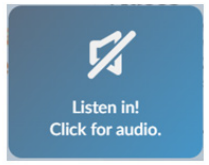
Pioneers in Quality

Expert to Expert Webinar Series

2023 Annual Updates
Safe Use of Opioids—Concurrent Prescribing (CMS506)

February 16, 2023

Webinar Audio – Information & Tips



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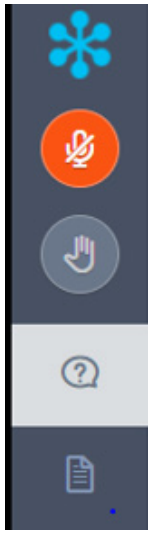

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Welcome!

But first things first…

"Get Started with eCQMs"

The Joint Commission

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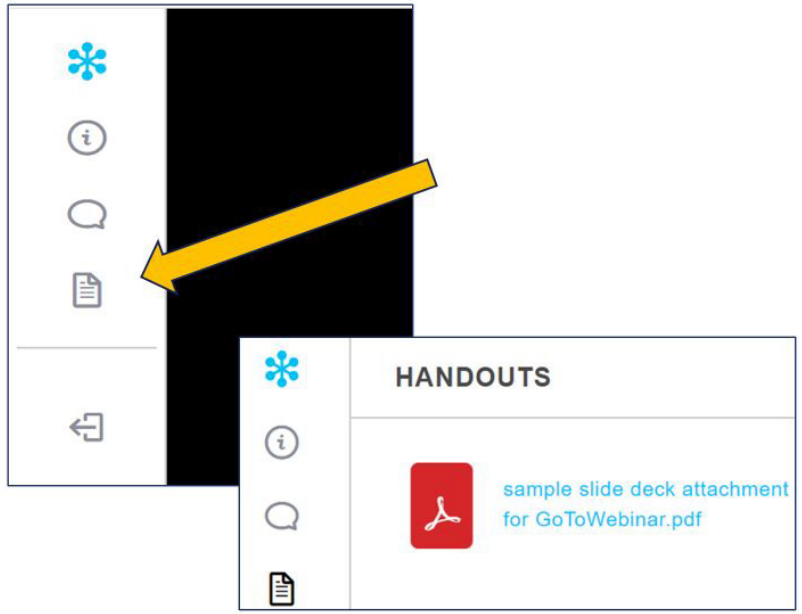

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- American College of Healthcare Executives (ACHE)
- California Board of Registered Nursing
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At the end of this webinar, participants should be able to:

- 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 2023 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.

- Susan Funk, MPH, LSSGB, Associate Project Director, Measurement Coordination and Outreach
- Theresa Feeley-Summerl, MPH, Researcher, Mathematica
- Marilyn Parenzan, MBA, RHIA, CPHQ, Project Director, Clinical Quality Informatics, The Joint Commission
- Susan Yendro, RN, MSN, Associate Director, Measurement Coordination and Outreach

Pioneers in Quality Expert to Expert Webinar Agenda: Safe Use of Opioids—Concurrent Prescribing eCQM

- Demonstrate navigation to measure specifications, value sets, measure flow diagrams and technical release notes
- Introductions
- Review the measure flow/algorithm
- Review changes made to the eCQM
- FAQs
- Facilitated Audience Q&A Segment

eCQI Resource Center Website Demo

eCQI Resource Center Website https://ecqi.healthit.gov/

eCQM Resources	Short Description	Published
Implementation Checklist eCQM Annual Update	Implementation checklist	--
Guide for Reading eCQMs 8.0 (PDF)	Assists implementers and measured entities with information on how to read eCQM specifications	May 2022
Hospital Quality Reporting Table of eCQMs (PDF)	List of eCQMs available for use	May 2022
eCQM Specifications for Hospital Quality Reporting (ZIP)	eCQM technical specifications	May 2022
Measure Authoring Tool (MAT) Global Common Library (GCL) Technical Specifications and Technical Release Notes (ZIP)	MAT-CGL specifications and technical release notes	May 2022
eCQM Value Sets	Value sets used in eCQMs	May 2022
EH/CAH Pre-Rulemaking Value Sets CMS334 (ZIP)	Value sets used in CMS334v4	May 2022
eCQM Direct Reference Codes List	eCQM Direct Reference Codes used in eCQMs	May 2022
Binding Parameter Specification (BPS) (ZIP)	Value set metadata	May 2022
eCQM Logic and Implementation Guidance v6.0 (PDF)	Assists implementers and measured entities with how to use eCQMs and report issues	May 2022
Technical Release Notes (PDF)	Year over year changes to eCQM logic and terminology	May 2022
Technical Release Notes (ZIP)	Year over year changes to eCQM logic and terminology	May 2022
Standards and tool versions used for reporting period	Tools and standards versions measure developers used to create eCQMs and versions of standards and tools used for their reporting	May 2022
eCQM Flows (ZIP)	Assists implementers and measured entities with steps to take to calculate an eCQM	Aug 2022
2023 CMS QRDA I Implementation Guide for Hospital Quality Reporting (PDF)	Format for reporting eCQMs to CMS	May 2022
2023 CMS QRDA I Schematrons and Sample Files (ZIP)	Rules to validate eCQM reports with samples	May 2022
eCQM Annual Update Pre-Publication Document (PDF)	Standards and code system versions for the eCQM Annual Update	Mar 2022

Live Demo

Pioneers in Quality™ Expert-to-Expert Series: Safe Use of Opioids—Concurrent Prescribing (CMS506)

Inpatient and Outpatient Measure Maintenance

Contract Number: 75FCMC18D0032
Task Order Number: 75FCMC19F0003

February 2023

Introductions

Measure team

/ Mathematica

- Robert Dickerson, project director
- Jamie Lehner, annual update advisor
- Theresa Feeley-Summerl, measure lead

/ Lantana

- Angela Flanagan, clinical lead
- Lynn Perrine, clinical analyst

Overview of Safe Use of Opioids—Concurrent Prescribing (CMS506v5)

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).**
- **2016 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 specifications – no changes

Description: Proportion of inpatient hospitalizations for patients 18 years of age and older prescribed, or continued on, two or more opioids or an opioid and benzodiazepine concurrently at discharge

Denominator

- Inpatient hospitalization
- 18 years or older
- One new or continuing opioid or benzodiazepine at discharge

Denominator exclusions

- Cancer
- Palliative or hospice care
- Discharge to an acute care facility
- Death

Numerator

- Prescribed or continued on two or more opioids at discharge
- OR
- Prescribed or continued on an opioid and benzodiazepine at discharge

Measure component comparison between 2022 and 2023 reporting – no changes

Measure components	2022 reporting period	2023 reporting period
Denominator/ initial patient population	Patients discharged from inpatient stays with at least one new or continuing opioid or benzodiazepine	**No functional change except in value set**
Numerator	Patients with two or more distinct new or continuing prescriptions for opioids OR an opioid and benzodiazepine	**No change except in value set**

Measure component changes between 2022 and 2023 reporting

Measure components	2022 reporting period	2023 reporting period
Denominator exclusions	• Patients with cancer • Patients who received palliative or hospice care or are discharged to hospice care • Patients discharged to an acute care facility • Patients who expired before discharge	• Patients with cancer • Patients who received palliative or hospice care during an inpatient stay or during an emergency department visit or observation stay immediately prior to inpatient admission or are discharged to hospice care during an inpatient stay • Patients discharged to an acute care facility • Patients who expired before discharge

Updates to Measure Value Sets and Logic: 2023 Reporting Period

Notable value sets (1)

/ Initial population/denominator

- Encounter inpatient (2.16.840.1.113883.3.666.5.307)
- Schedule II & III opioid medications (2.16.840.1.113762.1.4.1111.165)
  - Removed buprenorphine/naloxone combination medications
- Schedule IV benzodiazepines (2.16.840.1.113762.1.4.1125.1)
- Removed LOINC code 21112-8 for Birth Date

Notable value sets (2)

/ Exclusions

- All Primary and Secondary Cancer (2.16.840.1.113762.1.4.1111.161)
- Palliative or hospice care (2.16.840.1.113883.3.600.1.1579)
  - Comfort measures (1.3.6.1.4.33895.1.3.0.45)
  - Palliative SNOMED (2.16.840.1.113883.3.600.1.1578)
- Hospice Care Referral or Admission (2.16.840.1.113762.1.4.1116.365)
- Discharge to Acute Care Facility (2.16.840.1.113883.3.117.1.7.1.87)
- Patient Expired (2.16.840.1.113883.3.117.1.7.1.309)

Notable value sets (3)

/ Exclusion value sets added to 2023 reporting

- Emergency Department Visit (2.16.840.1.113883.3.117.1.7.1.292)
- Observation Services (2.16.840.1.113762.1.4.1111.143)

Notable value sets (4)

/ Numerator

- Schedule II & III opioid medications (2.16.840.1.113762.1.4.1111.165)
  - Removed buprenorphine/naloxone combination medications
- Schedule IV benzodiazepines (2.16.840.1.113762.1.4.1125.1)

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 substantive 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

Denominator

Initial Population

Denominator

"Initial Population"

No changes in 2023 reporting period

Denominator exclusions (1) – 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

/*Excludes encounters of patients with cancer or who are receiving palliative or hospice care at the time of the encounter*/

"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"

Denominator exclusions (2) – new to 2023

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 ))
```

Global.HospitalizationWithObservation

Global.HospitalizationWithObservation(Encounter "Encounter, Performed")

```
Encounter Visit
    let ObsVisit: Last(["Encounter, Performed": "Observation Services"] LastObs
            where LastObs.relevantPeriod ends 1 hour or less on or before start of
            Visit.relevantPeriod
            sort by
            end of relevantPeriod),
    VisitStart: Coalesce(start of ObsVisit.relevantPeriod, start of Visit.relevantPeriod),
    EDVisit: Last(["Encounter, Performed": "Emergency Department Visit"] LastED
            where LastED.relevantPeriod ends 1 hour or less on or before VisitStart
            sort by
            end of relevantPeriod)
    return Interval[Coalesce(start of EDVisit.relevantPeriod, VisitStart),
    end of Visit.relevantPeriod])
```

Denominator exclusions (3) – 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 "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")
```

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))

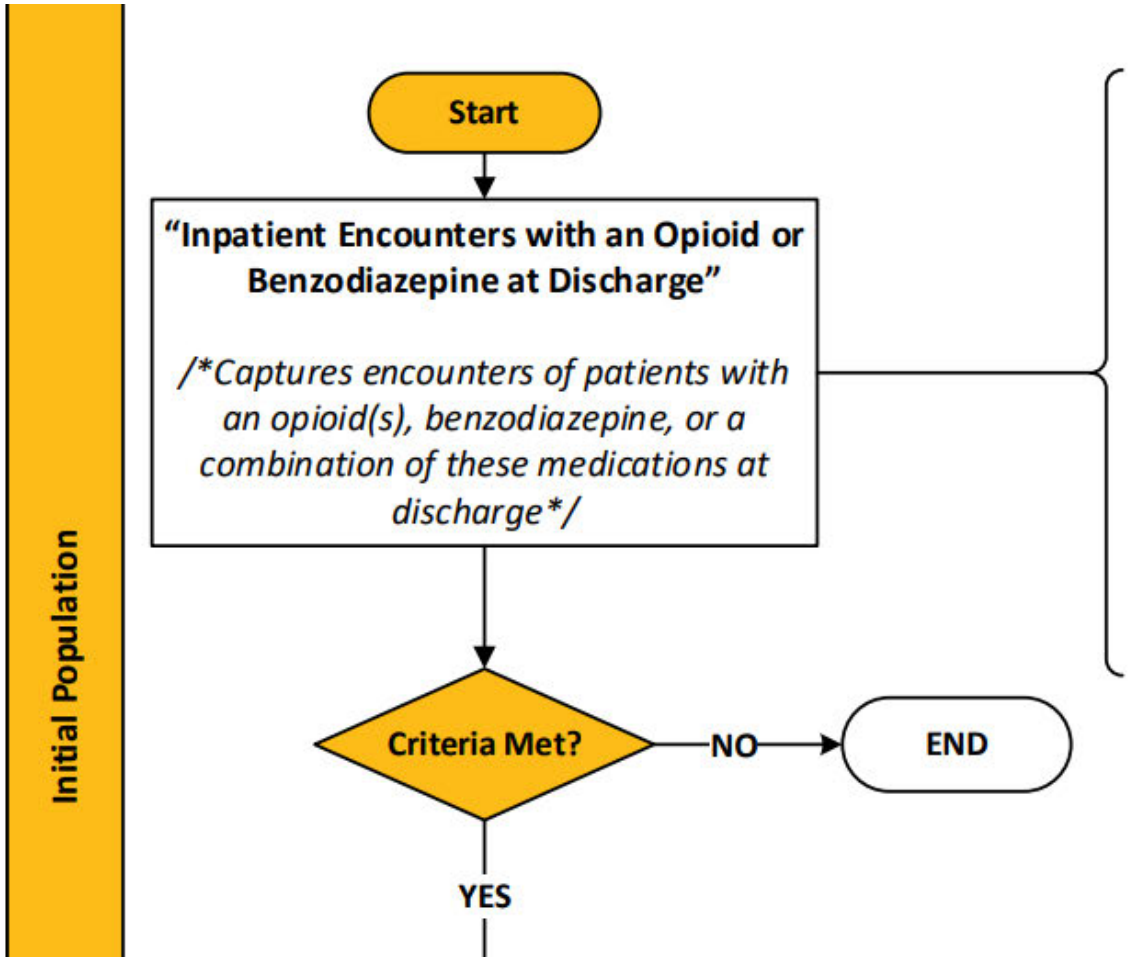
Numerator logic – no changes (2)

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: Initial Population

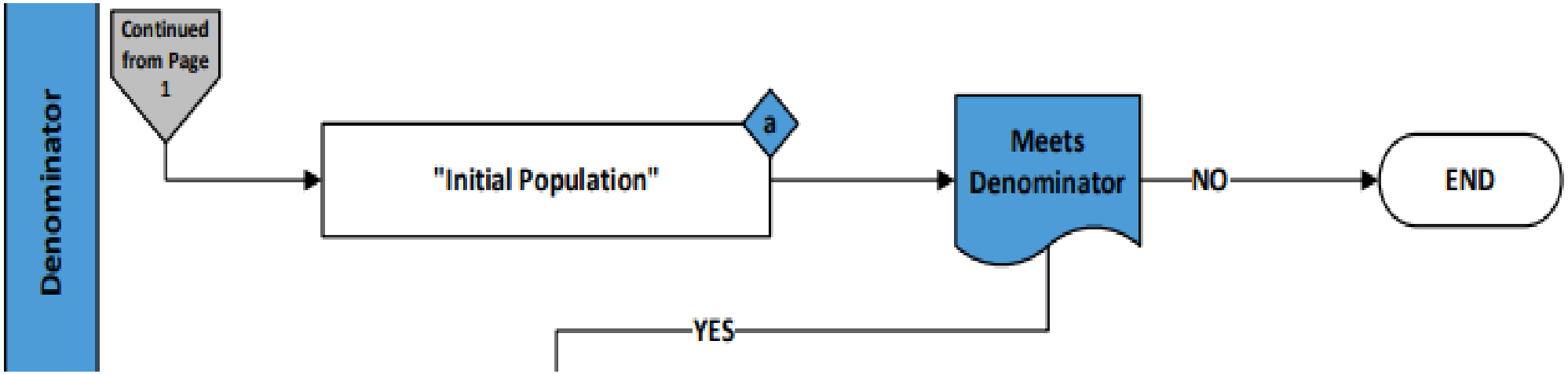


"Inpatient Encounter with Age Greater than or Equal to 18"

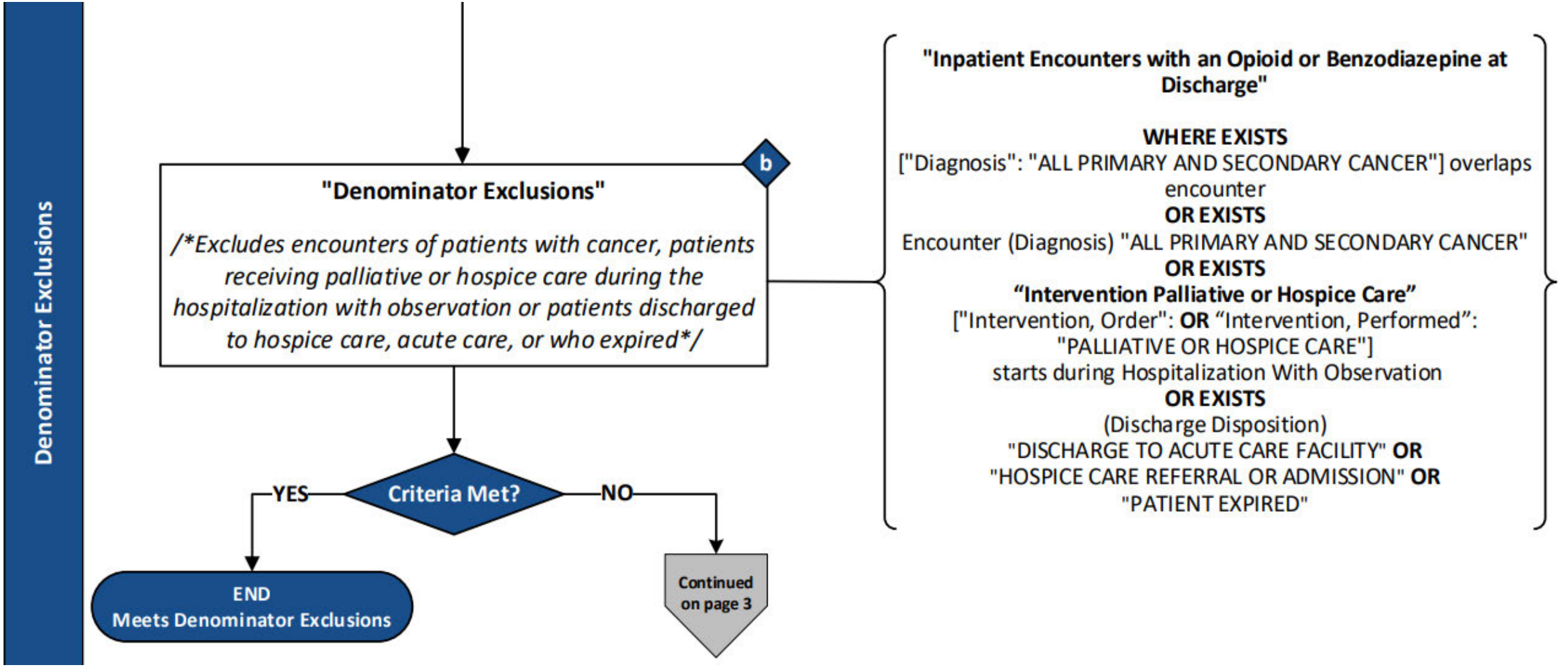
"Inpatient Encounter"
["Encounter, Performed": "ENCOUNTER INPATIENT"] **WHERE** Length In Days <= 120 **AND** ends during day of Measurement Period
WITH
Age In Years >= 18 at start of encounter

WITH
["Medication, Discharge": "SCHEDULE II & III OPIOID MEDICATIONS"]
OR
["Medication, Discharge": "SCHEDULE IV BENZODIAZEPINES"]
during encounter

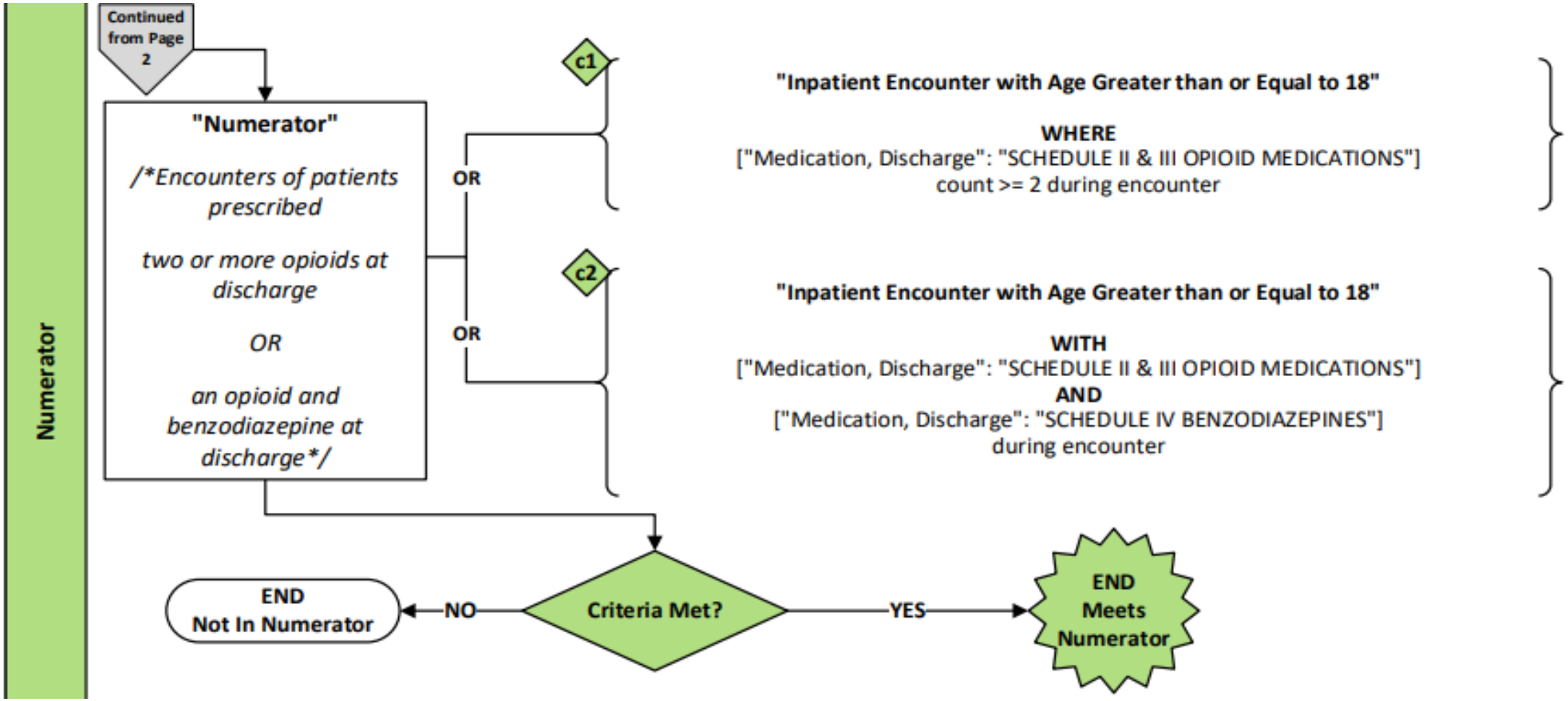
Flow diagram: Denominator



Flow diagram: Denominator Exclusions



Flow diagram: Numerator



Flow diagram: sample calculation

Sample Calculation
$$\text{Performance Rate} = \frac{\text{Numerator (c1 + c2 = 20)}}{\text{Denominator (a = 100) - Denominator Exclusions (b = 10)}} = 22\%$$

Measure considerations

Measure is not expected to have a zero rate

- 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

- Initial population
  - Inpatient hospitalizations with discharge medications of:
    - A new or continuing **opioid** *OR*
    - A new or continuing **benzodiazepine**
- Numerator
  - Inpatient hospitalizations with discharge medications of:
    - **Two or more** new or continuing **distinct opioids** *OR*
    - A new or continuing **opioid AND benzodiazepine**

Frequently Asked Questions

What can be mapped to palliative and hospice exclusions?

- **Palliative care or hospice consultations**
  - Map to palliative or hospice care orders
  - Harmonized with STK-5/CMS72
- **Palliative care or hospice orders** (Palliative or Hospice Care 2.16.840.1.113883.3.600.1.1579)
- **Palliative care or hospice interventions** (Palliative or Hospice Care 2.16.840.1.113883.3.600.1.1579)
  - If patients begin palliative or hospice care before or during their inpatient stay, they qualify for an exclusion
- **Discharge to hospice** (Hospice Care Referral or Admission 2.16.840.1.113762.1.4.1116.365)
  - This includes referrals and admissions to hospice, discharge to hospice, and the qualifier for home hospice services

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
  - 12 HR oxycodone hydrochloride 15 mg extended release oral tablet
- 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

References

Dowell, D., T. Haegerich, and R. Chou. “CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016.” *MMWR Recommendations and Reports*, vol. 65, 2016. Available at http://www.cdc.gov/media/dpk/2016/dpk-opioid-prescription-guidelines.html. Accessed March 27, 2020.

Rudd, R., N. Aleshire, J. Zibbell, and M. Gladden. “Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014.” *Morbidity and Mortality Weekly Report*, vol. 64, no. 50, January 2016, pp. 1378–1382. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm. Accessed March 27, 2020.

Sun, E., A. Dixit, K. Humphreys, B. Darnell, L. Baker, and S. Mackey. “Association Between Concurrent Use of Prescription Opioids and Benzodiazepines and Overdose: Retrospective Analysis.” *BMJ*, vol. 356, 2017, p. j760. Available at http://www.bmj.com/content/356/bmj.j760. Accessed March 27, 2020.

Helpful links

- **Electronic Clinical Quality Improvement (ECQI) Resource Center**
  https://ecqi.healthit.gov/
- **Value Set Authority Center (VSAC)**
  https://vsac.nlm.nih.gov/

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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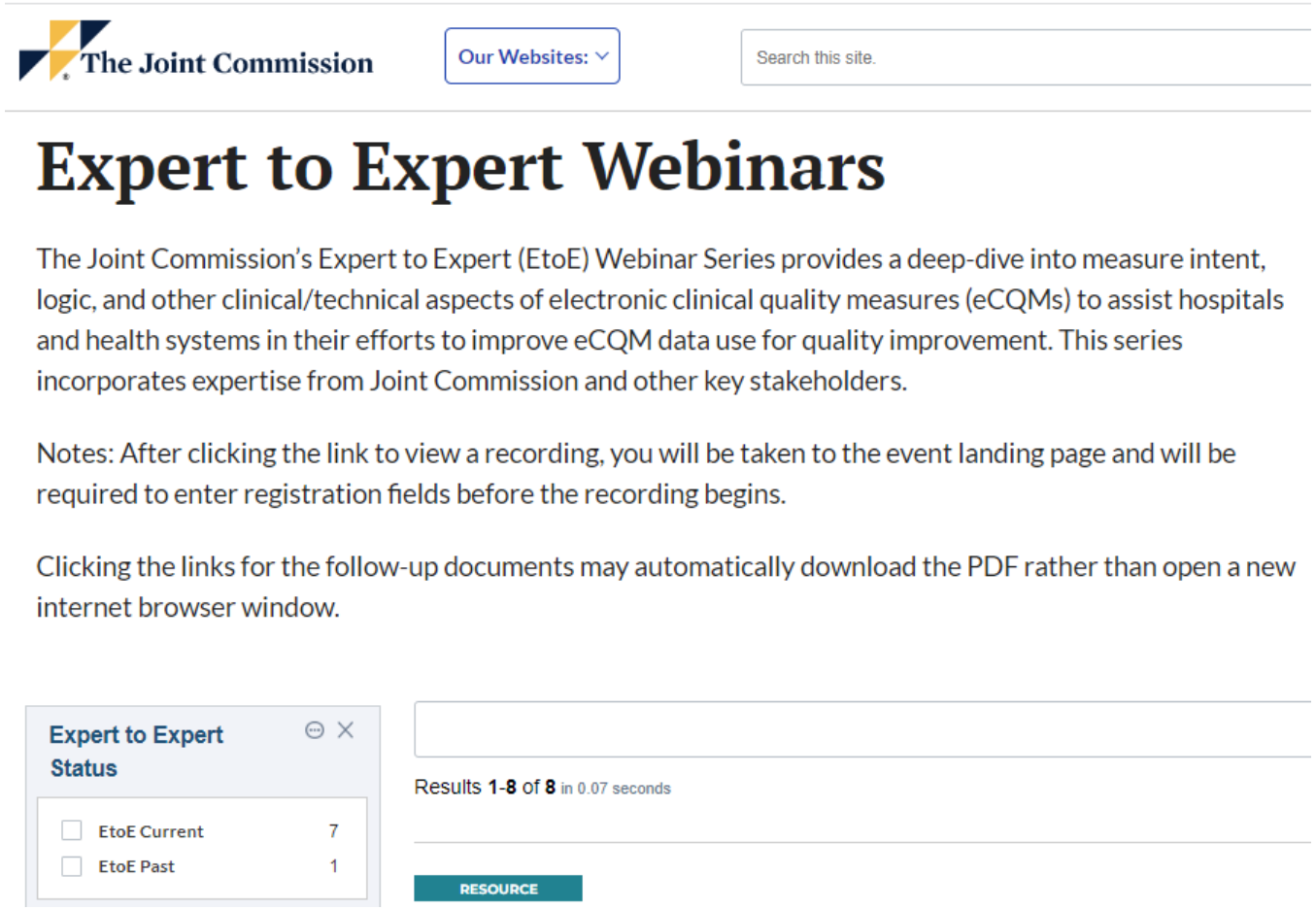

Expert to Expert Annual Update Webinars

- 2023 eCQM Annual Update Webinar series began in August with Joint Commission's PC-01 and PC-06 eCQMs.
- The series incorporates expertise from The Joint Commission, Centers for Medicare & Medicaid Services, Mathematica, and other measure stewards to address the 2023 eCQM Annual Updates for: STK, VTE, PC, ED, Safe Opioid Use, and Hyper- and Hypo-Glycemia measures.
- Use this link to access information about all the previous webinars: https://www.jointcommission.org/measurement/pioneers-in-quality/pioneers-in-quality-expert-to-expert-series/

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- We use your feedback to inform future content and assess the quality of our educational programs. The evaluation closes in 2 weeks.

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Joint Commission Pioneers in Quality Expert to Expert Webinar Series 2023 Annual Updates Safe Use of Opioids-Concurrent Prescribing (CMS506)

Broadcast date: February 16, 2023

00:00:03

Welcome everyone and thank you for joining us today for our Expert to Expert Series Webinar 2023 Annual Updates for the Safe Use of Opioids Concurrent Prescribing eCQM.

00:00:17

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.

00:00:32

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00:00:58

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. If you are new to eCQMs, this content might be too technically advanced for your comprehension. We recommend that those new to eCQMs 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.

00:01:38

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00:01:50

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00:02:01

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00:03:14

The learning objectives for this session are, navigate to the eCQI Resource Center for 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 2023 eCQM reporting period, and identify common issues and questions regarding the Safe Use of Opioids, Concurrent Prescribing eCQM.

00:03:51

These topics will not be covered during today's session. Basic eCQM concepts, topics related to chart abstracted measures, process improvement efforts related to this measure, and eCQM validation.

00:04:07

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.

Myself, Susan Funk. Theresa Feeley-Summerl. Marilyn Parenzan and Susan Yendro.

00:04:38

The agenda for today's discussion follows. Demonstrate navigation to the eCQI Resource Center for the measure specifications, Value Sets, measure flow diagrams, and technical release notes; Introductions; Review the measure flow and algorithm; Review the changes made to the eCQM; Frequently Asked Questions; and then a facilitated audience question and answer segment.

00:05:03

We will now share a demo that illustrates the navigation to the eCQI Resource Center to show the measure specifications, Value Sets, measure flow diagrams, and technical release notes.

00:05:37

Before we dive into our measures, we'd like to refer you to the eCQI Resource Center website where you can find measure specifications, measure flow diagrams, Value Sets, and technical release notes for all the measures in the CMS program. And this is where I'll go to the live demo.

00:05:52

Here is the landing page for the eCQI Resource Center. If you hover over the eCQM item on the main menu and the eligible hospital Critical Access Hospital eCQMs and then you can select the reporting period here of 2023, you'll see multiple resources listed, so we're going to focus on four resources that were highlighted on the previous slide in red, starting with the eCQM specifications for hospital quality reporting.

00:06:18

So, you're going to click it, double click on this zip file and then we're going to use the 506 version here. I'm choosing it because this is the Safe Use of Opioids Concurrent Prescribing measure. Now you can see all the files in the measure package. I'm not going to go into detail on all of these files, but if you want to know more, go to the Get Started with eCQM site on the eCQM Resource Center.

00:06:39

We'll take a quick look at the HTML document. It's also known as the human readable file. By double clicking on the name the HTML file opens and this is where you'll find all details related to the measure. The top portion of the document highlighted in gray is referred to as the metadata or credit information. This is where you'll find the measure developer right here. The rationale references helpful guidance and the populations defined in easy-to-understand language. If you scroll down, you'll see the population criteria and further down all the definitions making up the logic functions are listed, followed by terminology also known as Value Sets or direct reference codes, and then the quality data model or QDM data elements. Supplemental data elements and risk adjustment variables are also listed here. But as you'll note, Safe Use of Opioids measure does not have any risk adjustment variables, so this is your source of truth or all of the measure details. I went through this pretty quickly but wanted you to be aware of how to locate this document and have a basic understanding of its contents.

00:07:38

Back to the eCQI Resource Center. We can download the Value Sets by clicking on the eCQM Value Sets and notice that you're going to have to be signed in to the VSAC to access Value Sets. So, but let's open up the most recent value set by clicking on 2023. But as you can see, we've got several different available here. So, choosing the first option, which is the 2023 year, I'm going to select data sorted by CMS ID in Excel format by. Opening the Excel file, I then can select the measure that I'm interested in and what we can do is we see that here on the bottom of the screen. So, I've chosen the tab for 506. You can see the CMS ID, the value set name, the object identifier also known as the OID, QDM category, and other pertinent information for every code in every value set for the measure. Note that the direct reference codes are not listed on this because they are not included in Value Sets. This Excel spreadsheet is Value Sets only. But you can find direct reference codes in measure specifications. Let's take a look at technical release notes. You can either open up a PDF file containing the TRNs for all measures or a zip file that contains TRNs ends in separate Excel files. I'm going to choose the second option and open 506. Here's a nice consist list of all the changes to the measure in the 2023 reporting year. Participant feedback from previous webinars asked for a concise list of changes to the measure, so we hope this meets your needs in addition to the information will cover in the webinar.

00:09:10

Notice that the first column contains technical release notes, the second column contains the type of TRN, and the trends are listed by the type of TRN like header logic and value set. So, all the header changes are grouped, all the logic changes and all the values that changes.

00:09:28

The last link that we're going to take a look at are for eCQM flows. If we double click on that, it's going to show us the measures that were included in 2023.

00:09:39

So, the eCQM flows are designed to assist in interpretation of eCQM level and logic and calculation methodology for the Performance Rates. The eCQM flows provide an overview of each of the measure population criteria components and associated data elements that lead to the inclusion or exclusion into the measure. These flows are intended to be an additional resource when implementing eCQMs and shouldn't be used in place of eCQMs specification, you'll see that there's a CMS number and version number of the measure. So, you've got CMS506, version five. And the diagrams include a horizontal row for every population applicable to the measure. So, this measure has an Initial Population, Denominator, Denominator Exclusion, and Numerator. If you're looking at a measure that has a Denominator exception, it would come next. Safe Use of Opioids does not have any Denominator Exceptions.

00:10:30

You'll also see an algorithm guiding you through each population. Standard flow chart symbols are used. For example, diamonds would indicate a question or decision, and input and output symbols are used for denoting inputs and outputs. After the flow diagram you'll find a sample calculation and after those 2 pages describing each population using a narrative.

Stay tuned for more details on the measure flows later in the presentation.

00:11:08

Great. When you're ready, Theresa, go right ahead and you can take over the presentation.

00:11:18

Great. Thank you, Susan. OK. So go ahead and start, pardon me, with introductions of our measure team. So, on the Mathematica side, I'm Theresa Feeley-Summerl. I'm the measure lead. We also have Robert Dickerson, the Project Director and Jamie Lehner, the Annual Update Advisor. And on the Lantana side of things, we have Angela Flanagan and Lynn Perrine.

00:11:47

So, we'll go ahead and start with the overview of Safe Use of Opioids Concurrent Prescribing. This is version five of the measure. So, reducing the number of unintentional overdoses has become a priority for numerous federal organizations, including, but not limited to, the Centers for Disease Control and Prevention, CDC. The Federal Interagency Workgroup for Opioid Adverse Drug Events and the Substance Abuse and Mental Health Services Administration.

00:12:19

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 for overdose. Rates of fatal overdose are 10 times higher in patients who are code dispensed opioid analgesics and benzodiazepines versus opioids alone. The number of opioid overdose deaths involving benzodiazepines increased 14% on average each year from 2006 to 2011. While the number of opioid analgesic overdose tests not involving benzodiazepines did not change significantly.

00:12:57

Further, concurrent use of benzodiazepines with Opioids was prevalent in about 30 to 50% 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 risk of opioid overdose related ED and inpatient visits by 15%, and potentially could have prevented an estimated 2600 deaths related to opioid painkiller overdoses in 2015.

00:13:37

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 about 20% overall and .86% of patients per month. So that's about 780 patients per month receiving concurrent benzodiazepine with an opioid among all adult VHA patients who filled out outpatient opioid prescriptions from opioid 2012 to September 2014.

00:14:15

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.

00:14:34

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

00:14:59

The measure looks at the proportion of inpatient hospitalizations for patients 18 and older prescribed or continued on two or more opioids or an opioid and benzodiazepine concurrently discharge. For this measure, a lower rate indicates higher quality care, though we understand that there are cases when concurrent prescriptions are clinically appropriate. Although lower rates are considered higher quality care, we don't expect a score of 0. We'll go over each of the definitions in detail in just a bit, but I will say that all of these basic definitions are the same as version four of the measure.

00:15:38

The Denominator includes patients ages 18 years of age and older with an eligible hospital encounter, which will define shortly during the measurement period who are discharged with at least one new or continuing opioid prescription or a new or continuing benzodiazepine prescription. And to clarify, these prescriptions include those newly prescribed for patients at discharge and continuing prescriptions that may have been prescribed before the hospital encounter and should still be taken after the inpatient encounter, both of which should be listed in the medication discharge list. Note that the Denominator only includes patients newly prescribed or continued on an opioid or benzodiazepine, not all patients discharged. I also want to add that all patients in the initial patient population are included in the Denominator. Excluded from the Denominator are patients with an active cancer diagnosis that begins prior to or happens during the eligible encounter. And patients receiving Palliative or Hospice Care, which includes comfort measures, terminal care and dying care. The Palliative and Hospice exclusions in this measure have been harmonized with other measures and we added Hospice discharge disposition codes in 2022 reporting in order to more easily identify these patients. Both these exclusions and the patients who are discharged to an Acute Care Facility or who died during their inpatient stay are excluded in 2023.

00:17:16

So, this aligns with the CDC guidelines that also provide recommendations for primary care clinicians who are prescribing Opioids to adults in an outpatient setting outside of active cancer treatment, Palliative care, and end of life care. The Numerator is formed of patients who've been prescribed 2 or more Opioids at discharge or an opioid and benzodiazepine. So just to emphasize that patients can trigger the Numerator by either having prescriptions for two opioids at discharge or prescriptions for an opioid and benzodiazepine. So again. Scoring a lower rate on this measure would be an indication of higher quality care.

00:18:03

To show you the big picture differences between the measure for reporting in 2022 and 2023, we have two slides with the table comparing the measure components. We only have cosmetic logic changes to the Denominator and no logic changes to the Numerator in 2023. Just to reiterate, the Denominator remains patients discharged with at least one opioid or benzodiazepine and the Numerator contains any patient discharged with two or more distinct opioids or an opioid and benzodiazepine.

00:18:35

As in 2022, 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. We've updated the Denominator logic to reduce burden for EHR vendors and to make it easier to read, but it'll function the same. We do have some changes to the Denominator Exclusions, which we'll cover in the next slide.

00:19:03

Here the measure Denominator Exclusions show the difference between 2022 and 2023 highlighted in red. We'll dive into the value set and logic changes next. Most of the Denominator Exclusions in 2023 are unchanged from 2022, such as patients with cancer or patients discharged to an Acute Care Facility and patients who expired during an inpatient stay. Patients who receive orders for Hospice or Palliative care, receive Hospice or Palliative care during their inpatient stay, or are discharge to Hospice are also still excluded from the measure. However, now the measure logic also looks at Palliative or Hospice orders and care of patient receives directly before inpatient admission, either during an emergency room visit or during an observation stay.

00:19:54

This change aims to reduce burden by harmonizing with other hospital measures and by better aligning with the intent of the CDC guidelines to exclude patients receiving Hospice or Palliative care. This change drives the majority of differences you'll see in the 2023 Measure Value Sets logic, which we will continue on to now.

00:20:19

You'll find the Value Sets for the measure listed under the terminology section of the logic. Here I just want to pull out some of the particularly notable Value Sets, some of which we've gotten questions on, and some of the updates.

00:20:33

All Value Sets on this slide are included in both the 2022 and 2023 reporting versions of the measure, with one exception. The Value Sets in black contain only standard Annual Updates from 2023, such as adding new relevant codes and deleting expired codes. But Schedule II and III opioid medications, the first value set in red, has changed slightly in intent, in addition to the standard updates. The first three Value Sets and previously the LOINC code help us define our Initial Population, which for this measure is also the Denominator. The encounter inpatient set should look familiar. It's an extensional set, a value set that contains codes from only one code system, in this case SNOMED CT codes that represent the most common inpatient encounter types. This value set is used by several other hospital measures. Schedule II and III opioid medications is a grouping value set containing codes for all of the opioid medications used for this measure to define both the Denominator and Numerator. This is a similar set to what was used in 2022, with a major change being that we've removed all buprenorphine/naloxone combination medications. We made this change partly because interested parties were concerned that including medication used to treat opioid use disorder could disincentivize clinicians from prescribing evidence-based treatment and partly to align with the Department of Veterans Affairs' outpatient opioid measures.

00:22:10

Our goal in removing combination medications specifically is to balance the need to carefully monitor opioid use disorder, patients receiving opioids who are at higher risk for respiratory depression and many other patients and to avoid disincentivizing appropriate treatment for patients with OUD or Opioid Use Disorder.

00:22:31

We also made minor updates such as adding through codes based on terminology updates and deleting five obsolete codes. This value set is restricted to Schedule II and III opioid medications. We do not include Schedule IV or V opioids in the measure, in part to align with the intent of the measure to focus on opioids with high and moderate potential for abuse and in part to reduce the burden of reporting, particularly Schedule V opioids, which include cough preparations with less than 200 milligram grams of codeine per 100 milliliters or per 100 grams, so things like Robitussin.

00:23:13

Schedule IV opioid or sorry, that's Schedule IV benzodiazepines is an extensional set containing all of the benzodiazepine medications used for this measure. We added five codes based on terminology updates from RXNorm. Both of the Schedule II and III opioid medications and the Schedule IV benzodiazepines are used to define the initial patient population, and that patient should be prescribed at least one medication from at least one of the Value Sets. The same Value Sets are also used to define the Numerator in that patients are prescribed to Opioids from this Schedule II and III opioid medication list or one opioid from the Schedule, two and III Opioids medications and one benzodiazepine around the Schedule for benzodiazepine value set.

00:24:02

You may not have seen the LOINC code before because it's not normally notable. Birth date depicted by a single LOINC Code was used by most electronic clinical quality measures to ascertain a patients age due to the switch across measures. To using CQL function, which we'll cover shortly. We don't need this code anymore, so we've removed it from the measure.

00:24:31

All of these exclusion Value Sets were included in the 2022 version of Safe Use of Opioids. All primary and secondary cancer value set is a grouping value set that contains both ICD10 and SNOMED CT codes. This group of Value Sets identifies patients with a current cancer diagnosis, either primary or secondary. And excludes benign tumors, cancer institute, unspecified or uncertain behavior neoplasms as well as codes indicating in remission.

00:25:04

So, this is the same value set used in the 2022 version, with individual codes updated as appropriate. With removal of expired codes and addition of new codes, we added five SNOMED CT codes based on terminology updates and deleted 16 SNOMED CT codes. Patients receiving Palliative or Hospice Care are excluded using the Palliative and Hospice Care grouping value set. A grouping harmonized with other eCQMs. I'm going to go into a bit more detail here because it includes one value set you may recognize and when you may not. Within the grouping is the comfort measures value set, which is used by several other hospital measures. The grouping also contains the Palliative SNOMED set, which is more frequently used in eligible clinician measures. We include both sets because the measure evaluates care at the point of discharge and our goal here is to ensure that we're aligning with the CDC guidelines and not applying this measure to patients receiving Palliative or Hospice Care. Like the cancer value set, the Palliative or Hospice Care set was used in the 2022 version of the measure and has only had the standard Annual Updates.

00:26:20

The next three Value Sets identify patients for exclusion at the point of discharge using discharge disposition codes. The Hospice Care referral or admission is another way to identify patients who should be excluded on the basis of Hospice Care. But at the point of discharge, using SNOMED codes that identify patients referred to discharge to and admitted to Hospice Care.

00:26:44

Discharge to Acute Care Facility contains SNOMED codes and is used to exclude patients discharged to a short-term acute care hospital, including a specialty hospital. Again, this is because the CDC guidelines are intended to apply to patients in an outpatient setting and would not apply to patients being transferred to another Acute Care Facility.

00:27:06

Our final value set on the slide; patient expired is a single SNOMED code that's used to identify patient who's expired. This code is to help hospitals whose workflow does not automatically discontinue medication upon a patient's death.

00:27:26

For 2023, we added two new Value Sets used to identify patients receiving Palliative or Hospice Care during an emergency department visit or observation stay immediately prior to being admitted to a relevant inpatient stay. These two encounter sets are only used with the Palliative or Hospice Care value set that we saw in the last slide. We do not use any other ED or observation data in the measure. These sets are used to help us appropriately exclude patients who received Palliative or Hospice Care just before their inpatient stay. We'll go into more detail on that when we review the exclusion logic in just a few slides.

00:28:08

Here in the Numerator, I just want to emphasize that two of the Value Sets we used to define the initial patient population are also the same Value Sets used to define the Numerator. Schedule II and III opioid medications and Schedule IV benzodiazepines. To be in the Denominator, a patient only needs to have one of these medications that discharge. To be in the Numerator, a patient must have two or more medications from Schedule II and III opioid list or one medication from Schedule II and III opioid list and one medication from the Schedule IV benzo list.

00:28:40

So how does the change to the opioid value set affect the Numerator? In 2022, if a patient was discharged with a combination of buprenorphine, naloxone medication and a benzo, that patient would be in the Numerator.

00:28:56

In 2023, if a patient is discharged with the same medications So one buprenorphine, naloxone and one benzo, the patient will be in the Denominator but not in the Numerator. And just as a reminder, a lower score is indicative of higher quality care. As of 2023, the measure essentially no longer sees buprenorphine naloxone combination medications.

00:29:26

So, this is the logic for the Initial Population which is represented by the clinical quality language or CQL and the data quality model QDM data elements used to create the logical expression for the Initial Population, population criteria. This definition has no changes between the 2022 and 2023 reporting period. However, we will talk about a cosmetic change in a nested definition in the next slide, a term that helps define inpatient encounters.

00:30:03

The logic in this definition is represented by the narrative statement in the header for inpatient encounters with an opioid or benzodiazepine at discharge. And has not changed since 2022. The purpose of this logic is to capture inpatient hospitalizations so inpatient stays 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 then filtering those encounters to include only patients with new or continuing opioid or benzodiazepine prescriptions at discharge.

00:30:41

The inpatient encounters with an opioid or benzodiazepine it discharge definition also contains another, hold it here, definition within it. Inpatient encounter with age greater than or equal to 18. The definitions in the logic can be found in the definition list under population criteria in the measure specifications. The inpatient encounter logic has one change to increase readability, but does not change how the measure is calculated, and we'll review that change on the next slide.

00:31:15

Once we're looking at only the eligible inpatient encounters, the term “With” indicates that the inpatient stay must also be associated with the medication from the Schedule II and III opioid medication list, or as indicated by the term “union”, a medication from the Schedule IV benzodiazepines list. The final section of logic indicates that the medication at the patients discharge from an inpatient stay from either the Schedule II and III Opioids medication list or from the Schedule IV benzodiazepine list. Here we've pulled it Schedule II and three opioid medications as a reminder that we've removed combination 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 the buprenorphine naloxone combination medication and a methadone prescription will be included in the measures Initial Population.

00:32:23

This is the logic that defines an inpatient stay where patients are 18 years or older at the start of the relevant encounter. We use the global definition global inpatient encounter, which defines an inpatient stay of 120 days or less, and then clarify that the patient must be at least 18 years at the start of the encounter listed here as the start of the inpatient hospital encounter relevant period. Age in years listed emboldened Red is a change from the function GlobalCalendarAgeInYearsAt used in 2022.

00:32:59

Our purpose is to harmonize across measures, to take advantage of existing or native CQL features such as the age in years function, and to make it easier for folks to read. Using this function also makes it easier for each our vendors to implement as a result of this change the LOINC code, 21112-8, which represents birth date, is no longer required. And so, we've removed it from the terminology section of the human readable specification which we discussed earlier. This is what is known as a global change, which means you'll see it across several measures this year. But this change does not impact how the measures calculated.

00:33:44

In this measure, the measure Denominator does not add any new criteria to the Initial Population, as simply returns the same value as the Initial Population, and this hasn't changed from the 2022 reporting period.

00:34:01

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 facility. This slide shows the same exclusions present in both 2022 and 2023. The cancer exclusion has not changed at all from the 2022 reporting version. The measure excludes patients with cancer that exist during the patient 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 that the diagnosis remains active. This is how we make sure we are only applying this exclusion to people with active cancer and not folks who are in remission.

00:34:56

We also continue to exclude patients with an order for Palliative or Hospice Care and patients who are receiving Hospice or Palliative care during their inpatient stay. Although the red text shows us that the logic around this exclusion has changed to harmonize with other hospital measures by also reviewing 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. They’re both terms used the same value set Palliative or Hospice Care.

00:35:32

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 hospitalization with observation. Global hospitalization with observation 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'll look at this nested definition on the next slide.

00:36:06

Coalesce allows us to check relevant date time, relevant period, or author date time to look for the positive result for Hospice Palliative care. If it's not present, it means you exclusion was not met and therefore the hospitalization would be retained in the Denominator eligible population. Again, the purpose here is to align with CDC guidelines, which are not intended for patients at the point of Hospice or Palliative care. The Palliative or Hospice Care grouping value set includes orders and services for comfort measures, Palliative and Hospice Care and aligns with several EC measures that exclude patients receiving Palliative or end of life care.

00:36:53

So how does the global hospitalization with observation function work? You can find the detailed explanation under the function section of the measure logic. Let's start with two repeating sections of the logic within this function. The first section identifies any relevant observation stays, as shown by let ObsVisit. The second section is for emergency department stays and begins with ed visit. Even though the function is called Global.HospitalizationWitOservation it includes both observation stays and ED visits. And this is where we get to use the new observation and ED encounter Value Sets to identify these types of visits. I've also highlighted in red text the relevant time period.

00:37:41

The observation stay or ED visit must end one hour or less before the patient begins their inpatient stay. If a patient is in the ED and checks out at 10:00 PM on Thursday, then comes back and is admitted to inpatient at 1:00 PM on Friday, we would not look at any Hospice or Palliative care given during that Thursday ED visit. If a patient stem spends 3 days under observation and is transferred from observation directly to inpatient. Then we would look for Palliative and Hospice Care during both inpatient and the entire observation stay. Only the time between discharge from observation or ED to inpatient admittance matter here, and it's worth remembering that we're only using this function to look for Palliative or Hospice Care. We do not need any other data from the ED or observation stay.

00:38:39

As you can see, these three exclusions are all the same as 2022. I'll use the attribute patient encounter, discharge disposition. All of these exclusions look at the discharge disposition codes of the relevant inpatient stay to appropriately exclude patients in any of the three following links.

00:39:01

Discharge to an Acute Care Facility. I mentioned earlier that CDC guidelines for prescribing Opioids are intended to apply in an outpatient setting. That's why the measure looks at medication upon discharge as opposed to during the inpatient stay.

00:39:16

Second, patients discharged to Hospice Care. This exclusion is just another, hopefully more convenient way to identify and exclude patients who would be receiving Palliative or Hospice Care. In this case, my apologies, just Hospice Care at the point of discharge.

00:39:34

And three, patients who expire during their inpatient stay. Some hospitals don't automatically discontinue medication in the patient record when a patient expires, and stakeholders brought this to our attention as a potential challenge for implementation. We added this exclusion to reduce burden on implementers since the guidelines clearly do not apply.

00:39:58

Overall, these exclusions are intended to reduce burden and to more closely aligned with the CDC guideline that provides recommendations for patients in an outpatient setting and which note that these guidelines are not for patients in active cancer treatment, relative care, and end of life care.

00:40:20

The Numerator logic depicts inpatient hospitalizations, in which a patient is prescribed or continuing to take two or more distinct Opioids or an opioid and a benzodiazepine discharge. This logic is exactly the same in both 2022 and 2023 reporting period. I've bolded the two embedded definitions that have updates we've already covered. So that includes the inpatient encounters with an opioid or benzodiazepine at discharge while working the same uses a streamlined CQL function. And let's Schedule II and III opioid medication value set which no longer includes buprenorphine naloxone combination medications.

00:41:03

We'll start at the top, where you can see the part of the Numerator definition that this section of the logic speaks to. We're focusing on patients who meet the Numerator because 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 logic statement. As well as the QDM data element medication discharge. And the Schedule II and III opioid medication one of the same Value Sets that we use to define the Initial Population. So, if an opioid prescription got the patient into the Denominator, it can also count towards the Numerator.

00:41:45

The first where indicates the patient encounter needs to have this condition in the second clause. The second clause says that we need to have a count of what we need to have so an inpatient encounter where and here's that second, where to filter encounters the count of opioids in the discharge list is greater than or equal to two. The change for the 2022 reporting year specifies that these need to be separate opioid RXNorm codes. So, for example, a 12-hour oxycodone hydrochloride 10 milligram extended-release oral tablet which is an RXNorm code of 1049502. And a 12-hour oxycodone hydrochloride 15 milligram extended-release oral tablet which has a different RXNorm code of 1049543. Have different opioid codes. If a patient were prescribed both of these medications that discharge, they would be in the Numerator. However, if a patient had the ten milligram tablet with instructions to take a 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 records more than once, inadvertently triggering the Numerator.

00:43:19

So, the addition of distinct opioid codes is meant to help avoid incorrectly triggering Numerator. And thanks to the count function of greater than or equal to two, we're looking at a list of patients who have at least two active opioid prescriptions. And again. Our timing word during indicates that the opioids from the discharge medication list must be recorded in the HER during the relevant patient inpatient encounter.

00:43:50

In the second clause of the Numerator, starting at the top of the slide, we see the Union again between two lists, one listing opioids on the medication discharge list on the last slide and the next one we're about to define an opioid and benzodiazepine at discharge. If either condition of the two lists met noted by the Union. If either condition of the two lists noted by the Union are met, the Numerator is met. So, this section of the logic defines how we identify a patient prescribed an opioid and benzodiazepine at discharge. Like the last list, we start with an 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 benzodiazepine at discharge. For both filters, we use the terms such that enduring to add the conditions 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 the medication discharged QDM term again, listing ongoing and new prescriptions existing at the time of the patient's discharge and referring back to the value set Schedule IV benzodiazepines also used to define the Initial Population. The difference here is that the Numerator requires that the benzodiazepine must be concurrent with an opioid prescription. Again, there are no changes to the Numerator logic in 2023. The only thing to be aware of, are the updates to the embedded definitions which should have already been applied to the initial patient population.

00:45:37

Now that we've reviewed the detailed logic for 2023, let's circle back to the measure flow diagram that we briefly looked at earlier while on the eCQI Resource Center. The purpose of the measure flow diagrams is to highlight relevant data criteria and are organized to help keep 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. 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 flow for the measures.

00:46:31

Let's start with the Initial Population. The measure flow diagram defines and summarizes the Initial Population logic on the left-hand side of the page. On the right-hand side of the page shows the embedded logical definition associated with the population name. For example. Inpatient encounters with an opioid or benzodiazepine is the definition to 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 Population criteria is not met, processing ends. If Initial Population is met, the encounter, is in the Initial Population. Note yes indicates, continued to page 2.

00:47:25

We've split up the second page of the flow diagram to show only the Denominator here. 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. This is why we don't see any steps or logic between the Initial Population and Denominator.

00:47:50

Once we confirm that an encounter should be in the Denominator, we check for encounter, or we check for Denominator Exclusions. Here we can see that if a patient during the relevant encounter has cancer receives Palliative or Hospice Care, whereas discharge to Hospice Short Term Acute Care or dies encounter meets the Denominator Exclusion. If any of these conditions apply, then we should 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.

00:48:29

Finally, all patient encounters in the Denominator that do not fall into Denominator Exclusion or 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 and encounter where patient is discharged with an opioid and benzodiazepine. An encounter may fall into either population to meet the Numerator criteria. If a population or an encounter does not meet the Numerator criteria at this point, it is only counted in the Denominator population.

00:49:10

Here are the sample calculation 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. Twenty Numerator encounters divided by 90 Denominator encounters results in a Performance Rate of 22%. And in this measure, a lower score indicates higher quality care.

00:49:40

So, to wrap things up, I want to touch on some of the changes that we have in the 2023 version of the measure compared to the 2022 version.

00:49:52

First, there are no substantive changes to the initial patient population Denominator or Numerator logic. We've made a change to increase readability related to the patient's age, which also means we no longer need the LOINC code for birth date.

Second, we removed all buprenorphine naloxone combination medications from the value set Schedule II and III opioid medications, which is used to determine the Initial Population and the Numerator.

00:50:24

And third, we've updated the Palliative and Hospice exclusions to exclude patients who receive Palliative or Hospice services while in an emergency room encounter or observation state immediately prior to being admitted to inpatient. By immediately prior we mean that the patients ER or observation stay ends within an hour of their admittance to the relevant inpatient stay. And as a final reminder first, we understand that there may be some clinically appropriate times for patient to be prescribed to unique opioids or an opioid benzodiazepine. And we don't expect this measure to have a Numerator of 0. One goal of the measure is to identify these patients, especially because we know they're at higher risk for respiratory depression.

00:51:12

The Denominator includes patients discharged from an inpatient stay with at least one opioid or one benzodiazepine, whether it's a new or continuing prescription. For example, this would include patients discharged within seven days of opioids after 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 2022 reporting period.

00:51:44

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 that 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 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 naloxone medication. In that case, only the benzodiazepine would count towards the measure and the patient would be in the Denominator.

00:52:34

And now we will move to some of our most Frequently Asked Questions. We've received questions about whether orders for consultations for Palliative or Hospice Care count as an exclusion. To align with the guidance given by another hospital measure team for measure STK-5 or CMS72 that comfort measures consultant, that comfort measure consultations can also be used for exclusion. We will also consider consultations as exclusions for patients in the Safe Use of Opioids measure. Our purpose is to exclude patients who are receiving or will at discharge be receiving Palliative or Hospice Care. This also means that if a non-clinician such as a social worker, documents Palliative or Hospice Care that overlaps with the patient's day and a hospital can regularly document this in the EHR, those services can be mapped to the appropriate Palliative or Hospice Care code under the intervention performed and the patient should be excluded from the measure. Now, these orders and services that occur in an ED visit or observation state immediately prior to the inpatient stay can also be used to an exclude a patient from the measure. These exclusions align with the CDC guidelines that provide recommendations for primary care clinicians who are prescribing Opioids for chronic pain and which note that these guidelines are not for patients in active cancer treatment, Palliative Care and End of Life Care.

00:54:08

This slide may look familiar to those who saw last year's presentation, but the concept is tricky enough that it bears repeating. To give you some context on whether an RXNorm. Will have a different code for medication. If you are talking about two types of opioids such as morphine and hydrocodone RXNorm codes for these medications will be different. If the dose of the active ingredient is different, such as in the example in the slide, the RXNorm code will be different. 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. If any additional components beyond active ingredients are different. The RXNorm code will also be different.

00:54:58

So, when are RXNorm codes not going to differ? The codes don't distinguish based on dosing instructions given to patients. 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 RX code won't distinguish between the two.

00:55:28

We've gotten several questions asking us to clarify the exclusion for patients discharge 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 included patients discharge to long term care and acute rehab facilities when it was reviewed by experts, receive National Quality Forum endorsement and went through public comment. So that said, we are currently evaluating whether a patient discharges to other care facilities, should be excluded from the measure.

00:56:14

We've also had several people ask if there's a CMS benchmark for the Safe Use of Opioids. This measure does not currently have a benchmark. We also want to emphasize that we don't expect hospitals to score 0 on the measure. We understand that there may be some clinically appropriate times for patient to be prescribed to unique opioids or an opioid and benzodiazepine and we don't expect this measure to have a Numerator of 0. Again, one of the goals of this measure is to identify these patients, especially because we know they're at higher risk for respiratory depression.

And the next couple slides have a few resources that we hope will be useful to you.

00:56:57

So, these are references that were used in the slide describing the rationale for this measure. And here we have helpful links such as to the eCQI Resource Center, a little bit more general than you'll see on the next slide, and the Value Set Authority Center, also known as VSAC. So, the eCQI Resource Center has the measure specifications, information on CQL and QDM's, and a platform to ask questions about the measure. The VSAC contains the specific codes for the Value Sets used in the measure.

And with that, I am going to turn it over to Susan.

00:57:38

Theresa, thanks so much for your great presentation. So, umm this... I'm sorry, we're getting a little feedback from someone's speaker. I think Theresa, you might need to mute yourself before I go. OK.

00:57:56

So, the additional resources slide here, it has some additional links to take you out to the Eligible Hospitals measures page, the Teach Me Clinical Quality Language video series, Pioneers in Quality landing page, Expert to Expert webinar series landing page in the ONC Issue Tracking System and that's where the clinical and technical questions about these eCQM should be submitted. So, if we don't get to your question today and you don't want to wait several weeks for the question and answer document and the written follow up document to be released, you can go to this link and submit your question regarding the eCQM there. And with that, if you can go to the next slide Theresa, we'll open up the Q&A segment.

00:58:42

As a reminder, please submit questions via your question pane. Click on the Question Mark icon in the Audience Toolbar, a panel will open for you to type and submit your questions include a slide reference number if that's possible and all questions not answered verbally during the live event will be addressed via a written follow up Q&A document. And I just mentioned that a moment ago. That follow up document will be posted on The Joint Commission website several weeks after the live event. And with that, I'll turn things over to Susan Yendro and Marilyn Parenzan to do the facilitation on the Q&A segment. Thank you.

00:59:22

First, our apologies for the slides not being present in the icon on the... on the toolbar. We did put the link to the slides in the chat, so please do find them there.

00:59:37

So, the first question, we did receive some questions in advance of the webinar and so those are kind of sprinkled in with some of the live questions that we're receiving today. Iust to reiterate, this question is asking about the benchmarks and if they exist, what are they? And as Theresa just mentioned, the Safe Use of Opioids does not yet have a benchmarks at this time.

Thank you. OK. Next question,

01:00:02

"What are the current guidelines for prescribing opioids for surgery and chronic care needs?"

We would refer you to the Safe Use of Opioids, which is based on the CDC clinical practice guideline for prescribing opioids for pain with the date of 2022. OK.

01:00:25

The next question is regarding discharge disposition of other facility, in this case a drug and alcohol inpatient rehab unit. Would that be excluded for this measure?

And the answer is no, only discharge to Hospice, Short Term Acute Care, and discharge to due to death would be qualified as a patient encounter for Denominator Exclusion in the Safe Use of Opioids measure.

OK. Next question,

01:00:53

"If there's documentation of plan taper for transitioning addiction treatment, can the measure be revised to reflect this?"

We do thank you for that suggestion, but we are not currently planning to include documentation of planned taper in the measure. Please note that probably going to mess this up word up, buprenorphine/naloxone medications, are not included in the measure.

Thank you. Good job Marilyn.

01:01:28

"So sometimes the measure specifications do not match the measure CQL exactly when this happens, which should we refer to? The measure specifications or the measure CQL?"

The logic is the source of truth. Thank you.

01:01:47

OK. “Does Concurrent Prescribing count toward the hospital score if there are routine home medications that are continued to discharge?”

Yes, routine home medications counted it discharge count towards the Safe Use of Opioids. Hospital score.

OK. The next question asks,

01:02:08

"Does measure, does the measure include encounters that are not billed as inpatient if brief inpatient status is changed before discharge?"

So, the answer is that you should please use the value set encounter inpatient, to see if an encounter qualifies for the measure. If any of the codes on this value set are applied to the encounter and a patient is discharged with at least one opioid or benzodiazepine, you should include encounter in the Safe Use of Opioids measure.

01:02:47

OK. And Theresa touched on this question in her presentation, but I'll repeat it.

01:02:53

"If the same opioid is bordered in two different dosages, is that counted as one or two Opioids at discharge?"

So, if the dosages have different RXNorm codes, the medication should be treated as distinct and would be 2 opioids at discharge?

OK, this is another one that's frequently asked about is,

01:03:19

"If there is a consult for Hospice Palliative Care, CMO, but the patient chose not to accept. Are these examples of qualifiers?"

And the answer is a consultation for Hospice or Palliative care would qualify and encounter for Denominator Exclusion even if the patient does not accept Hospice or Palliative Care.

01:03:49

OK. "If the patient is an inpatient and post total joint replacement and discharge to home on an opioid, home medications include benzo continued at discharge, how can we achieve compliance?"

01:04:04

So, the measure is intended to have clinicians carefully evaluate whether a patient should be discharged with two or more opioids or an opioid in a benzodiazepine and to discourage Concurrent Prescribing unless clinically appropriate. Please note that we do not expect hospitals to have a score of 0.

Great. Thanks.

01:04:28

So, the next question, "Is there any plan to allow an exception for patients with specific chronic diseases documented like chronic pain or the like?"

01:04:39

And the answer is we are currently considering excluding encounters in which a patient has a sickle cell disease or sickle cell crisis diagnosis, but do not plan to exclude patients diagnosed with chronic pain generally.

OK. This next question has a lengthy answer, but I think it's important. So, I'm going to go ahead and share it.

01:05:04

“It is difficult for hospitals to adjust patients, chronic benzodiazepines on a short hospital visit strategies would be helpful.”

01:05:14

And the response to that is to Please note that the 2022 CDC guidelines for prescribing opioids recommend against abrupt tapering of benzodiazepines. The guidelines do recommend in patients receiving opioids and benzos long-term, clinician should carefully weigh the benefits and risk of continuing therapy with opioids and benzos and discuss with patients and other members of the patients care team. Risk of concurrent opioid and benzo use are likely to be greater with unpredictable use of either medication with use of higher dosage opioids and higher dosage benzos, in combination or with use with other substances, including alcohol.

01:06:06

In specific situations, benzos can be beneficial, in stopping benzos can be destabilizing. Clinicians should taper benzos gradually before discontinuation because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and rarely death. The rate of tapering should be individualized if benzo prescribed for anxiety are tapered or discontinued. Or if patients receiving opioids require treatment for anxiety, evidence-based psychotherapies, specific antidepressants or other non-benzo medications approved for anxiety, or both should be offered. Thank you.

01:06:57

OK. So, I'm going to skip a little bit. We have about 5 minutes left for questions to find some that are a little bit different. This question is

01:07:03

"What elements of our current Numerator should or could be excluded from the cases altogether that may not be currently?"

01:07:14

So, the answer to that is that the Safe Use of Opioids measure does not have any Numerator exceptions at this time.

01:07:25

OK, "In general, do we eCQMs pull data from the specified visit or is it supposed to pull data from previous encounters?"

01:07:35

And the answer to that is it really depends on how the logic is written eCQMs can pull data from previous encounters, as well as the the current encounter, especially if you're looking for history of diagnosis.

01:07:56

OK. Getting lots of questions about the discharge to facilities and about sickle cell. There's a question here is,

01:08:07

"Where is the list of Schedule II and III Opioids and Schedule IV for benzos found?"

So, the Schedule II and III opioid medications and Schedule IV benzodiazepine Value Sets are all located within the value set, the VSAC repository.

01:08:25

Thank you. OK. "Should observation be included in the initial patient population?"

01:08:35

The measure only assesses for these medications in inpatient hospitalization, since observation is an outpatient typing encounter and is not included.

OK. "Would a patient who leaves against medical advice without a discharge order count into the Numerator?"

01:09:05

The answer is that the initial patient population Denominator assess for opioid or benzodiazepine at discharge, medication at discharge, Schedule II and III opioid medications and does not assess for discharge disposition. So, if the patient had either an opioid or a benzodiazepine at discharge, the patient would be included in the initial patient population.

01:09:32

OK, someone asked, "Where can I find the RXNorm codes?"

Those can be found on the VSAC, which I believe was included on the resources slide that Theresa presented. That's VSAC.nlm.nih.gov.

01:09:59

So, this question asks, "So ED only patients are not included in the encounter?"

And the answer is that emergency department encounters are not evaluated in the initial patient population.

01:10:19

OK. All right. "Is methadone for detoxification being considered as an exception to this measure?"

Similarly, to the morphine naloxone similar question, I think I are we answered previously. Methadone is included in the Schedule II and in III opioid medications grouping value set. Opioids including naloxone are not included in these Value Sets.

OK. And here's another question about discharging patients.

01:10:56

"So, to clarify patients with Opioids or benzodiazepine during hospital encounter? To be excluded from the Numerator if discharge to a SNIFF or acute care rehab, for example an 80-year-old post-op THR."

So, the answer is that the Numerator assesses for patients discharged on an opioid or benzodiazepine where the patient was discharged to does not come into play here.

01:11:29

OK. And someone asked for clarification.

01:11:32

"So, if the patient is in the emergency room only patient, they are not included as an encounter?"

That is correct. Emergency Department encounters are not evaluated in the Initial Population.

01:11:48

OK. And we received a number of questions about CE certificates.

01:11:53

And so, with that I will turn it back over to Susan Funk, she'll give you the answer to that and a few other wrap up details. We thank you all for your great questions.

Thanks Marilyn and Susan. Theresa, if you can go to the next slide, great.

01:12:10

The webinar recording will be available at the slide listed on this or the link listed on this slide.

01:12:22

So, the the Expert to Expert Annual Update webinars started back in August of 2022 for the 2023 Annual Updates, and we covered the Stroke PC measures, ED, VTE, Glycemia measures and we're concluding this series with the Safe Use of Opioids eCQM today.

01:12:43

If you missed any of those other webinars, we are continuing to post all of the recordings and the materials. The follow up document, the transcript, the slide decks all are able to be found at the link on this slide.

01:13:01

Before the session concludes, just a few comments about the CE survey. We use your feedback to inform future content and assess the quality of our educational programs. Tomorrow an automated e-mail sent will be sent to the participants e-mail address that you used to register and that will include your survey link. 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 CE certificate. An automated e-mail will also be sent to you that includes. Link to a printable and downloadable PDF CE certificate.

01:13:38

Thank you, everyone for joining us. Theresa, thank you for your presentation and Susan and Marilyn for facilitating the Q&A segment and the content experts that we had in the background answering the submitted questions. Most importantly, thanks to all of you that attended and have a great day.

Questions and Answers
Expert to Expert Webinar – 2023 Annual Updates for the Safe Use of Opioids – Concurrent Prescribing eCQM

Broadcast February 16, 2023

Question Asked	Answer Given
Medication	
Does concurrent prescribing "count" toward the hospital score if these are routine home medications that are continued at discharge?	Yes, routine home medications continued at discharge count towards the Safe Use of Opioids hospital score.
Buprenorphone/naloxene is only removed for 2023 reporting year? and not for 2022?	Yes, buprenorphone/naloxene combination medication is removed from the measure beginning in the 2023 reporting year.
Where can I find the RXNorm codes?	This can be found in the downloadable resources on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov. A free UMLS user account is required to download the value set and coding files from the 'Download' tab.
Where is the list of schedule II and III opioids and schedule IV benzos found?	Schedule II & III Opioids Medications and Schedule IV Benzodiazepines value sets are in the VSAC repository. They can be found in the downloadable resources on the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov. A free UMLS user account is required to download the value set and coding files from the 'Download' tab.
So, if a patient is discharged on the two same medications as admission they are excluded?	The measure assesses for 2 or more opioids or 1 opioid and 1 benzodiazepine at discharge. If a patient is discharged with 2 or more distinct opioids or an opioid and benzodiazepine, the encounter is in the numerator, regardless of whether the medications are new or continuing home medications the patient was on at admission.
Why do specs say count DISTINCT Opioid codes? What if 2+ Medication data elements w/same code exist, each with different dates?	Opioids with the same RXNorm code are not considered distinct and will count as one opioid in the measure.
If the same opioid is ordered in 2 different dosages, is that counted as 1 or 2 opioids at discharge?	If the two dosages have different RXNorm codes, the medications should be treated as distinct, and would be two opioids at discharge.
What if one medication is extended release and the other is not but they are the same drug and dosage?	Since extended release and immediate release medications would have different components, the RXNorm codes should be different, and, therefore, count as two distinct opioid medications.

Question Asked	Answer Given
Same opioid dosage, 2 orders one every 8 hrs and other every 4 hrs. Is this considered 2 opioids prescribed?	Only if the medication is distinct, meaning that it has different RXNorm codes, would opioids be considered two prescriptions. The same prescription with different dosing instructions, such as "take every 8 hours" compared to "take every 4 hours", would not be considered distinct opioids.
When an exact medication concentration or route is not provided, should we use one of the general RX Norms for the same med in the value set?	Please use the most specific RXNorm code you can that is available from "Schedule IV Benzodiazepines" (OID: 2.16.840.1.113762.1.4.1125.1) or "Schedule II & III Opioid Medications" (OID: 2.16.840.1.113762.1.4.1111.165).
Denominator	
Should Observation be included in the IPP?	The measure only assesses for these medications in inpatient hospitalizations since Observation is an outpatient type encounter, it is not included.
So, ED only patients are not included as an encounter?	Emergency department encounters are not evaluated in the initial population.
Would a patient who leaves Against Medical Advice without a Discharge order count into the denominator?	The initial population/ denominator assesses for an opioid or benzodiazepine at discharge (Medication Discharge: "Schedule II & III Opioid Medications" and does not assess for discharge disposition, so if the patient had either an opioid or benzodiazepine at discharge, the patient would be included in the initial population.
Would a patient who leaves Against Medical Advice without a Discharge order count into the denominator?	The initial population/ denominator assesses for an opioid or benzodiazepine at discharge (Medication Discharge: "Schedule II & III Opioid Medications" and does not assess for discharge disposition, so if the patient had either an opioid or benzodiazepine at discharge, the patient would be included in the initial population.
Are BH IP facility patients excluded in CMS506 measure?	Although BH IP facility patients are not specifically excluded from the measure, the measure is only implemented in the Inpatient Quality Reporting program for hospital encounters of 120 days or less. Please use the value set "Encounter Inpatient" (OID: 2.16.840.1.113883.3.666.5.307) to identify eligible encounters.
We have ED Hold patients in observation and inpatient status. Would these patients be included?	Patients with an encounter code from the value set "Encounter Inpatient" (OID: 2.16.840.1.113883.3.666.5.307) should be included in the measure. This should only be inpatient encounters, not ED or observation stay encounters.
Do observation visits count?	The measure assesses for inpatient hospitalizations that end during the measurement period, are equal to or less than 120 days. Outpatient encounters like Observation are not considered in the initial population.

Question Asked	Answer Given
Does the measure include encounters that are not billed as inpatients if brief inpt status is changed before discharge.	Please use the value set "Encounter Inpatient" (OID: 2.16.840.1.113883.3.666.5.307) to see if an encounter qualifies for the measure. If any of the codes in this value set are applied to the encounter, and a patient is discharged with at least one opioid or benzodiazepine, you should include the encounter in the Safe Use of Opioids measure.
Denominator exclusions	
Does primary or secondary cancer need to be a final coded diagnosis, or can it also be present on a problem list?	The measure does not require the cancer diagnosis code to be final and yes, the cancer diagnosis may be found in a problem list.
Is there consideration to include sickle cell disease crisis (pain crisis) as an exclusion for this measure?	We are currently considering excluding encounters in which a patient has a sickle cell disease or sickle cell crisis diagnosis.
Can sickle cell patients be considered for exclusion? They are often on multiple pain medications due to their conditions	While the measure does not exclude sickle cell patients from the measure, we are currently considering excluding sickle cell patients.
Isn't "hospice care referral or admission" one of the exclusions? i see not listed in the slide.	Patients receiving palliative or hospice care are excluded using the Palliative and Hospice Care grouping value set, a grouping harmonized with other eCQMs.
If there is a consult for hospice, palliative care, CMO but the patient chose not to accept, is these examples of qualifiers?	A consultation for hospice or palliative care would qualify an encounter for denominator exclusion, even if the patient does not accept hospice or palliative care.
How about SNF and long-term care facility?	Patients discharged to SNF, and long-term care facilities are included in the measure. These encounters do not qualify for denominator exclusion.
Are patients discharged to a Rehab facility or Skilled Nursing Facility excluded?	No, patients discharged to Rehab facilities or skilled nursing facilities are included in the measure.
For denominator exclusions discharge to an "acute care facility" only or discharged to another inpatient care facility as per eCQI specification?	The value set "Discharge to Acute Care Facility" (OID: (2.16.840.1.113883.3.117.1.7.1.87) contains SNOMED CT codes and is used to capture a discharge disposition to exclude patients discharged to a short-term acute care hospital, including a specialty hospital.

Question Asked	Answer Given
Discharge disposition of "Other Facility" in this case, a drug and alcohol inpatient rehab unit, be excluded for this measure?	No, only discharge to hospice, short-term acute care, and discharge due to death would qualify a patient encounter for denominator exclusion in the Safe Use of Opioids measure.
Why are patients discharged to Rehab not excluded? Their medication orders are being managed by a provider at this time and they probably will discharge home with different med orders.	CMS506 was originally tested and endorsed without excluding patients to rehab, but we appreciate your suggestion and will consider it for future iterations of the measure.
If the measure can assess for discharge to inpatient facility, why can't it assess for patients who leave AMA and be excluded from the denominator?	Thank you for your question related to excluding encounters in which patients leave against medical advice ending in (AMA). We are currently considering excluding AMA in future iterations of the measure.
Are they excluded if on the same two meds at discharge as on admission	Patients with only one opioid or benzodiazepine at discharge are in the CMS506 denominator. Patients with two or more distinct opioids, or an opioid and benzodiazepine, are in the numerator, regardless of whether the two medications were continued or newly prescribed at discharge. None of the denominator exclusions are related to a patient being discharged with one or more opioid.
Are there exclusions for post-surgical patients who are already on a benzodiazepine as a home med and prescribed an opioid at discharge for post op pain?	There are no exclusions for post-surgical patients.
Are discharges to Inpatient Psychiatric Facilities and Inpatient Rehabilitation Facilities under consideration for exclusion criteria?	The current guidance is that only discharges to short-term acute care hospitals would qualify for a denominator exclusion under "Discharge To Acute Care Facility" (2.16.840.1.113883.3.117.1.7.1.87). We are currently reviewing guidance related to what may be mapped to codes in the "Discharge To Acute Care Facility" (2.16.840.1.113883.3.117.1.7.1.87) valueset.
Is methadone for detoxification being considered as an exception to this measure, similarly to buprenorphine/naloxone?	Methadone is included in the value set "Scheduled II and & III Opioid Medications" (OID: 2.16.840.1.113762.1.4.1111.165) grouping value set. Opioids including naloxone are not included in these value sets. We are currently assessing if and how patients prescribed medically assisted treatment for opioid use disorder should be excluded from the measure.

Question Asked	Answer Given
We have patients that are discharged to skilled nursing facilities on comfort measures. These SNF have hospice care come in for these patients even though they are not considered hospice facility. How can we get these patients excluded?	To exclude patients receiving hospice or palliative care, the encounter would need to have a hospice referral, consult, or services recorded in the EHR and mapped to a value in the value set "Palliative or Hospice Care" (OID: 2.16.840.1.113883.3.600.1.1579) or value set "Hospice Care Referral or Admission" (OID: 2.16.840.1.113762.1.4.1116.365)
Is there any plan to allow exclusions for patients with specific Chronic Diseases documented? Like Chronic Pain, etc.	We are currently considering excluding encounters in which a patient has a sickle cell disease or sickle cell crisis diagnosis, but do not plan to exclude patients diagnosed with chronic pain, generally.
Will there be more exclusions added in the future?	We are currently considering additional exclusions, such as a diagnosis of sickle cell disease, for future iterations of the measure.
Numerator	
To clarify, patients with opioid, or benzodiazepine during hospital encounter, be excluded from the numerator if discharged to SNF and/or acute rehab (i.e.) 80 y/o post op THR.	The numerator assesses for patients discharged on an opioid(s) and/or benzodiazepines where the patient was discharged to does not come in to play here.
What elements of our current numerator should or could be excluded from the cases all together, that may not be currently?	Safe Use of Opioids does not have any numerator exclusions exceptions.
If patient comes into the hospital on 2 opioids or 1 opioids and 1 benzo and medications are continued at discharge this will be considered a numerator/fall out. Correct?	Yes, this encounter would be a numerator hit.

Question Asked	Answer Given
At discharge, providers are required to order certain opioids in 2 different orders: 2 doses i.e., 5mg for mild pain, 10 mg for moderate pain. Our filters are including these patients as meeting the numerator which we believe is causing our numbers to be falsely high. Is this a common issue?	Patients prescribed two different opioid medications at discharge, such as a 5mg pill and a 10mg pill, would be in the measure numerator. Patients given instructions to take one 5mg pill for mild pain and two 5mg pills (adding to 10 mg) for moderate pain are not considered as having prescriptions for two distinct opioids and would not be in the numerator.
Benchmarks and improving a score	
Inpatient is post total joint replacement & DC home on opioid. Home med benzo continued at DC. How can we achieve compliance?	The measure is intended to have clinicians carefully evaluate whether a patient should be discharged with two or more opioids or an opioid and benzodiazepine, and to discourage concurrent prescribing unless clinically appropriate. Please note that we do not expect hospitals to have a score of zero on the measure.
What are the current guidelines for prescribing and opioids for surgery and chronic care needs?	Safe Use of Opioids is based on the CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022
Do benchmarks exist yet? If so, what are they?	Safe Use of Opioids does not have benchmarks at this time.

Question Asked	Answer Given
It is difficult for hospitals to adjust patient's chronic benzodiazepines on a short hospital visit. Strategies would be helpful.	Please note that the 2022 CDC guidelines for prescribing opioids recommend against abrupt tapering of benzodiazepines. The guidelines do recommend "In patients receiving opioids and benzodiazepines long term, clinicians should carefully weigh the benefits and risks of continuing therapy with opioids and benzodiazepines and discuss with patients and other members of the patient's care team. Risks of concurrent opioid and benzodiazepine use are likely to be greater with unpredictable use of either medication, with use of higher-dosage opioids and higher-dosage benzodiazepines in combination, or with use with other substances including alcohol (compared with long-term, stable use of lower-dosage opioids and lower-dosage benzodiazepines without other substances). In specific situations, benzodiazepines can be beneficial, and stopping benzodiazepines can be destabilizing. Clinicians should taper benzodiazepines gradually before discontinuation because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, rarely, death. The rate of tapering should be individualized. If benzodiazepines prescribed for anxiety are tapered or discontinued, or if patients receiving opioids require treatment for anxiety, evidence-based psychotherapies (e.g., cognitive behavioral therapy), specific antidepressants or other nonbenzodiazepine medications approved for anxiety, or both, should be offered.
Miscellaneous	
Documentation of planned taper for transitioning addiction treatment- can measure be revised to reflect this?	Thank you for your suggestion. We are not currently planning to include documentation of planned taper in the measure. Please note that buprenorphine/naloxone medications are not included in the measure.
Sometimes the measure specifications do not match the measure CQL exactly. When this happens, which should we refer to, the measure specification, or the measure CQL?	The logic is the source of truth.

Question Asked	Answer Given
Is there a plan to have a measure like this for outpatient setting? Since majority of opioids and benzos are from home medications. Seems like it would be more beneficial for outpatient settings instead of inpatient.	Thank you for your question. CMS is considering implementing the measure in additional settings.
TJC questions	
Can you make the screen bigger the slides and wording is small? Thank you	The viewer can control the size of the display. You can click the maximize view based on your internet browser.
Can we see the mapping slide one more time please?	You can view it within the slide deck available here: https://jointcommission.az1.qualtrics.com/WRQualtricsControlPanel/File.php?F=F_HAaAA7KKBrQBuil
In general, do eCQMs pull data from the specified visit, or is it supposed to pull data from previous encounters?	Depending on how the logic is written, eCQMs can pull data from previous encounters as well as the current encounter. Each individual eCQM can be written to specify the timeframe for measure criteria.
Is this measure voluntary/ mandatory?	CMS506 is mandatory to report as of the 2022 reporting period.
Will you have a session for Outpt STEMI measure?	This measure is an Outpatient eCQM and falls under a separate CMS support contract. Please check the eCQI Resource Center to see if a webinar or education about this eCQM will be offered.
Are the 2023 changes effective as of 1/1/23?	Yes, CMS506v5 should be used to assess patient encounters as of January 1, 2023.
What is the rationale behind making measure required?	We refer you the FY 2020 IPPS/LTCH PPS final rule (84 FR 42448 through 42459) where CMS adopted the Safe Use of Opioids eCQM into the Hospital IQR Program beginning with the CY 2021 reporting period/FY 2023 payment determination, the FY 2020 IPPS/LTCH PPS final rule (84 FR 42503 through 42505) in which CMS finalized their policy requiring hospitals to report on the Safe Use of Opioids eCQM beginning in the CY 2022 reporting period, and to the FY 2021 IPPS/LTCH PPS final rule in which CMS finalized reporting of the Safe Use of Opioids eCQM as one of the four required eCQMs beginning with the CY 2022 reporting period/FY 2024 payment determination (85 FR 58933 through 58939).