you will see all the files that make up the measure package. Note the first file is the HTML file we just looked at. I will not go into detail on all of these files, but if you want to know more, go to the Get Started With eCQM site on this eCQI Resource Center.

Next we look at the technical release notes by clicking on this link and opening up the Excel spreadsheet. Here is a nice concise list of all of the changes to the measures for the 2024 Reporting Period. In the first column, you will see the details of the change listed here. The next column indicates the type of change. Did it impact the header, the logic, or the value set? The next column is a specific section of the measure that was impacted. In this last column, you will see the source of change. Going back to the eCQI Resource Center website, again, we can access the value sets, by clicking the link under Value Sets. You are now taken to the Value Set Authority Center, also known as the VSAC. You will see all the value sets used for this eCQM. Please notice that you must be signed into the Value Set Authority Center to see the details within each value set. I will log into the VSAC now by clicking on Sign In and then by clicking the Login button. If I would like to see the details of the

Abnormal Presentation value set, I click on the OID, and all of the codes making up that value set are displayed.

Please note that if you prefer to download the value sets, select all value sets by clicking in this box and click Download. This will return a zip file containing each value set in a separate Excel document. If you prefer to have all of the value sets in one file, go back to the homepage, select the Eligible Hospital/ Critical Access Hospital eCQM tab again. Select the Reporting Period that you're interested in. I'm going to stick with 2024. And click Apply Filters. On this page you will see eCQM and hybrid measure value sets, as well as eCQM Direct Reference Codes List. Let's look at the value sets. Open the most recent Reporting Year or whatever year you're interested in, I'm going to stick with 2024, and then click on the May 2023 release. You will see several available downloads.

Choosing the first option, I will select data Sorted by CMS ID in Excel format. Opening the downloaded Excel file, so open the Excel spreadsheet here. And here you will see all the tabs for all the different measures. Let's stick with CMS334. And here you see the CMS ID NQF number, value set name, and value set OID for every code, for every value set within the measure.

Scrolling over to column L, you will see the actual codes within each value set, the code description, and the code system. Note that direct reference codes are not listed here, as they are not included in value sets. You will find information on direct reference codes in the measure specifications or from the file on the eCQM Resources tab that I just called out. This concludes our eCQI Resource Center navigation demo.

00:15:00

Great, we are going to transition over to Erin who will begin her presentation regarding the Safe Use of Opioids eCQM, and she's just getting her deck up and ready. And great, Erin, when you're ready, take it away.

Thank you Susan, and thank you all for joining. We'll start with an overview of the Safe Use of Opioids - Concurrent Prescribing Measure. To start, I'll cover the measure rationale.

Reducing the number of unintended overdoses has become a priority for numerous federal organizations, including but not limited to the Centers for Disease Control and Prevention, the Federal Inter-Agency Work Group for Opioid Adverse Drug Events, and the Substance Abuse and Mental Health Services Administration.

By concurrent prescriptions we mean two different prescriptions that patients will be taking at the same time.

Patients who have multiple opioid prescriptions have an increased risk of overdoses. Rates of fatal overdose are 10 times higher in patients who are co-dispensed opioid analgesics and benzodiazepines versus opioids alone.

The number of opioid overdose deaths including benzodiazepines increased 14% on average each year from 2006 to 2007, or 2011, while the number of opioid analgesic overdose deaths, not including benzodiazepines, did not change significantly.

Furthermore, concurrent use of benzodiazepines with opioids was prevalent in 31 to 51% of fatal overdoses.

Studies of multiple claims and prescription databases have shown that 5 to 20% of patients receive concurrent opioid and benzodiazepine prescriptions across various settings.

One study found that eliminating concurrent use of opioids and benzodiazepines could reduce the number of opioid overdose-related emergency department and inpatient visits by 15%, and potentially could have prevented an estimated 2,630 deaths related to opioid painkiller overdoses in 2015.

A study on the opioid safety initiative in the Veterans Health Administration, which includes an opioid and benzodiazepine concurrent prescribing measure that this measure is based on, was associated with a decrease of 20.67% overall and 0.86%, or 781 patients, per month receiving concurrent opioids and benzodiazepines among all adult Veteran Administration patients who filled outpatient opioid prescriptions from October 2012 to September 2014. The safe use of opioids measure aligns with the CDC guideline for prescribing opioids for chronic pain, and it serves to encourage providers to identify patients taking two or more opioids at the same time and also to identify those patients taking an opioid and benzodiazepine at the same time.

Given the risk of concurrent opioid and benzodiazepine medications, the intent of the measure is to first identify patients with concurrent prescription for review and careful monitoring, and second to discourage providers from prescribing two or more opioids or opioids and benzodiazepines concurrently, or at the same time.

To show you the big picture differences between the measure for reporting in 2023 and 2024, we have two slides with a table comparing the measure components. We have no logic changes to the Denominator or Numerator in 2024. To reiterate, the Denominator remains patients discharged with at least one opioid or benzodiazepine, and the Numerator is any patient discharged with two or more distinct opioids or an opioid and benzodiazepine. As in 2023, distinct opioid prescriptions are determined by having different RXNorm codes, and prescriptions can either be continued from prior to the inpatient stay or prescribed at discharge. Here the Denominator Exclusions show the differences between 2023 and 2024 in bold. Most of the Denominator Exclusions in 2023 are unchanged this year.

00:20:01

Patients with cancer, patients discharged to an acute care facility, and patients who expire during the inpatient stay are excluded from this measure. Patients who receive orders for hospice or palliative care, receive hospice or palliative care during their inpatient stay, or are discharged to hospice are also still excluded from this measure. Last year measure logic that looks at palliative or hospice orders and care a patient receives directly before inpatient

admission, either during an emergency room visit, or during an observation stay, was added to the measure. This year we have added clarifying language to the Denominator Exclusions. I'll read the Denominator Exclusion all together. Inpatient hospitalizations where patients have cancer that begins prior to or during the encounter or are ordered, or are receiving palliative or hospice care, including comfort measures, terminal care, and dying care, during the hospitalization or in an emergency department encounter or observation stay immediately prior to hospitalization, patients discharged to another inpatient care facility and patients who expired during the inpatient stay.

We will now dive into the value set and logic changes. Changes were made to value sets and logic based on expert feedback and standard updates to codes such as retired and newly added codes. Here you'll find the definition of the Initial Population.

Below that is the logic for the Initial Population, represented by the clinical quality language and quality data model data elements used to create the logical expression for the Initial Population criteria. This definition has no changes between the 2023 and 2024 Reporting Period.

For initial encounters, the logic in this definition is represented by the narrative statement in the header for Inpatient Encounters for an Opioid or Benzodiazepine at Discharge, and is not changed from 2023. The purpose of this logic is to capture inpatient hospitalizations and inpatient stay less than or equal to 120 days that end during the measurement period where the patient is 18 years of age or older at the start of the encounter, and filtering those encounters to include only patients with a new or continuing opioid or benzodiazepine prescription at discharge.

The inpatient encounters with an opioid or benzodiazepine at discharge definition also contains another bolded definition within it, Inpatient Encounter With Age Greater Than or Equal to 18. The definitions in this logic can be found in the definition list under population criteria in the measure specifications.

Once we are looking at only those eligible inpatient encounters, the term with indicates that the inpatient stay must also be associated with a medication in the Schedule II and III Opioid Medication list, or as indicated by the term union in medication from the Schedule IV Benzodiazepines list.

The final section of the logic indicates that medications in the patient's discharge list from an inpatient stay from either the Schedule II and III Opioids Medication list, or from the Schedule IV Benzodiazepines list. Here we've bolded Schedule II and III opioid medications as a reminder that we have removed combinations buprenorphine naloxone medications from the opioid list, determining both the Initial Population and the Numerator. A patient discharged with only combination medications will not be included in the initial patient population. A patient discharged with a buprenorphine naloxone combination medication and a methadone prescription will be included in the measure's Initial Population.

On this slide you'll find the logic that defines the inpatient stay where patients are 18 years or older at the start of the relevant encounter. We use the global definition

Global.'InpatientEncounter' which defines an inpatient stay of 120 days or less. Then clarify that the patient must be at least 18 years or older at the start of the encounter, listed here as start of InpatientHospitalEncounter.relevantPeriod.

00:25:05

Regarding the Denominator of this measure, the Denominator does not add any new criteria to the Initial Population. It simply returns the same value as the Initial Population. This has not changed from the 2023 Reporting Period version. The next three slides outline the Denominator Exclusion logic.

The Denominator Exclusions are applied once the Denominator has been established. The exclusions for this measure are cancer, palliative and hospice care, death, and discharge to an acute care facility. The cancer exclusion has not changed from the 2023 reporting version. The measure excludes patients with cancer that exists during the inpatient stay. We can identify these patients due to an overlapping cancer prevalence period, or because the patient receives a cancer diagnosis during their inpatient stay. If there is a cancer diagnosis and no abatement date, the measure assumes the diagnosis remains active. This is how we can make sure we are only applying this exclusion to people with active cancer and not people who are in remission.

In bold you can see that we added a clarifying phrase at the beginning of the logic to include patients who are discharged to another inpatient care facility or expired during the inpatient stay. Also, to simplify the logic, we removed additional language around inpatient encounter.

Continuing through the Denominator Exclusion logic, you can see that we also still exclude patients with an order for palliative or hospice care and patients who receive hospice or palliative care during their inpatient stay. The logic around this exclusion has not changed since last year when it was updated to harmonize with other hospital measures to review a patient's time in the emergency room or observation stay for palliative or hospice care. We use two QDM terms here to differentiate between orders and services received, though both terms using the same value set, Palliative or Hospice Care.

The term Coalesce allows us to check for data or missing data in a more flexible way than other functions. In this case, we are looking for palliative and hospice orders or services during something called Global.HospitalizationWithObservation. This is a global CQL function that allows us to look at the entire inpatient stay and any emergency room visits or observation stays directly prior to the inpatient stay. We will look at this nested definition on the next slide. Coalesce allows us to check relevantDatetime, relevantPeriod, and authorDatetime to look for positive results for hospice or palliative care. If it is not present, it means that the exclusion was not met, and therefore the hospitalization would be retained in the Denominator population.

Again, the purpose here is to align with the CDC guidelines, which are not intended for patients in hospice or palliative care. The palliative or hospice groups being value set

includes orders and services for comfort measures, palliative and hospice care, and aligns with several other measures that exclude patients receiving palliative or end-of-life care.

As you can see on our final denomination exclusion slide, these three exclusions are all the same as last year, and all use the attribute InpatientEncounter.dischargeDisposition.

Again, to simplify the logic we removed language around inpatient encounters.

All of these exclusions look at discharge disposition codes of the relevant inpatient stay to appropriately exclude patients in any of the three following ways, discharge to an acute care facility. To align with guidelines, this measure looks at medications upon discharge, as opposed to during the inpatient stay. Patients discharged to hospice care. This exclusion is a more convenient way to identify and exclude patients who would be receiving hospice care at the point of discharge. And patients who expired during their inpatient stay. Some hospitals do not automatically discontinue medications in the patient record when a patient expires, and stakeholders brought this to our attention as a potential challenge for implementation. This exclusion was added to reduce burden on implementers since the guidelines clearly do not apply.

Overall, these exclusions are intended to reduce burden and more closely align with the CDC guideline that provides recommendations for opioid prescribing, and which note that these guidelines are not for patients in active cancer treatment, palliative care, and end-of-life care.

00:30:43

The Numerator logic depicts Inpatient hospitalizations in which the patient is prescribed or continuing to take two or more distinct opioids or an opioid and benzodiazepine at discharge. This logic is exactly the same in both 2023 and 2024 Reporting Periods. The following information may be familiar to you, but we want to emphasize this important content.

Starting at the top, patients meet the Numerator when they've been prescribed two or more opioids at discharge.

You'll note the definition "Inpatient Encounters with an Opioid or Benzodiazepine at Discharge" is reused in this CQL statement, along with the QDM data element "Medication, Discharge," and Schedule II and III Opioid Medications, just as they were used to define the Initial Population, meaning if an opioid prescription got the patient into the Denominator, it can also count towards the Numerator.

The first where indicates the inpatient encounter needs to also have the condition in the second clause. The second clause said that we need to have a count of what we need to have an inpatient encounter where the count of opioids in the discharge list is greater than or equal to two. You may remember that a change made in the 2022 Reporting Year specifies that these need to be separate opioid RXNorm codes. As an example of how that

works, a 12-hour oxycodone hydrochloride 10 milligram extended-release oral tablet, RXNorm code 1049502 and a 12-hour oxycodone hydrochloride 15 milligram extended-release oral tablet RXNorm code 1049543, have different opioid codes. If a patient was prescribed both of those medications at discharge, they would be in the Numerator. If, however, a patient had the 10-milligram tablet with instructions to take the tablet every four hours and a second prescription for the 10-milligram tablet with instructions to take a pill every eight hours, the patient would not be in the Numerator. We were hearing from stakeholders that the same medication could mistakenly appear in a patient's record more than once, inadvertently triggering the Numerator. The addition of distinct opioid codes is meant to help avoid incorrectly triggering the Numerator.

To continue with the remaining logic on this slide, thanks to the count function of greater than or equal to, we are looking at a list of patients who have at least two active opioid prescriptions. And again, our timing word during indicates that opioids from the discharge medication list must be recorded in the EHR, represented by Opioids.authorDatetime during the relevant inpatient encounter.

In the second clause of the Numerator, starting at the top of of the slide, we see the union, again, between two lists, one listing opioids in the medication discharge list from the last side, and the next one we are about to define, an opioid and benzodiazepine at discharge. If either condition of the two lists noted by the union are met, the Numerator is met.

This section of the logic defines how we identify a patient prescribed with an opioid and benzodiazepine at discharge. Like the last list, we start with the inpatient encounter filtered using with to those that have an opioid on the medication discharge. Once we have those, we filter again, also using the term with, to patients who have a benzodiazepine at discharge.

For both filters we use the terms such that and during to add the condition that we are only interested in these prescriptions that take place at a certain time, in this case, during the relevant inpatient encounter.

We also see that the medication discharge QDM term appears again, listing ongoing and new prescriptions existing at the same time of the patient's discharge and referring back to the value set Schedule IV of benzodiazepines also used to define the Initial Population. The difference here is that the Numerator requires the benzodiazepine to be concurrent with an opioid prescription. Again, there are no changes to the Numerator logic in the 2024 Reporting Year. The only thing to be aware of are the updates to the embedded definitions, which also have already been applied to the initial patient population.

00:35:58

Now that we have reviewed the detailed logic for the 2024 Reporting Year, we will review the measure flow diagram. The purpose of the flow diagrams is to highlight relevant data criteria and are organized to help interested parties to interpret the logic and understand how performance rates are calculated. These eCQM flows are intended to be an additional resource to help hospitals implement eCQMs. They're not intended to replace the eCQM

specifications for reporting purposes. The eCQM flows are a condensed representation of the measure specifications and may not include all definitions, data elements, functions, or timing criteria. Population criteria are color coded to help users follow the flows for measures.

Starting with the Initial Population, the measure flow diagram defines and summarizes the Initial Population logic on the left-hand side of the page, and on the right-hand side of the page it shows the embedded logical definitions associated with the population name.

For example, "Inpatient Encounters with an Opioid "or Benzodiazepine" is the definition on the left. The embedded definition, "Inpatient Encounter "with Age Greater than or Equal to 18" and subsequent logic are shown in detail on the right.

If initial patient population is not met, processing ends. If Initial Population is met, the encounter is in the Initial Population. Note yes indicates continued to page two.

We've split up the second page of the diagram to show only the Denominator here on page two. The flow chart just illustrates that if the Initial Population criteria is met, so is the criteria for the Denominator, and we can continue to the Denominator Exclusions. That is why we do not see any steps or logic between the Initial Population and the Denominator. Once we confirm that an encounter should be in the Denominator, we check for Denominator Exclusions. Here we can see that if a patient during the relevant encounter has cancer, receives palliative or hospice care, or is discharged to a hospice or acute care or dies, the encounter meets the Denominator Exclusion. If any of these conditions apply, then we would end on this page and consider the relevant encounter a Denominator Exclusion. If a patient does not meet any of these criteria during the relevant encounter, we proceed to the Numerator.

Finally, all patient encounters in the Denominator that do not fall into a Denominator Exclusion are evaluated for the Numerator. The flow chart shows two Numerator populations, C1, an encounter where a patient is discharged with two or more opioids; and C2, an encounter where a patient is discharged with an opioid and a benzodiazepine. An encounter may fall into either population to meet the Numerator criteria. If an encounter does not meet the Numerator criteria at this point, it is only in counted in the Denominator population.

Here is a sample calculation that shows us adding the two Numerator populations for a total of 20 inpatient hospitalizations. Once we have subtracted the exclusions from the Denominator, we have a performance Denominator of 90. 20 Numerator encounters divided by 90 Denominator encounters results in a performance rate of 22. In this measure, a lower score indicates higher quality care.

00:40:03

To summarize, there are no substantive changes to the initial patient population Denominator or Numerator logic. We have made a change to increased readability of the Denominator Exclusion logic.

And now for some final measure considerations. First, we understand that there may be some clinically appropriate times for a patient to be prescribed two unique opioids or an opioid and benzodiazepine, and we do not expect this measure to have a Numerator of zero. One goal of this measure is to identify these patients, especially because we know that they're at higher risk for respiratory depression.

Second, the Denominator includes patients discharged from an inpatient stay with at least one opioid or one benzodiazepine, whether it is a new or continuing prescription. For example, this would include patients discharged with seven days of opioids after a surgery. It could also include a patient whose primary care physician prescribed them benzodiazepines for anxiety as long as those prescriptions are active. This is the same definition as the 2023 Reporting Period.

The Numerator includes patients discharged from an inpatient stay with two distinct opioid prescriptions or an opioid and benzodiazepine prescription. Again, these can be new or continuing prescriptions at discharge, but they must be distinctly different prescriptions. A patient discharged with two opioid prescriptions, perhaps one for chronic pain and one for acute surgical pain, would also be included in the Numerator. A patient on benzodiazepines for anxiety and released from the hospital with an opioid prescription would be counted in the Numerator unless the opioid prescription is a combination buprenorphine and naloxone medication. In that case, only the benzodiazepine would count towards the measure and the patient would be in the Denominator.

I'm now going to review a few frequently asked questions. This slide may look familiar to those who saw last year's presentation, but the concept is tricky enough that it bears repeating, especially since it is recently come up during measure testing. Here is some context on whether RXNorm will have a different code for a medication. First, if you're talking about two types of opioids, such as morphine and hydrocodone, RXNorm codes for those medications will be different. Second, if the dose of the active ingredient is different, such as the example on the slide. If the form of the drug is different, for example, if one is an injectable and one is a tablet, the RXNorm code will be different. And finally, if any additional components beyond the active ingredient are different, the RXNorm code will be different. So, you may be asking yourself, "When are RXNorm codes not going to be different?" The codes don't distinguish based on dosing instructions given to patients. For example, if one prescription for 10 milligrams of oxycodone slow release says take every four hours and another prescription for the same medication says take every eight hours, the RXNorm codes will not distinguish.

We've also received several questions asking us to clarify the exclusion for patients discharged to acute care facilities. The measure uses the value set "Discharge to Acute Care Facility" to identify these patients for exclusion. The value set includes community hospitals, tertiary referral hospitals, and short-term acute care hospitals. I do want to mention that the measure does include patients discharged to long-term care and acute rehab facilities. This was established when it was reviewed by experts, received National Quality Form endorsement, and went through a public comment. That said, we are currently evaluating whether patient discharges to other care facilities should be excluded from the measure.

We also have questions about a CMS benchmark for Safe Use of Opioids. The measure does not currently have a benchmark. We also want to emphasize that we do not expect hospitals to score zero on the measure. We understand there may be some clinically appropriate times for a patient to be prescribed two unique opioids or an opioid and benzodiazepine, and we do not expect this measure to have a Numerator of zero. Again, one goal of the measure is to identify these patients, especially because we know that they're at higher risk for respiratory depression.

And now I'll pass the floor back to Susan to go over resources.

00:45:34

Excellent, thanks so much, Erin, for your presentation, and thanks for keeping the slide deck up for a moment. I'll switch back over when we get to the question segment. So we wanted to provide some additional resources here to direct the audience to the eCQI Resource Center Eligible Hospitals Measures page; the Teach Me Clinical Quality Language Video Series that includes shorts on several clinical quality language concepts that are listed on the slide; Pioneers in Quality landing page on The Joint Commission's website; the Expert to Expert Webinar Series landing page; and the ONC Issue Tracking System, and that's where your clinical and technical questions about these eCQMs should be submitted following this webinar. So, if there's anything we don't get to to today and you would rather have a more speedy response than the published Q&A from this webinar, you can also submit your question to Jira. And with that I'm going to just take a second to take over screen sharing while the rest of the team starts looking at the questions in the Q&A, and then we'll get underway with our facilitated Q&A segment. Okay, that took a second to navigate out of the the dashboard and everything, but we are now showing the directions for the live Q&A segment.

So as a quick reminder, please submit questions via the question pane. Click the question mark icon in the audience toolbar. A panel will open for you to type and submit your question. All questions not answered verbally during the live event will be addressed in a written follow-up Q&A document, and that follow-up document will be posted on The Joint Commission website within several weeks after the live event. With that, Melissa, and Susan, when you are both ready, please feel free to start the Q&A segment. And Melissa, I think we decided that you would go first. Thanks. Thanks, Susan.

The first question is "Are inpatient transferred to mental institutions included in the measure?" And the answer is that patients discharged or transferred to mental institutions are included in the measure. Thanks, Melissa. Are you hearing me okay? Yes, we are indeed, thanks. Awesome.

Great, okay, so I'll go on to the next question. "Can sickle cell patients be excluded from the measure?" And the answer is that patients with sickle cell disease are not currently excluded from the measure. This is something we are taking into consideration for future measure updates. Thank you.

My next question, "How to address OUD and ED without impacting throughput?" And the answer, patients with opioid use disorder are included in the measure for the 2024 Reporting Period. Exclusion of these patients is something we are looking further into. Please note that CMS does not expect a performance rate of zero, because they recognize that there are some patients for whom concurrent prescribing is clinically appropriate.

Okay, next question. "How will pain level scoring be implemented "to PRN options for opioids "based on pain level prescribing?" The measure does not take pain level scoring into account. We appreciate your question, and we'll take this into consideration for future updates to the measure.

Okay, next. "Many of our cases that impact this measure are hospitalists continuing home medications prescribed by PCP. Can you discuss this?" Since this measure looks at opioids at discharge, patients who are discharged with two or more opioids, regardless of when they are prescribed, would be remaining in the measure. The intent of this situation is for the discharging clinician to consider appropriateness of additional opioids at discharge in addition to the patient's home medications. CMS recognizes that there are some patients for whom concurrent prescribing is clinically appropriate and does not expect a performance rate of zero. This could be the case for a patient with more than one opioid, or an opioid and a benzodiazepine as a home medication and there's not an explanation that discharging clinician would necessarily change home medications.

Great, okay, so the next question asks about "A patient with a valid diagnosis of benzo with a prescription prior to admission but is discharged with an opioid, will that still fall out?" So yes, this situation you described will result in a patient being included in the Numerator. So once again, just to reiterate the recognition that for patients whom prescribing an opioid in addition to a benzo, there are times when this is clinically appropriate, and can't emphasize this enough, that the measure is not expected to be at a performance rate of zero. Thank you.

00:50:02

Okay, next question. "When can we expect a benchmark to be announced for this measure?" "And will sickle cell patients be eventually excluded?" Answer, we are not able to speak to when benchmarks may be available for this measure. Individual hospital's performance results are available for the 2022 Reporting Period in the timely and effective care hospital data download from the CMS Care Compare Provider Datasets for Hospitals. We are looking further into the exclusion of these sickle cell disease patients from the measure. Okay, thanks.

And this next question is a similar question about, asks about "When will the first round of national comparative data be expected to be available for this measure?" Individual hospital

performance results are available for the 2022 Reporting Period. Once again, that's located in the Timely and Effective Care Hospital Data download on the CMS Compare Provider Dataset for Hospital's website. National and state results are not available yet.

Okay, we have a question here. "If a patient is discharged from acute care to skilled care at your CAH, your Critical Access Hospital, does the patient count once or twice in this measure." The answer, if the skilled care is not considered an inpatient hospitalization status, then only the data from the acute care admission will be evaluated for this measure.

Okay, the next question is asking about "eCQM inpatient discharges, can they be sampled? Or do they have to be 100% of patients, barring any exclusions?" And the answer is that the eCQMs do not make use of sampling. All patients who qualify for an eCQM and are not excluded should be reported on.

Okay, "Does transfer or discharge to an acute rehab facility qualify under the discharge to acute care facility Denominator Exclusion?" And the answer is that acute rehab facilities are not an exclusion for this measure.

Okay, next question is, "Are the studies being referenced going to be included in the slide deck references?" So that was the one that was answered in the wrong place, but yes, we have included the slide in the slide deck the references. And that PDF is available under the handout section on your control panel off screen.

Question, "Are patients discharged to skilled nursing facilities excluded from this measure?" Answer, patients discharged to a skilled nursing facility are included in this measure.

Okay, so the next question was asking about the new opioid harm measure, and while that wasn't covered on today's broadcast, the registration is open for that webinar, which will address the new ORAE, or Opioid-Related Adverse Events eCQM, and that'll be on January 25th. You can find the webinar information on the Expert to Expert landing page on The Joint Commission website, www.jointcommission.org under the Measurement tab, and we will also include this link in the Q&A document. Thank you.

Thanks, next question. "Current logic is set to have Critical Access Hospital swing bed patients included in the measure. What are the plans to have these patients "excluded from the measures since these are not inpatients?" The answer is patients discharged to swing beds are not excluded from the Denominator, but this is an exclusion we are considering for future versions of the measure. Thank you, okay.

This question, we may have covered it, but I'll just read it to reiterate, "Does the cancer diagnosis need to be coded or can it also be pulled from the problem list?" So, the answer is that the cancer value set does include the codes required for this exclusion. Thank you.

Okay, next question. "Observation patients are included in this measure?" Answer, inpatient encounters are included in this measure. It is constrained by the value set encounter inpatient, observation is an outpatient encounter, therefore, are not included in the measure.

All right, and then the next question is regarding Tramadol. "Tramadol will not be included in this measure since it's a Schedule IV, correct?" And the answer is that Tramadol is not currently excluded in the measure since it is a Schedule IV.

55:12

Okay, and next question, "Will the patient meet Numerator requirements if they have two identical opioid prescriptions at discharge? Same drug, strength, and administration? For example, two 10 by 325 milligrams oxycodone acetaminophen by mouth once as needed for pain." The answer, the operator distinct eliminates duplicates from a list. So, if the opioid prescriptions are the exact same drug, same RXNorm code, then that opioid is only in the list for one time. Same drug, different milligrams for each opioid, have different RXNorm codes, both medications will be in the list.

Okay, the next question is another discharge clarification, and it asks, "Is discharge to a psychiatric facility considered an acute care facility?" The answer is that patients discharged or transferred to psychiatric facilities are included in this measure.

Okay, we may have answered this one, or something similar, "But will there be consideration for sickle cell patients being excluded from the population? This population is treated with multiple opioids for regular and breakthrough pain control. We had previously submitted for consideration and had believed it would be coming in the future." And the answer is that future iterations of this measure may exclude encounters of patients with sickle cell disease, as this is currently being discussed with stakeholders. Okay, I'm just kind of glancing through. It looks like we have a number of similar questions coming through. And so at this point I'm going to go ahead and hand things back over to Susan Funk to close things out, but just a reminder that any of the questions that you asked that we were not able to get to today, we will be posting a final Q&A document with all of the answers to these wonderful questions you've asked. Thanks, and I'll now hand it back over to Susan.

57:29

Thanks, thanks Melissa and Susan for facilitating the Q&A segment, and thanks to the team in the background that we're answering so many of them. We'll post the responses to any questions that we didn't address today via a written document that will be posted online. And then let me go here to the next slide.

Great segue to let everyone know that all of these Q&A documents, webinar recording links, slides, transcripts, those can all be accessed within several weeks of the live event on Joint Commission's webpage at the link that's noted on your slide. Just to do a short recap and a plug for the future webinars that are in the Expert to Expert Series. The 2024 eCQM Annual Update Webinar Series began with an On-Demand webinar released in August on The Joint Commission's PC-01, 05, and 06 eCQMs, continued with the PC measures in September and then the Stroke measures in October, VTE in November, and then Glycemia in December, and concluded today with the Safe Use of Opioids Concurrent Prescribing eCQM. In January and February, we will also address the new measures for 2024 implementation,

the Opioid Related Adverse Events eCQM and the Global Malnutrition Composite Score eCQM.

This series incorporates expertise from The Joint Commission, Centers for Medicare and Medicaid Services, Mathematica, and other measure stewards. If you missed any of these topics, the link on this slide will provide you access to the recording and slides when they are available. Before the session concludes, just a few words about the CE survey. We use your feedback to inform future content and also to assess the quality of our educational programs. You can access the CE survey in two ways. On the next slide, we provide a QR code that you can scan with your mobile device to immediately access the survey. If you miss that QR code, the link will be provided within an automated email sent to the email address that you used to register. To obtain your CE certificate, at the end of the survey, when you click submit, you are redirected to a page from which you can print or download a PDF certificate. You will also receive an automated email that includes the link to the same PDF certificate.

So, with that, thank you to Erin so much for your presentation, Susan, and Melissa for facilitating the Q&A segment, and thanks to all of our content experts in the background that we're answering the submitted questions. Finally, thanks to all of you who attended today's webinar broadcast, and we'll pause here for just a few moments for anyone that wishes to access the survey via the QR code on the slide. Have a great day.