Transcript – Expert to Expert Webinar: Annual Updates for the Safe Use of Opioids – Concurrent Prescribing eCQM for 2026 Reporting Year

Broadcast March 26, 2026

Slide 1 [00:00:00]

[Susan Funk] Welcome and thank you for joining us for this Joint Commission Expert to Expert Webinar addressing the 2026 annual updates for the Safe Use of Opioids - Concurrent Prescribing electronic clinical quality measure. The Expert to Expert Webinar Series is offered in partnership with the Centers for Medicare and Medicaid Services and eCQM Stewards. CE Credit is available for this webinar for the live broadcast attendance only. I'm Susan Funk, Associate Project Director for Engagement and Quality Improvement Programs at the Joint Commission, and today, I'll be serving as this webinar's moderator. Next slide, please.

Slide 2 [00:00:43]

Before we begin with the webinar content, we would like to offer just a few tips about webinar platform functionality. Audio is by voice over internet protocol only – Use your computer speakers or headphones to listen. There are no dial in lines. Participants are connected in listen-only mode. Feedback or dropped audio are common for live streaming events; if you experience such audio or streaming issues, refresh your screen, or leave and rejoin the session. We will not be recognizing the Raise a Hand or Chat features. To ask a question, click on the Question Mark icon in the audience toolbar. A panel will open for you to type your question and submit. The slides are designed to follow Americans with Disabilities Act rules. Next slide, please.

Slide 3 [00:01:41]

Speaking of the slides, they are available now. There are many links provided throughout this webinar, but they are not clickable on screen. By downloading the slides, you'll be able to access the links and also take notes. To access the slides now within the webinar participant navigation pane, select the icon that represents a document. A new pop-up window will open, and you can select the name of the file. A new browser window will open, and from it, you can download or print the PDF of the slides. Slides will also be available within two to three weeks of the webinar on Joint Commission's website at the link included at the bottom of this slide and will also be available on the eCQI Resource Center. Next slide, please.

Slide 4 [00:02:36]

I'm sure that many of you attending today's webinar will wish to receive continuing education credit or qualifying education hours. All relevant information about continuing education credit is available within a handout that we've included within the webinar resources and has also been communicated on the webinar registration page. The attachment includes: the list of entities that will provide credit, the requirements for participants to earn credit, and information about how to complete the survey and obtain a certificate. So be sure to download that attachment to learn more. Credit is available for attendance during this live webinar broadcast only. For information on Joint Commission's continuing education policies, visit the link provided at the bottom of this slide. Next slide.

Slide 5 [00:03:40]

Now, I'll just run through the webinar participant learning objectives. The participant learning objectives are locate eCQM resources on the eCQI Resource Center, facilitate your organization's implementation

of the Safe Use of Opioids-Concurrent Prescribing eCQM annual updates for the 2026 reporting year, and utilize answers to common issues and questions regarding the Safe Use of Opioids-Concurrent Prescribing eCQM to inform your 2026 use and implementation. Next slide, please.

Slide 6 [00:04:21]

This webinar does not cover these topics: basic eCQM concepts, topics related to chart abstracted measures, and process improvement efforts related to these measures. While we will not address how to validate eCQM data during this webinar, before submitting your eCQM data to CMS, please ensure your data is validated. Specifically, please ensure that extreme outlier results are verified. For example, extreme outliers can include reporting 0% or 100%. Please note that Joint Commission is not accepting data for the Safe Use of Opioids eCQM for the 2026 reporting year. Next slide.

Slide 7 [00:05:13]

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

Slide 8 [00:05:43]

During this webinar, we will review the annual updates and changes to the Safe Use of Opioids-Concurrent Prescribing eCQM for the 2026 reporting year. We'll then provide an overview of the measure flow and algorithm, and then we'll address some frequently asked questions. Finally, we'll have a live Q&A segment. Next slide, please.

Slide 9 [00:06:06]

Before we transition to the discussion about the changes for the 2026 reporting year, we wanted to point you to a PDF handout that includes directions to locate and access eCQM specifications, value sets, measure flow diagrams, and the technical release notes. The link to the eCQI Resource Center landing page is provided on this slide. However, be sure to download the PDF handout that has additional links and navigation guidance. You can locate that PDF within the resource section of the audience navigation pane, and we explained how to access those documents within the resource pane earlier in the presentation. Next slide.

Slide 10 [00:07:15]

[Erin Buchanan] Thank you, Susan. Hello, everyone. Thank you for joining us to review the updates for the Safe Use of Opioids-Concurrent Prescribing eCQM for the 2026 reporting year. My name is Erin Buchanan, and I am representing the Mathematica team that maintains this measure.

Before I jump into content, I wanted to give a quick disclaimer, because we've gotten this question before. So, as I noted before, this webinar is specifically related to the Safe Use of Opioids-Concurrent Prescribing measure. You may be familiar with another opioid eCQM, called the Hospital Harm-Opioid-Related Adverse Events measure. And I want to be clear that we will not be covering materials or questions related to that measure during this webinar. If you do have questions related to that measure, we encourage you to submit them to the ASTP ONC Issue Tracking System where that team can respond to them. So now, before jumping into the updates, I'll be going over some background information on the Safe Use of Opioids-Concurrent Prescribing measure. Next slide, please.

Slide 11 [00:08:41]

So, for background, Safe Use of Opioids-Concurrent Prescribing assesses the 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. This measure was adopted into the Hospital Inpatient Quality Reporting Program for voluntary reporting in 2022 and became mandatory in 2023. Next slide, please.

Slide 12 [00:09:25]

Next, I will review the rationale for this measure. This measure exists for the following reasons. One: reducing the number of unintentional overdoses has become a priority for numerous federal organizations, including but not limited to: the Center for Disease Control and Prevention, or CDC, the Federal Interagency Workgroup for Opioid Adverse Drug Events, and the Substance Abuse and Mental Health Services Administration. Unintended opioid overdose fatalities are a major public health concern. Concurrent prescriptions of opioids or of opioids and benzodiazepines places patients at a greater risk of unintentional overdose due to the increased risk of respiratory depression.

By concurrent prescriptions, we mean two different prescriptions that patients will be taking at the same time. Patients who have multiple opioid prescriptions have an increased risk of overdose, and rates of fatal overdose are 10 times higher in patients who are co-dispensed opioid analgesics and benzodiazepines versus opioids alone. The number of opioid overdose deaths involving benzodiazepines increased 14% on average each year from 2006 to 2011, while the number of opioid analgesic overdose deaths not involving benzodiazepines did not change significantly. Furthermore, concurrent use of benzodiazepines with opioids was prevalent in 31 to 51% of fatal overdoses. Studies of multiple claims and prescription databases have shown that 5 to 20% of patients receive concurrent opioid and benzodiazepine prescriptions across settings.

Eliminating concurrent use of opioids and benzodiazepines could reduce the risk of emergency room and inpatient visits related to opioid overdose by 15%. One study showed that also potentially eliminating concurrent use of opioids and benzodiazepines could have prevented an estimated 2,630 deaths related to opioid pain killer overdoses in 2015. A study on the Opioid Safety Initiative in the Veterans Health Administration, which includes an opioid and benzodiazepine concurrent prescribing measure, that this measure is actually based on, was associated with a decrease of 20.67% overall and 0.86% patients per month, or 781 patients per month, receiving concurrent benzodiazepines with an opioid among adult VHA patients who filled outpatient opioid prescriptions from October 2012 to September 2014.

And finally, the Safe Use of Opioids measure aligns with the CDC guideline for prescribing opioids for chronic pain, and it encourages 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. And as the slide mentions, that guideline is the 2022 Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and it recommends avoiding concurrently prescribing two or more opioids or opioids and benzodiazepines whenever possible. Next slide, please.

Slide 13 [00:14:04]

Given the risk of concurrent opioid and benzodiazepine medications taken at the same time, as I noted on the previous slide, the intent of this measure is to:

1) identify patients with concurrent prescriptions for review and careful monitoring, and 2) encourage providers to consider alternatives to prescribing two or more opioids or opioids and benzodiazepines

concurrently. As a reminder, this is an inverse measure, meaning that a lower measure score indicates higher quality. We also want to note that we understand there may be some clinically appropriate times for a patient to be prescribed two unique opioids or an opioid with a benzodiazepine.

We do not expect this measure to have a numerator of zero. One goal of the measure is to identify these patients, especially because we know that they are at higher risk for respiratory depression. Next slide, please.

Slide 14 [00:15:21]

On this slide and the following slide, I'm going to show you the big picture differences between the measure for reporting in 2025, which was version 7 of the measure, and 2026 which is version 8 of the measure. On these slides, green text with a strikethrough are removals and bold with underlining indicates added text, and I'll be repeating that throughout this presentation so that you know what has been added and what has been removed.

The Initial Population header language was updated to reflect one opioid or benzodiazepine are needed to qualify for the Initial Population. The measure logic and intent around this remains unchanged. The measure header was updated just to align with intent and provide some clarity.

The Denominator, which is the same as the Initial Population, includes patients discharged with an inpatient stay with at least one opioid or one benzodiazepine, whether it is a new or continuing prescription. For example, this would include patients discharged with a 7-day prescription of opioids after a surgery. It could also include a patient whose primary care physician prescribed them benzodiazepines for anxiety as long as those prescriptions are active. While the language in the header was updated, as I mentioned before, the logic itself did not change.

The Numerator includes patients discharged from an inpatient stay with two distinct opioid medications or an opioid and a benzodiazepine prescription. Again, these can be new or continuing prescriptions at discharge, but the opioids 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 such as in the example before and released from the hospital with an opioid prescription would be counted in the Numerator unless the opioid medication is a combination of buprenorphine naloxone.

Combination buprenorphine naloxone medications meet the denominator exclusion, patients receiving medications for opioid use disorder. In that case, only the benzodiazepine would count towards the measure, and the patient would only be in the Denominator.

While the language in the header was updated, the logic here did not change either. The Numerator header logic was updated to remove language around continuing medications to reduce redundancy and confusion. In the Guidance section of the header, we have also added clarifications around this aspect of the measure. New or continuing opioids and benzodiazepine medications are already included with the use of the QDM medication discharge data type that you can find in the logic. This data type indicates medications that should be taken by or given to the patient after being discharged from an inpatient encounter, which could include previously or newly prescribed medications. Next slide, please.

Slide 15 [00:19:31]

Here, the Denominator Exclusions show the difference between 2025 versus 2026. The Denominator Exclusion header language was updated to provide more detail around the opioid use disorder Denominator Exclusion. The full language now reads, "Patients receiving medication for opioid use

disorder with active OUD or Opioid Use Disorder diagnosis or Opioid Medication Assisted Treatment MAT." The language is updated to clarify that: The patients receiving medication for Opioid Use Disorder must also have an active OUD diagnosis or be receiving medication assisted treatment. The logic was also updated to reflect this update. Next slide, please.

Slide 16 [00:20:33]

So now we're going to review the measure flow. The purpose of the measure flow is to highlight different relevant criteria in the measure. They're organized, as you can see on the slide, to help interested parties 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 are 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.

Slide 17 [00:21:25]

Population criteria are color coded, such as in the Initial Population, it's a yellowish color to help users understand the flow of the measure logic. And so, in the measure flows, we'll see some of the changes that I mentioned on the previous slides. So, before I sort of walk you through this, I did want to flag that we're aware that the information is sort of very small on the screen. We encourage you to download the slides and zoom in and enlarge within the PDF so that you can see it in more detail.

So, yeah let's jump in with the Initial Population. So, the measure flow diagram defines and summarizes the Initial Population logic on the left-hand side of the page, and on the right-hand side of the page, you can see the embedded logical definitions associated with the population. For example, here we have the "Inpatient Encounters with an Opioid or Benzodiazepine" as the definition on the left, the embedded definition, Inpatient Encounter with Age Greater than or equal to 18 and the subsequent logic are shown in detail on the right. If the Initial Population criteria is not met, processing ends, as you can see when you follow the "No." And if the Initial Population is met, the encounter is in the Initial Population, so you follow the "Yes," and we move on to page two. Next slide, please.

Slide 18 [00:23:25]

We've split up the second page of the diagram to show only the Denominator here. The flow chart here just illustrates that the Initial Population criteria is met, and you can see a little diamond 'a' there. So, the criteria for the Denominator, is also met. And we can continue to the Denominator Exclusions. Because the Initial Population and the Denominator are equal, we don't see any steps or logic between these two pages. Next slide, please.

Slide 19 [00:24:07]

Thank you. So, once we've confirmed that an encounter should be in the Denominator, we check for Denominator Exclusions, which are diamond 'b' in our flow here. The red boxes here indicate changes that have been made to the Denominator Exclusions in the logic for reporting year 2026. The first change was to reverse the order of the cancer-related pain and sickle cell disease exclusions. This isn't really a substantive change. It was made to… group the cancer exclusions together, so that it flows better.

The second change was to move the diagnosis of Opioid Use Disorder into the treatment for Opioid Use Disorder logic. That update is the same update I described in an earlier slide, and it was made to ensure that we are not capturing a diagnosis of Opioid Use Disorder alone but instead captured in conjunction

with the medications for Opioid Use Disorder. Here in the flow as a whole, we can see that if during the relevant encounter, a patient has cancer-related pain, if they have received palliative or hospice care, have sickle cell disease with or without crisis, if they're receiving treatment for Opioid Use Disorder, if they are discharged to hospice or acute care, if they leave against medical advice or die, then they meet the criteria for the Denominator Exclusion.

If any of those conditions apply, the relevant encounter meets the exclusion, as I mentioned before, and you can see where it follows the "Yes" and they are removed from the measure. If the patient does not meet any of the criteria on this page, then you follow the "No," and we proceed onto the Numerator. So, patients who meet the Denominator Exclusion do not move on to the Numerator. Next slide, please.

Slide 20 [00:26:57]

Finally, all patients that... all patient encounters in the Denominator that do not fall into a Denominator Exclusion are evaluated for the Numerator. The flow chart shows two Numerator populations. 'c1', the diamond at the top of the page: an encounter where a patient is discharged with two or more opioids. And 'c2', an encounter where a patient is discharged with an opioid and an opioid and a benzodiazepine. An encounter may fall into either population to meet the Numerator criteria.

If an encounter does not meet the Numerator criteria at this point, it is only counted in the Denominator population. There were no updates to the Numerator between 2025 and 2026 for this measure. Next slide, please.

Slide 21 [00:28:01]

So finally, the last part of the flow diagram is the Sample Calculation. So, this is where the letters in the diamonds come into play. The sample calculation shows us adding the two Numerator criteria for a total of 20 inpatient hospitalizations, and then for the second part of the equation, once we've subtracted the Exclusions from the Denominator, we have a performance Denominator of 90. Excuse me. 20 Numerator encounters divided by 90 Denominator Encounters results in a performance rate of 22%. As a reminder, in this measure, a lower score indicates higher quality care. Next slide, please.

Slide 22 [00:31:12]

Excuse me, while I take a sip of water. So next, we'll move on to: Logic Updates for the 2026 Reporting Period. We sort of talked about them a little bit before already. There are no updates to the logic for the Initial Population or the Numerator for 2026, so we won't be reviewing those pieces. However, we will review updates to the Denominator Exclusions, which I mentioned before. Next slide.

Slide 23 [00:50:43]

Thank you. So, Denominator Exclusions are applied once the Denominator has been established. The exclusions listed on this page are cancer-related pain, sickle cell disease, palliative care, and treatment of opioid use disorder. The first update that I noted before and might not be super obvious looking at this slide, is the swapping of the cancer- related pain diagnosis with the sickle cell with or without crisis diagnosis. So, where it says, "Or exists inpatient encounter diagnosis where diagnosis code in cancer-related pain," was switched with, "Or exists diagnosis sickle cell disease with or without a crisis, sickle cell disease, where sickle cell disease prevalence period overlaps inpatient encounter relevant period." So those two sections switched.

And then for the more substantive update, here you can see that we've removed diagnosis of Opioid Use Disorder as a standalone exclusion in the logic for 2026. This is shown with green text with strikeout. This change was made because the intent of the exclusion is not only to exclude patients with

a diagnosis of OUD, but also to but also those patients should also be taking medications for OUD. And so, we'll see that on the next slide.

And before I move on, I wanted to flag that you might notice that, "Treatment for Opioid Use Disorder," is bold on this page, and there isn't any specific reason; that isn't a change. It's just a holdover on this slide, so feel free to ignore that formatting. Next slide, please.

Slide 24 [00:53:18]

So here we dive a little deeper into the definition of treatment of Opioid Use Disorder where we can find the update that was previously mentioned. The first part of the logic stayed the same, and that first section of the logic looks at the union of Active: Medications for Opioid Use Disorder and Medication Orders for Opioid Use Disorder, along with an Intervention, Performed for Opioid Medication Assisted Treatment. The new logic first looks at The new logic, which is underlined in bold on this slide, looks for Opioid Use Disorder Active, as well and then looks for the diagnosis for Opioid Use Disorder.

Oh, sorry, I misspoke. The first part looks for MEDICATIONS for Opioid Use Disorder, active or ordered. Then we look for the DIAGNOSIS of Opioid Use Disorder. The update, as I mentioned before, was to ensure we're not capturing a diagnosis of Opioid Use Disorder alone as the logic in the previous reporting year indicated, but instead, we want to capture it in conjunction with the Medications for Opioid Use Disorder. Next slide, please.

Slide 25 [00:55:55]

Yeah, so those were all of the updates, and now I'm going to go over a couple of Frequently Asked Questions that we get on Jira. The first one is, "Are continuing medications "included in this measure?" And the answer is: Yes, continuing medications are included in this measure. As I noted before, we understand that there may be clinically appropriate circumstances for a patient to be on two unique opioids, or an opioid and benzodiazepine CMS does not expect this measure to have a numerator of zero. Next slide, please.

Slide 26 [00:56:03]

Another Frequently Asked Question that we get is, "What are distinct opioids for the numerator?"

So, to answer that: Medications must have different RxNorm codes. So as part of this measure, there are value sets that list out all of the medications, and they're defined by RxNorm codes, and so they must be two different codes in order to meet the numerator. In this example, RxNorm codes distinguish medications from each other. We have a 12 hour oxycodone hydrochloride 10 milligram extended release oral tablet that has the RxNorm code of 1049502. And then we have another 12-hour oxycodone hydrochloride 15 milligram extended release oral tablet that has RxNorm code 1049543. Those are considered two distinct opioids, and if a patient is prescribed both of these, they would meet the numerator.

We also want to note here that RxNorm codes do not distinguish prescriptions by dosing instructions. And... so I'll also add that if you're taking two different types of opioids such as morphine and hydrocodone, RxNorm codes for those medications will be different. If the dose of the active ingredient is different, such as the example on 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 codes will be different. If any additional components beyond the active ingredients are different, the RxNorm codes will be different in that case as well.

So, the question is: When are RxNorm codes not going to differ? The codes do not distinguish based on dosing instructions given to the patient. If one prescription for 10 milligrams of oxycodone still release says take every four hours and another prescription for the same medication says take every eight hours, the RxNorm codes will not be different, and they will not be considered distinct opioids for the numerator. Next slide, please.

Slide 27 [00:37:21]

I think I am passing it back to Susan.

[Susan Funk] Great, yeah, coming straight back to me. Erin, thank you so much for all of that. I know that was a lot to get through. I'll give you a couple slides here to catch your breath. You can put yourself on mute, and I will take over for a little bit.

So, here we've included on this slide some resources that the audience might find useful. The first slide provides links to the eCQI Resource Center, CMS Eligible Hospital Measures page, and the Get Started with eCQMs links. We've also linked the "Teach Me Clinical Quality Language" video series, and specifically the video shorts on "Hospitalization with Observation" and "What is a Value Set?" Next slide.

Slide 28 [00:38:17]

Okay, continuing on with the additional resource links on this slide, we've provided the link to the Value Set Authority Center or the VSAC support. We've also included the link where you can find information about the Expert to Expert Webinar Series on the Joint Commission's website, and finally, the ASTP/ONC issue tracking system where clinical and technical questions about these eCQMs should be submitted following the webinar. Next slide, please.

Slide 29 [00: 38:49]

Before we jump into this live Q&A segment, I just wanted to give a little context about that ASTP/ONC issue tracking system. Before we head into this live Q&A, I wanted to point out that the same subject matter experts on today's webinar are also the staff that respond to questions that are submitted via the ASTP/ONC issue tracking system. So, to clarify, the Q&A document that we publish following this webinar will likely take a few weeks, and that document requires CMS approval before we can distribute. So, if you need a more immediate answer, please consider submitting your question via the issue tracker. As I noted it's the same subject matter experts that are staffing today's Q&A that answer the responses on that platform.

So, with that said, I'm just going to restate some of the directions to be able to ask questions, and then we'll move into the live Q&A segment. So, you can submit questions via the question pane. Click on the question mark icon in the audience toolbar, and that will open a panel that permits you to type and submit your question. The questions that are submitted today will be addressed in that written follow-up Q&A document that I noted, and that follow-up document will be posted on the Joint Commission's website several weeks after the live event as noted earlier after CMS reviews and approves it.

Our subject matter experts from the Mathematica team have been very busy during the presentation responding to as many of your questions as they are able. We will now share some of those questions and answers, so I will now welcome Erin back to facilitate the Q&A segment. So, Erin, when you're ready, please have your little questions widget open, and you can jump into the first question.

[00:40:45]

[Erin Buchanan] Thank you, Susan. Before I jump in, I did want to give a few reminders. First, I want to encourage everyone who has questions. We understand that some of your questions may be highly specific to your facility or your situation or your EHR. If you have questions like that, please submit those to the ASTP ONC issue tracking system that Susan mentioned. We want to get through as many questions as possible in the time we have left, and specific questions like that will take more time for our team to respond to. And then I also want to remind everyone again that questions should only be about the CMS 506 of the Safe Use of Opioids-Concurrent Prescribing measure. We won't be answering any questions about the Hospital Harm-Opioid-Related Adverse Events measure. Please submit questions related to that measure to the ASTP/ONC issue tracking system as well so that that other team can respond to them.

So now jumping into the Q&A, thank you all for submitting your questions so far. Our team has been working hard in the background to respond to them. Yeah, so first question we have here is, "Where can I find national performance on eCQM measures?" National and state average performance rates are available in Care Compare under timely and effective care. Individual hospital's performance results are available in the Timely and Effective Care Hospital Data Download from the CMS Care Compare Provider Data Sets for Hospitals website which is data.cms.gov/provider-data.

"How often is this eCQM measured and submitted?" The measurement period for Safe Use of Opioids is January 1 through December 31. Data is submitted for this measure annually, and guidance for reporting can be found at qualitynet.cms.gov, and you would navigate to the inpatient page, then measures, eCQM, and participation.

"What is the difference between the QRDA I and QRDA III for submitting the Safe Use of Opioids measure?" QRDA I files are individual patient-level reports. It contains quality data for one patient, for one or more eCQMs, and are used for Eligible Hospital reporting. QRDA III files are aggregate quality reports that contain quality data for a set of patients, for one or more eCQMs, and are for Eligible Clinician reporting.

"Is there a goal for calendar year 2026 or one planned for the future, and how does this eCQM affect CMS Star Ratings?" So, the same as for calendar year 2025, there is no goal for 2026 either. Safe Use of Opioids contributes to CMS Star Ratings because it is one of 13 Timely and Effective Care measures, along with up to 34 other measures whose performance is used in calculating the CMS Star Ratings. We are not able to comment on how it contributes or to what degree it contributes, because this may vary based on numerous factors. You can get more information about Star Ratings at the overall Quality Star Rating page on the CMS Provider Data Catalog, and it's at that same link that I mentioned previously. So, data.cms.gov/provider-data /topics/ hospitals /overall-hospital-quality-star-rating. So, a lot of these data questions can be found, the answers can be found at data.cms.gov.

"What EHR tools in Epic are currently available to help improve this eCQM measure?" So, for this one, we would actually encourage you to work with your EHR vendor to determine what tools are available to improve on the Safe Use of Opioids eCQM. Different vendors may have different tools available.

"When can we expect a benchmark to be announced for this measure, and will sickle cell patients eventually be excluded?" So, there are no plans to establish a benchmark for this measure at this time, and patients with sickle cell disease are excluded from this measure as of version seven, so the previous version of this measure, for the 2025 reporting period, and that continues to be the case for the 2026 reporting period. And I guess to further clarify here, I did mention the sickle cell disease with or

without crisis exclusion in the presentation this afternoon. However, the exclusion itself did not change, just the location of the logic for that exclusion.

So, another question here about benchmarks. "What is the current benchmark for this measure?" There are currently no national benchmarks for this measure. Hospitals can compare their performance results to the national average and the national top 10% performance rates available on Care Compare in the downloadable Hospital Timely and Effective Care National File. Excuse me. All right.

[00:47:44]

"Can you please explain the Denominator Exclusion for MOUD and with MAT? For a patient with an active MOUD medication, buprenorphine patch, and no Opioid Use Disorder diagnosis, does the patient need to have the patch given the same day the medication is identified in the chart?" If the medication is captured on med rec on day of admission, but withheld until the next day, the patient will not be excluded. So, this is described in the definition for treatment for Opioid Use Disorder: An active Opioid Use Disorder medication or order must be during a day that the MAT intervention was performed. Both must occur during the hospitalization.

"Does this eCQM [Excuse me] Does this eCQM only pertain to Medicare or all payers?" This medication [Measure] does not evaluate by payer. All patients meeting measure criteria will be included.

"Just to clarify, Safe Use of Opioids is required by CMS for 2026, correct? "I thought I heard they weren't accepting, but maybe that was TJC." This is a required eCQM for CMS for reporting year 2026. Joint Commission is not accepting data for this eCQM for 2026. Excuse me, while I take a sip of water.

[Susan Funk] Erin, if you'd like, I can grab one of the questions that we get frequently about where everyone can find this document. So, in an upcoming slide, we have a link for where all of these follow-up pieces go, so the recording, the slides, and the Q&A document. So, in my closing, I'll go through that piece.

[Erin Buchanan] Thanks, Susan.
"The patient population includes only those observation patients that convert to inpatient status, correct?" Straight observation patients are not included in the Denominator. Patients with an observation encounter alone not transitioning into inpatient status will not be included. An observation encounter must end within one hour of the inpatient encounter to be included within the denominator.

"What about chronic pain patients? Who is excluded in this measure?" So chronic pain patients are not excluded by this measure. The Denominator Exclusions are limited to specific conditions and scenarios defined in the logic, including inpatient hospitalizations where patients have cancer pain that begins prior to or during the encounter, or are ordered or are receiving palliative or hospice care, including comfort measures, terminal care, and dying care during the hospitalization or in an emergency department encounter or observation stay immediately prior to hospitalization, patients receiving medication for Opioid Use Disorder with active OUD diagnosis, or opioid Medication Assisted Treatment, MAT, patients with sickle cell disease, patients discharged to another inpatient care facility, or left against medical advice, and patients who expire during the hospital stay. If a chronic pain patient does not meet one of those defined exclusions, they are included and may be counted in the numerator if discharged on concurrent opioids or an opioid and benzodiazepine. And I also want to note here that, as I mentioned several times during the presentation, we do not expect the numerator to be zero. Patients with chronic pain are likely to fall into the numerator.

"Follow-up question on observation patients. If a patient is in observation for 24 hours then converts to inpatient, will they still be in the denominator?" The length of observation encounter makes no

determinations of measure inclusion. The time between the observation encounter end time and the inpatient encounter start time is used to determine. And as I mentioned before, that time span is one hour.

"When you say distinct, is there a list?" No, there's no list. For this measure, the numerator requires two distinct opioid medication codes. A single medication code occurring twice or more will not qualify for the numerator. And to further clarify about this question, there isn't a list, in that, we list out the distinct opioids, but as part of the measure logic, there is a list of opioid medications. So, your EHR would pull from the value set, and if they're two different RxNorm codes from that value set, they would meet the numerator. If they are the same RxNorm code, it's not considered distinct, and it would not meet the numerator.

[Susan Funk] So Erin, while you're grabbing the next question, I think we've got time for maybe, like, one more question, and then I can do the closeout. I know that the audience really appreciates all the extra time that we can spend on Q&A, so I'll be quick with my closeout.

[Erin Buchanan] Okay. Okay, so one more, let's see. Oh, actually, this is a good follow-up to the last question because it tells us about the name. "So, if hydrocodone is documented twice in the discharge summary, for example, 'Take one tablet for moderate pain,' then a separate instruction noting, 'To take two for severe pain.' Does this count as two opioids prescribed at discharge?" And so, the opioid medication codes must be unique or distinct and found in the Schedule II, III, and IV Opioids value set, and that's the value set I was talking about earlier, to meet the Medication Discharge QDM data type. So, in this situation, those would be the same medication, and they would not count as two opioids prescribed at discharge, assuming they have the same RxNorm code. If they're different medications with different RxNorm codes, they are considered distinct. Yeah, with one minute left, Susan, I'll pass it back to you.

[Susan Funk] That's fine, I can close us out quickly. So next slide, please.

Slide 30 [00:55:27]

Okay, as I was mentioning, we provide a link on this slide that goes to all of the previous webinar recording links, slides, and transcripts. You'll be able to find those on the Joint Commission website. And if you've got any questions about the webinar operations or obtaining your CE credit, you'll send them to tjcwebinarnotifications@jointcommission.org.

And we've included one additional handout. We told you how to get to those earlier in the resource pane. We included the links to all of the future webinars in the series, so that if you'd like to register for the upcoming ones that now are scheduled through May, you'll be able to do that. Next slide, please.

Slide 31 [00:56:13]

Okay, well, I'll hurry through this one. We always get a lot of questions about how to get to the survey, and how to get to your certificate. We use your feedback to inform future content, determine education gaps, and assess the quality of our educational programs. On the next slide, you can use your mobile phone to use the QR code that will take you directly into the survey. If you don't want to take it right away, you will get a follow-up email from the webinar platform that sends you to the survey. After you complete the survey using either the link or the QR code, you're redirected to a page where you can either print or download your…it is a blank CE certificate. You add your own name and credentials to that. In case you don't download it at that time, there is also a follow-up email from the survey platform. With that, next slide.

Slide 32 [00:57:07]

Okay, we are at the end of today's broadcast. I'm going to leave this slide up. Actually, Jessica will leave this slide up for a few moments so that the participants can scan the survey QR code. Erin, thank you so much. I know you had to pause a few times. It was a lot of speaking for you today, so thank you so much for doing both the presenting and the Q&A. Many thanks to the Mathematica team who are in the background answering all of those questions throughout the webinar and to the operations team that helped support the webinar. Finally, thanks to everyone in the audience for your participation today, and this concludes our presentation. I'm going to pause just a couple more seconds so people can get to that QR code, and then I will end this broadcast. Everybody have a great day. Thanks.