PIONEERS IN QUALITY

Q&A 2024 New Measure Review Webinar – Opioid Related Adverse Events

Broadcast January 25, 2024

Question	Answer
How is an operating room defined? Are opioids and antagonists given in procedural areas such as postop recovery (PACU), cardiac catheter or endoscopy labs, or intervential radiology being considered for measure evaluation?	Only opioid antagonists administered outside of the OR, following an opioid administration, would be considered for the numerator. Opioid antagonists administered in other settings outside of the OR, such as in the postop recovery unit (PACU), catheter and endoscopy lab, or interventional radiology would not be a routine component of an anesthesia plan. In those locations, opioid antagonist administration is most likely related to over-sedation and could be evaluated for the numerator. The measure identifies an operating room (OR) by documentation of hospital location (HSLOC) code 1096-7 operating room/suite.
Can you define the encounter start time? Does this include time in the emergency department (ED) and/or in Observation? Are opioid and antagonists administered in the emergency department (ED) and/or observation stays get evaluated for the numerator?	The measure uses a data element 'Encounter, Performed' to capture an encounter. There are different encounter types (e.g., inpatient encounter, emergency encounter, observation encounter, etc.). A patient must have an inpatient encounter to qualify for the measure. The term inpatient hospitalization is used to include ED and Observation encounters into the inpatient hospitalization timeframe since we know patients are treated prior to being admitted to Inpatient which should count towards their care during their hospitalization. Therefore, we use a function called, 'Global.HospitalizationWithObservation' to determine the start of the inpatient hospitalization. This function looks to see whether an ED encounter or Observation encounter exists prior to the Inpatient encounter. If one or both exist, then the logic will incorporate them into the inpatient hospitalization timeframe and use the earliest encounter start time to be the start of the inpatient hospitalization, and any opioid and opioid antagonist administrations given during the ED or Observation encounter would be evaluated against the numerator criteria. The function also references a timing constraint of '1 hour less' between any transitions that exist during the hospitalization. This is used to determine whether these ED or Observations encounters are related to the Inpatient admission. For example, a patient may have gone to the Emergency Department, received treatment, and then went home. 1 week later, the patient comes back to the hospital as a direct Inpatient admission. The timing of '1 hour or less' would exclude the ED encounter from the week prior as it did not end 1 hour or less before the start of the Inpatient encounter and therefore would not be a part of the Inpatient hospitalization. If neither an ED nor Observation encounter exist then the encounter starts at the time of the Inpatient admission. The source to determine the 'start' timestamp for each encounter type varies on hospital and EHR system workflows. However, an admit order can be used to determine the inpatient encounter start time.

Question	Answer
Are emergency department visits, observation stays, or same day surgeries/procedures without an inpatient admission counted in the measure's initial population/denominator?	To meet the initial population / denominator, an inpatient admission must occur. Therefore, an ED and/or observation stay, or same day surgery that are not followed by an inpatient admission will not be considered for the measure
Does it matter if the opioid is administered before the OR or in the OR, as long as the reversal agent is given within 12 hours of an opioid administration to be evaluated for the measure?	The measure's numerator includes inpatient hospitalizations where an opioid antagonist was administered outside of the operating room and within 12 hours following administration of an opioid medication. Therefore, if the naloxone was given outside of the OR and within 12 hours of the opioid administration, it would be evaluated for the numerator.
What if the delirium or respiratory depression turns out not due to opioids and due to some other condition pt. is experiencing	The measure requires an opioid antagonist administration outside of the OR that must be preceded by documentation of an opioid administration by the facility within 12 hours before the antagonist administration. This strengthens the causal link between the opioid and the subsequent antagonist administration.
Does this measure exclude a patient who have had spinal anesthesia for a cesarean section and are treated with IV naloxone for pruritis and are also treated with an opioid out of the OR, but are not having an opioid related adverse event?	The measure requires an opioid antagonist administration outside of the OR that must be preceded by documentation of an opioid administration by the facility within 12 hours before the antagonist administration. This strengthens the causal link between the opioid and the subsequent antagonist administration.
If a patient receives Naloxone within 12 hours of an opioid but it is clinically determined the event was related to an acute CVA or other acute condition and not related to the opioid administration, should the encounter still be counted in the numerator?	The measure requires an opioid antagonist administration outside of the OR that must be preceded by documentation of an opioid administration by the facility within 12 hours before the antagonist administration. This strengthens the causal link between the opioid and the subsequent antagonist administration.
Opioid antagonists are sometimes given when opioids are the suspected cause, but without improvement. How will these cases be filtered out from actual opioid-related events?	The measure requires an opioid antagonist administration outside of the OR that must be preceded by documentation of an opioid administration by the facility within 12 hours before the antagonist administration. This strengthens the causal link between the opioid and the subsequent antagonist administration.

Question	Answer
How do hospitals report this eCQM to CMS? Is it mandatory to report this measure for calendar year 2024?	A hospital may choose to submit the measure as one of the three self-selected eCQMs for four quarters of CY 2024 data (Q1, Q2, Q3 or Q4) to meet the eCQM reporting requirement for the Hospital IQR and Medicare Promoting Interoperability Programs. eCQMs are submitted to the Hospital Quality Reporting (HQR) System via Quality Reporting Data Architecture (QRDA) file. Please see QualityNet for more information on submission. Note that CMS evaluates measures on an annual basis to determine if submission is voluntary or mandatory. We refer you to CMS' Hospital Inpatient Quality Reporting Program website for more information: https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program.
What if a visitor brings in opioids to which a patient has a reaction or a patient takes an opioid at home before being admitted through the ED, is there an accommodation for this time of incident or do we need to capture the administration of the opioid prior to the ED for the denominator?	The measure requires that a documented administration of an opioid by hospital staff during the encounter must precede the opioid antagonist to be considered. Therefore, opioids taken prior to the start of the encounter (such as at home), or opioids taken secretly while in the hospital, would not be captured. This specification protects hospitals from being penalized for appropriately treating patients that enter the facility with opioids in their system or have taken opioids secretly while in the hospital and subsequently require naloxone administration
Please share any benchmarks you have for this measure. Are there thresholds? National rates?	Benchmarks are established using historical measure performance data. Since these measures were introduced beginning with 2024 reporting, performance rates and benchmarks from CMS will not become available until at least 2025.
Where can I get the value set?	The value sets for this measure can be found within the Value Set Authority Center (VSAC). A link to these value sets in VSAC can be found in the eCQI Resource Center website here: https://ecqi.healthit.gov/ecqm/eh/2024/cms0819v2#quicktabs-tab-tabs_measure-1
Is the age calculated at admission to inpatient date/time or the ED/Observation date/time?	The age of 18 or older is determined at the time the patient was admitted to inpatient.
What is the definition of acute care?	This eCQM applies to eligible hospitals in the Hospital Inpatient Quality Reporting (IQR) program. An 'eligible hospital' is an acute care facility, which is defined by CMS as "a hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition)." Additional information on the Hospital IQR program and the definition of an eligible acute care hospital can be found on CMS' website here: https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program

Question	Answer
Is there the ability to obtain granular details (e.g., patient specific identifier such as MRN (medical record number)) to review cases that were included in the numerator of the measure?	We are not in a position to provide instructions on how to obtain data elements that are not required for measure calculation and reporting, such as MRN's.
How do we exclude the medications that are given in the OR?	How medications administered within an operating room location are documented may vary between hospital organizations, so we recommend consulting with your implementation team.
How does this measure affect pregnant women and newborns?	The measure only includes inpatient hospitalizations for patients age 18 and older, therefore does not affect newborns. Adult pregnant women that are included in the measure could potentially have an opioid-related adverse event.
How should a hospital plan on following up pain management for facility-wide patients on opioids if there's no pain team?	We are not in the position to provide direction on hospital policies or procedures.
Our facility is not required to submit opioid data, but can you clarify what you want us to collect? SDOH (Social Determinants of Health) attestation question	The measure does not include any SDoH reporting requirements. To further clarify, this measure is currently available for voluntary, not mandatory, reporting for 2024.
For patients discharged to our SNF (Skilled Nursing Facility) unit with same EHR, how would you handle 2 or more opioids flowing into that next level of care?	Only inpatient hospitalizations for acute care are eligible for inclusion to the measure. If the patient was discharged to SNF unit from an acute inpatient hospitalization level of care, the measure will stop evaluation at the time of discharge.
Please discuss the intent of ORAE and also the intent of "safe use of opioids." Also, are discharge to LTC (Long Term Care) and swing beds are included?	The measure is intended to be used to identify and reduce unintended opioid-related adverse events such as over-sedation, delirium, and respiratory depression. Administration of an opioid antagonist is used as an indicator of a severe ORAE. Regarding the discharge, only inpatient hospitalizations for acute care are eligible for inclusion to the measure. If the patient is discharged to LTC and/or a swing bed from an acute inpatient hospitalization level of care, the measure will stop evaluation at the time of discharge. We do not steward the Safe Use of Opioids measure so cannot speak to the intent.

Question	Answer
What evidence establishes naloxone use as clearly indicating preventable iatrogenic harm among inpatients who receive opioids?	1. Naloxone has been long-used to track opioid safety and events in hospitals and has also been used as an outcome measure in studies of opioid safety: • Rizk et. al, 2019 from *American Journal of Health-System Pharmacy* - Quality indicator of opioid stewardship in hospital related to adverse events • Positive Predictive Value (PPV) of 91% (Nwulu, Nirantharakumar, Odesanya, McDowell, & Coleman, 2013) 2. During our validity testing, we found evidence that providers were administering the reversal agent because the patient was exhibiting signs of an opioid-related adverse event (e.g., respiratory distress or non-responsive) and their response post administration (e.g., more alert). 3. Our measure requires evidence of opioid administration within 12 hours preceding the Naloxone, strengthening the link between the two and supporting the naloxone as an ORAE.
What tips can you share on data validation for this measure?	Clinical codes, e.g., ICD10CM, ICD10PCS, SNOMEDCT, LOINC, RxNORM, etc., are used to define certain data elements used in the measures. These can be found in the value sets listed in the measure specifications. We are not in the position to provide direction on how data validation is performed within your organization.
Why aren't all opioids considered for the measure? Why are only II & III the main focus?	The “Opioids, All” value set includes all formulations of opioids that may be administered in an inpatient or outpatient setting regardless of intended use. According to federal law, no prescriptions may be written for Schedule I substances, and they are not readily available for clinical use. Substances that are Schedule IV and above have low risk for abuse (i.e., overdosing) and are less likely to be misused.
Can you clarify that this is an inverse measure?	Yes, this is an inverse measure because it is a measure in which a lower performance rate is better. The goal is to have the numerator equal to or very close to zero.