Pioneers in Quality Expert to Expert Series: 2025 Reporting Year Annual Updates for Safe Use of Opioids-Concurrent Prescribing eCQM (CMS506v7)

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Welcome, and thank you for joining us for today's Expert to Expert Webinar, 2025 Reporting Year Annual Updates for the Safe Use of Opioids - Concurrent Prescribing eCQM. I'm Susan Funk, an Associate Project Director with The Joint Commission's Engagement on Quality Improvement team, and today I'll be serving as the facilitator for this webinar.

To start off, just a few comments about this webinar platform. Use your computer speakers or headphones to listen. There are no dial in lines. Participants are connected in listen-only mode. Feedback or dropped audio are common for live streaming events. Refresh your screen or rejoin the event if this occurs.

We will not be recognizing the Raise a Hand or the Chat features. To ask a question, click on the Question Mark icon in the audience toolbar on the left side of your screen. A panel will open for you to type your question and submit.

The slides are designed to follow Americans with Disabilities Act rules.

Before we get started with today's eCQM content, we do want to explain that this webinar is highly technical and requires a baseline understanding of eCQM logic and concepts. Participant feedback from previous webinars indicated that the content is often too technical to comprehend for those that are new to eCQMs. We recommend that anyone new to eCQMs visit the eCQI Resource Center at the hyperlink provided on this slide. You will find a collection of resources to help you get started with eCQMs.

The slides are available now. Within the participant navigation pane, select the document icon. A new popup 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. The slides will be posted at the link at the bottom of this screen within two weeks following this broadcast. One last note, the links are not clickable on screen within this webinar platform. However, if you download the slides, all links are functional.

This webinar is approved for 1.5 continuing education credits or qualifying education hours for the following organizations. Accreditation Council for Continuing Medical Education, American Nurses Credentialing Center, American College of Healthcare Executives, and the California Board of Registered Nursing. Participants receive a certificate after completing the webinar and survey. Although we've listed the organizations that accredit Joint Commission to provide CEs, many other professional societies and state boards accept credits or will match credit from Joint Commission's educational courses.

To earn CE credit, participants must individually register for this broadcast webinar, participate for the entire webinar, and complete a post-program evaluation and attestation survey. For more information on The Joint Commission's continuing education policies, visit the link at the bottom of this slide.

Just a few words about the CE survey and certificate. You'll receive the survey link two ways. On the last slide, we've included a QR code accessible via most mobile devices. If you miss the QR code, you will also receive an automated email that includes the survey link. After you complete the online evaluation survey, you will be redirected to a link from which you can print or download and save a CE certificate. An automated email will also deliver that certificate link. Complete the certificate by adding your own name and credentials.

The learning objectives for this session are: Locate measure specifications, value sets, Measure Flow Diagrams, and Technical Release Notes on the eCQI Resource Center, facilitate your organization's implementation of the Safe Use of Opioids - Concurrent Prescribing eCQM for the 2025 reporting year, and utilize answers to common issues and questions for the Safe Use of Opioids - Concurrent Prescribing eCQM to inform 2025 use and implementation.

This webinar does not cover these topics. Basic eCQM concepts, topics related to chart abstracted measures, process improvement efforts related to this measure, and while we will not discuss eCQM validation during this webinar, if you are submitting eCQM data to CMS and The Joint Commission, please ensure your data is validated before submitting.

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All staff and speakers for this webinar 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, Erin Buchanan, Raquel Belarmino, and Susan Yendro.

The agenda for today's discussion follows. Highlight how to access resources on the eCQI Resource Center, review the Safe Use of Opioids-Concurrent Prescribing eCQM, review the measure flow and algorithm, and then we'll have a facilitated audience Q&A segment. Please note, you don't have to wait until the end of the presentation to submit questions. The content experts will be responding to questions in the queue throughout the webinar.

We will now highlight how to access the CMS eCQI Resource Center. The eCQI Resource Center provides a centralized location for news, information, tools and standards related to eCQMs. The majority of the tools and resources referenced within the eCQI Resource Center are openly available for use and provide a foundation for the development, testing, certification, implementation, reporting, and continuous evaluation of eCQMs. Raquel, I'll continue screen sharing. When you're ready, please go ahead and start your part of the presentation.

Great. Thank you, Susan. For the measure specifications and other helpful documents, navigate to the eCQI Resource Center website at https://ecqi.healthit.gov https://ecqi.healthit.gov. Click on the second orange rectangle labeled Eligible Hospital / Critical Access Hospital eCQMs, which leads to a new webpage where you can download specifications or click on the hyperlink title of the desired measure and access and readily view the specifications and data elements. Available documents include HTML version of the Human Readable measure specifications, value sets, data elements, the eCQM Flow, Technical Release Notes of all changes for this year, and even link out to view Jira tickets submitted for the selected measure. The eCQM Flow document depicts the process flow diagrams that some may refer to as algorithms. They walk through the steps to take to calculate an eCQM. Value sets links out to the Value Set Authority Center, VSAC, where one will find all the terms and associated codes contained within each value set. Note that a login is required, but anyone can request a UMLS account and it's free.

For more details, view the eCQI Resource Center Navigation video short.

Great. Thanks so much, Raquel. I'm going to forward to this next slide and then transition over to Erin. Erin, I'll stop screen sharing, and I'll make you the presenter. When you have your slides up and ready, please proceed with your presentation. One moment.

Thanks, Susan. And thank you all for joining us this afternoon. My name is Erin Buchanan, and I'm an Analyst at Mathematica. I'll be taking you through the updates to the Safe Use of Opioids - Concurrent Prescribing measure, starting with background information on the measure.

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, I'll review the rationale for this measure. One, 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, the CDC, the Federal Interagency Work Group for Opioid Adverse Drug Events, and the Substance Abuse and Mental Health Services Administration.

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Two, 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 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 various settings.

Three, 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 2,630 deaths related to opioid painkiller overdoses in 2015. A study on the opioid safety initiative in the Veterans Health Administration, which includes the opioid and benzodiazepine concurrent prescribing measure that this measure is based on, was associated with a decrease of 20.67% overall and 0.86% patients per month, which equates to about 781 patients per month, receiving a benzodiazepine concurrent with an opioid among adult VHA patients who filled outpatient opioid prescriptions from October, 2012 to September, 2014. And our fourth rationale is the Safe Use of Opioid measure aligns with the CDC guidelines for prescribing opioids for concurrent pain, and it serves to encourage providers to identify patients taking two or more opioids at the same time and also to identify those patients taking an opioid and benzodiazepine at the same time.

Given the risk of concurrent opioid and benzodiazepines medications, the intent of this measure is to first identify patients with concurrent prescriptions for review and careful monitoring, and second, to discourage providers from prescribing two or more opioids or opioids and benzodiazepines at the same time. As a reminder, this is an inverse measure, in that, a lower measure score indicates higher quality.

To show you the big picture differences between the measure for reporting in 2024 and 2025, we have two slides with a table comparing the measure components. The Initial Population was updated to remove mention of inpatient stay less than or equal to 120 days. This was removed as part of an update to the Global Common Library. Just to reiterate, the Initial Population still looks for 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.

One major change to the measure logic is the addition of Schedule IV opioid medications to the measure. These medications were added at the recommendation of the expert work group because prescription rates of Schedule IV drugs is increasing, and patients can develop tolerance which increases the likelihood for potential abuse.

Here, we show the difference between 2024 and 2025 for the measure Denominator Exclusions. Three new Denominator Exclusions were added to this measure for 2025 based on the feedback from implementers and measure testing. This includes patients receiving medications for opioid use disorder, patients with sickle cell disease, and patients who left against a medical advice. We will dive into the measure flow next.

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Before that, as a reminder, the purpose of the Measure Flow Diagram is to highlight relevant data criteria. The Measure Flow Diagrams are organized 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'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 of measures.

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, and the right hand side of the page shows the embedded logical definitions associated with the population name. For example, inpatient encounters with an opioid or benzodiazepine is the definition on the left. The embedded definition, inpatient encounter with age greater than or equal to 18, and subsequent logic are shown in detailed on the right. Here you can see an update to the logic to include Schedule IV opioid medications which we will show when we walk through the logic in detail later.

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

We've split 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, diamond A, so is the criteria for the Denominator, and we continue to the Denominator Exclusions. That is why we do not see any steps or logic between the Initial Population and Denominator.

Once we confirm that an encounter should be in the Denominator, we check for Denominator Exclusions, diamond b. The red box indicates updates made to the Denominator Exclusions between version six and version seven of the measure. These include changing the cancer exclusion to cancer-related pain, as well as adding sickle cell disease, treatment for opioid use disorder, and left against medical advice as Denominator Exclusions. Here we can see that if during the relevant encounter a patient has cancer-related pain, receives palliative or hospice care, is discharged to hospice or acute care, leaves against medical advice, or dies, the 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.

Finally, all patient encounters in the Denominator that do not fall into a Denominator Exclusion are evaluated for the Numerator. The flow charge shows two Numerator populations, c1, an encounter where a patient is discharged with two or more opioids, and c2, an encounter where a patient is discharged with an opioid and a benzodiazepine. An encounter may fall into either population to meet the Numerator criteria. If an encounter does not meet the Numerator criteria at this point, it is only counted in the Denominator population. Here again, we can see an update to the logic to include Schedule IV opioid medications.

Here is the sample calculation that shows us adding the two Numerator populations for a total of 20 inpatient hospitalizations.

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Once we've subtracted the Exclusions from the Denominator, we have a performance Denominator of 90. 20 Numerator encounters divided by 90 Denominator encounters result in a performance rate of 22. In this measure, a lower score indicates higher quality care.

Next, we will move on to logic updates for the 2025 reporting period.

This is the logic for the population represented by the Clinical Quality Language, CQL, and the Quality Data Model, QDM, data elements used to create the logical expression for the Initial Population criteria. The only update here was to include Schedule IV opioids in the opioids value set. The value set previously only included Schedule II and III opioids. As noted before, these medications were added to align with measure intent at the recommendation of the expert work group. Prescription rates of Schedule IV drugs are increasing, and patients develop tolerance which increases the likelihood of potential abuse, as noted before.

The logic in this definition is represented by the narrative statement in the header for Inpatient Encounters with an Opioid or Benzodiazepine at Discharge. The purpose of this logic is to capture inpatient hospitalizations that end during the measurement period where the patient is 18 years of age or older at the start of the encounter, and filtering those encounters to include only patients with a new or continuing opioid or benzodiazepine prescription at discharge. The Inpatient Encounter with an Opioid or Benzodiazepine at Discharge definition also contains another definition within it, Inpatient Encounter with Age Greater Than or Equal to 18. 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.'InpatientEncounter', which clarifies that the patient must be at least 18 years old at the start of the encounter, listed here as the start of the InpatientHospitalEncounter.relevantPeriod. The definitions in the logic can be found in the definitions list under population criteria in the measure specifications. Once we are looking at only those eligible encounters, the term with indicates that the inpatient stay must also be associated with a medication from the Schedule II, III, and IV opioids medication list, or as indicated by the term union, a medication from the Schedule IV benzodiazepines list. The final section of the logic indicates that medication at the patient's discharge from the inpatient stay from either the Schedule II, III, or IV opioids medication list or from the Schedule IV benzodiazepines list.

In this measure, the Denominator does not add any new criteria to the Initial Population. It simply returns the same value as the Initial Population. This has not changed from the 2024 reporting version.

Denominator Exclusions are applied once the Denominator has been established. The Exclusions for this measure are cancer, sickle cell disease, palliative and hospice care, death, and discharge to an acute facility. This measure shows two updates to the Exclusions for 2025. The cancer exclusion was updated to specify cancer-related pain rather than all primary and secondary cancer. We can identify these patients due to an overlapping cancer prevalence period or because the patient receives a cancer-related pain diagnosis during their inpatient stay. If there is a cancer-related pain diagnosis and no abatement date, the measure assumes the diagnosis remains active.

Diagnosis of sickle cell disease with and without crisis was also added to align with the clinical practice guidelines which were updated in 2022.

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Moving on to the next part of the Denominator Exclusions, this new logic first looks for diagnosis of opioid use disorder, then looks for treatment for opioid use disorder. This is defined by the union of active medications for opioid use disorder and medication orders for opioid use disorder in conjunction with intervention performed for opioid medication-assisted treatment. You'll notice a red box around the diagnosis of opioid use disorder logic. The logic includes patients whoever had a diagnosis of opioid use disorder. We wanted to call attention to this because we recognize that solely having a diagnosis of opioid use disorder does not align with the measure intent, as it can lead to patients being excluded from the Denominator in error. This may result in undercounting patients that meet the Denominator and potentially the Numerator. More information can be found on this known issue in EKI-31, which is a known issue.

Next, 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 care orders or services during something called Global.HospitalizationWithObservation. Global.HospitalizationWithObservation 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. Coalesce allows us to check relevant date, time, relevant period, or author date, time to look for a positive result for hospice or palliative care. If it is not present, it means the exclusion was not met, and therefore the hospitalization would be retained in the Denominator eligible population.

We also continue to exclude patients with an order for palliative care or hospice care, as mentioned in the prior slide, and patients who receiving hospice or palliative care during their inpatient stay. We use two QDM terms here to differentiate between orders and services received, though both terms used the same value set, palliative or hospice care. Again, the purpose here is to align with the CDC guidelines, which are not intended for patients at the point of hospice or palliative care.

The palliative or hospice grouping value set includes orders and services for comfort care, measures palliative and hospice care, and aligns with measure intent. As you can see, these three Exclusions are all the same as 2024, and all use the attribute InpatientEncounter.dischargeDisposition. All of these Exclusions look at discharge disposition codes of the relevant inpatient stay to appropriately exclude patients in any of the three following ways. Discharged to an acute care facility. I mentioned earlier that the CDC guidelines for prescribing opioids are intended to apply in an outpatient setting. This is why the measure looks at medications upon discharge as opposed to during the inpatient stay.

Two, patients discharged to hospice care. This exclusion is another more convenient way to identify and exclude patients who would be receiving hospice care at the point of discharge.

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

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And finally, the Exclusion, the new exclusion for patients with the discharge disposition left against medical advice.

Overall, these Exclusions are intended to reduce burden and more closely align with the CDC guideline that provides recommendations for patients in an outpatient setting and which note that these guidelines are not for patient in active cancer treatment, palliative care, and end of life care. The Numerator logic depicts inpatient hospitalizations in which the patient is prescribed or continuing to take two or more distinct opioids or an opioid and a benzodiazepine at discharge. The only update here is to include Schedule IV opioids in the opioids value set, as noted on the Denominator side.

We'll start with the top, where you can see that the part of the Numerator definition that this section of the logic speaks to where 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 the CQL logic statement, as well as the QDM data element, Medication, Discharge, and the Schedule II, III, and IV 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 could also count towards the Numerator.

The first where indicates the initial, the inpatient encounter needs to also have the condition in the second clause. The second clause says we need to have an inpatient encounter where, and here's where the second where comes to filter encounters, the count of opioids in the discharge list is greater than or equal to two. 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 EHR during the relevant inpatient encounter.

On this slide, you'll see the second part of the Numerator. Together, the two criteria work to define the Numerator as inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids or an opioid and benzodiazepine at discharge. From starting from the top of the slide, we see that the combination of the two logic criteria, one listing opioids on the medication discharge logic on the last slide, and the next one, an opioid and benzodiazepine at discharge. If either condition of the two are met, the Numerator is met. The only update here is to include Schedule IV opioids in the opioids value set, as noted on the previous slide. This section of the logic defines how we identify a patient prescribed an opioid and benzodiazepine at discharge. Like the last section of logic, we start with the inpatient encounter filtered using with to those that have an opioid on the medication discharge list. Once we have those, we filter again also using the term with to patients who have a benzodiazepine at discharge. For both filters, we use the terms where and exist to add the condition that we are only interested in these prescriptions that take place at a certain time, in this case, during the relevant inpatient encounter.

The logic was updated to use different terms to achieve the same filtering as in previous years.

We also see the Medication, Discharge QDM term again listing ongoing and new prescriptions existing at the same time as 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 the benzodiazepine to be concurrent with an opioid prescription. And that wraps up the overview of measure logic.

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We have a few measure considerations that we want to remind you all of. First, we understand that there may be some clinically appropriate times for a patient to be prescribed two unique opioids or an opioid and benzodiazepine. And we do not expect this measure to have a Numerator of zero. One goal of the measure is to identify these patients, especially because we know they're at higher risk for respiratory depression. The Denominator includes patients discharged from an inpatient stay with at least one opioid or one benzodiazepine, whether it is a new or continuing prescription.

For example, this would include patients discharged with seven days of opioids after 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 for the 2022 reporting period, so this is just a reminder that this logic still stands. The Numerator includes patients discharged from an inpatient stay with two distinct opioid prescriptions or an opioid and benzodiazepine prescription.

Again, these can be new or continuing prescriptions at discharge, but they must be distinctly different prescriptions. A patient discharged with two opioid prescriptions, perhaps one for chronic pain and one for acute surgical pain, would 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, combination medications meet the Denominator Exclusion, patients receiving medication for opioid use disorder. In that case, only the benzodiazepine would count towards the measure and the patient would only be in the Denominator.

Moving on to some frequently asked questions about this measure. You may have noticed before that I said distinct opioids, so what exactly are distinct opioids that we are considering for this Numerator? To give you some context on whether RxNorm codes will have a different code for medication, here's a few examples. If you're talking about two 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 codes will also be different. If the form of the drug is different, for example, 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.

So when are RxNorm code's not going to differ? The codes don't distinguish based on dosing instructions given to the patient. If one prescription for 10 milligrams of oxycodone still release says take every four hours, that another prescription for the same medication says take every eight hours, the RxNorm code will not distinguish.

Another question we've gotten several times is asking to clarify the Exclusions for patients discharged to acute care facilities. The measure uses the value set Discharge To Acute Care Facilities to identify these patients for exclusion. The value set includes community hospitals, tertiary referral hospitals, and short-term acute care hospitals. The measure included patients discharged to long-term care and acute rehab facilities. When it was reviewed by experts, it received consensus-based entity endorsement and went through public comment. We continued to evaluate whether patients discharge to other care facilities should be excluded from the measure. And we welcome your feedback on those potential facilities.

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When you download the slides, you can also access our references, as you can see here. And now I will pass the floor back to Susan to go over resources.

Excellent. Thanks so much, Erin. So we've included a couple slides here. Erin's going to keep screen sharing, so I'll just present a couple slides, and then we'll get moving towards our facilitated Q&A. So here we have the initial slides, slide links have links to the eCQI Resource Center, CMS Eligible Hospitals Measure page, and the Get Started with eCQM links, the Teach Me Clinical Quality Language Video Series landing page, as well as video shorts that are included on Hospitalization with Observation and What is a Value Set. Next slide, please.

The next slide has links that go out to the Value Set Authority Center or VSAC Support, the Pioneers In Quality landing page on The Joint Commission's website, the Expert to Expert Webinar Series landing page, and finally the ASTP/ONC Issue Tracking System. And that's where clinical and technical questions about these eCQMs should be submitted following this webinar. Next slide, please.

So now we'll start to move into our facilitated Q&A segment. Our Subject Matter Experts have been responding to questions as you've been submitting them throughout the webinar and as Erin has been presenting. As a quick reminder to anyone who hasn't yet submitted your question, click the Question Mark icon in the audience toolbar. That will open a panel where you can type and submit your question. A written follow-up Q&A document will address both the questions that we answer during the webinar and also those that we are not able to respond to during the broadcast. Some of the questions are very technical and sometimes require some additional time to respond to. So if your question is not responded today, we won't lose it. We will respond to it in the written document. And that follow-up document will be posted to The Joint Commission's website within several weeks after this broadcast. We need to wait for CMS's approval, so that's why there's a tiny bit of a lag between the webinar and when we can post the Q&A.

So Erin, I'll take over the screen sharing now. You don't need to do anything. I'll just take over. And as I noted, the Mathematica team has been very busy responding to questions throughout the webinar. We'll now share some of those questions and the responses to them. Raquel Belarmino and Susan Yendro from The Joint Commission's team will moderate this section. I don't know which of you decided to go first, so I'm going to pick on you, Susan Yendro, and see if you're ready to go first. And if you can, just please start whenever you're ready.

Sure, I'll get started. Again, my name is Susan Yendro. I'm a Director with The Joint Commission in the Quality Measure department. So our first question today asks, "I hear from a few Critical Access Hospitals that they are exempt due to the limited eCQMs that apply. Please clarify." And the answer is that Critical Access Hospitals are CAHs are required to report eCQMs through the Medicare Reporting Interoperability Program or PIP. The Safe Use of Opioids - Concurrent Prescribing eCQMs is one of the mandatory eCQMs for cause to report under the CMS PIP program. CAHs that do not have any patients who meet the safe opioids initial patient population criteria during the reporting period may submit a zero Denominator clarification for CMS. This case threshold extension for hospitals with a low number of eligibility cases cannot be applied for the Safe Use of Opioids measure.

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Hi, everyone. This is Raquel from The Joint Commission, and I'll take the next question here. "Can pain management providers ordering opioids be treated as an exclusion similar to palliative hospice care or post-op opioid?" The answer, pain management and post-op opioids are not excluded by this measure.

Okay, the next question asks, "Any specific ICD-10 codes that are Exclusions for the Numerator and/or Denominator of this measure, for example, Chronic Methadone use."

And the answer is that this measure does not have any Numerator Exclusions. However, ICD, sorry, ICD-10 codes for Denominator Exclusions of this measure can be found on the National Library of Medicine, NLM, Value Set Authority Center or the VSAC, and that's vsac.nlm.nih.gov. The complete link will be available in the Q&A document when we post it.

Next question. "One, if patient is discharged AMA, does this still count as a fallout? Two, if opioid med is prescribed, but two different doses, does this still count?"

The answer for the first question, for one, if discharge disposition is left against medical advice code 445060000, the case is excluded and not included within the performance rate. The answer for the second question, opioid medication codes must be distinct. If different codes are both found within the value set, yes, they are included.

Okay, next question. "What will the documentation requirements be for the new Exclusions?"

Documentation required for the new Exclusions for patients with sickle cell disease, patients receiving medication for opioid use disorder, and patients who left against medical advice can be found in the measure specifications on the eCQI Resource Center at ecqi.healthit.gov. And, again, this complete link to this specific website will be posted with the Q&A.

Next question, "Would you consider an exclusion the co-prescription of naloxone for surgical post-op patients?"

The opioid medication list for the measure value set Schedule II, III, and IV opioid medications does not contain naloxone as a standalone medication. A patient discharged from an inpatient stay with naloxone and an opioid would be in the Denominator due to the opioid but not the Numerator.

Okay, our next question asks, "Where can I find national performance on eCQM measures?"

The answer is that the national and state Average Performance Rate are available on Care Compare under Timely and Effective Care. Individual hospitals performance results are available in the Timely and Effective Care hospital data download from the CMS Care Compare provider dataset for hospitals, and that is at the data.cms.gov/provider-data data.cms.gov/provider-data website.

Next question. "If the same opioid was ordered at discharge twice but ordered to be taken differently, such as one at four to six hours and the same opioid ordered to be taken at six to 12 hours, would that still be considered two unique opioids, even though it was technically the same opioid ordered?"

The answer, the measure considers an opioid as a unique based upon the RxNorm code for the opioid. If there are two orders for the same opioid that have the same RxNorm code, the opioids are not considered unique. If the two opioids have different RxNorm codes, they are considered unique.

Okay, the next question, "Is there a way to recognize the continuation of chronic medications prescribed in an ambulatory setting?" And the answer is that continuation of chronic medications can be identified if they they're documented in the EHR at admission.

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Next question, "Does the measure consider Z-drugs, e.g., zolpidem, as benzodiazepines?"

Answer, the Schedule IV benzodiazepines included in the measure are listed in the Schedule IV benzodiazepines value set. You can view these specific drugs in the list on the Value Set Authority Center, VSAC, at vsac.nlm.nih.gov. And also the OID number for the value set that will be listed on the written document.

Okay, the next question is, "How often is this measured and submitted?"

The measurement period for Safe Use of Opioids is January 1st through December 31st. Data is submitted for this measure annually. Guidance for reporting to CMS can be found on the qualitynet.cms.gov website.

Next question, "What is the difference between the QRDA I and QRDA III for submitting the Safe Use of Opioids measure?"

Answer, 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.

Okay, next question. "Is there a goal for CY 25 or one planned for the future? And how does this new eCQM affect CMS star ratings?"

And the answer is there currently is no goal for 2025, CY 2025. Safe Use of Opioids contributes to CMS star ratings because it is one of the 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. For more information about star ratings, you can go to the overall hospital quality star ratings page on the CMS provider data catalog, and that again is at data.cms.gov.

Next question, "How does this measure apply to Critical Access Hospitals under CMS conditions of participation?"

Answer, Critical Access Hospitals are required to report on this measure.

Okay, next question. "What EHR tools in EPIC are currently available to help improve on this eCQM metric?"

We encourage you to work with your EHR vendor to determine what tools are available to improve the measure.

"When can we expect a benchmark to be announced for this measure? And will sickle cell patients be eventually excluded?"

Answer, there are no plans to establish a benchmark for this measure at this time. Patients with sickle cell disease are excluded from this measure as of version seven for the 2025 Reporting Period.

Okay, the next question is also looking for benchmark information. And again, there's no benchmark yet for this measure. Hospitals can compare their performance to national averages in national top 10% performance rates available on the Care Compare website in the downloadable hospital Timely and Effective national file.

Next question, "When looking at our patients who are discharged with Numerator criteria from an acute care settings, it is almost always a continuation of home medications which is appropriate. So is the intent to encourage acute care providers to discontinue medications managed by an outpatient provider?"

Answer, no, the intent is not to encourage acute care providers to discontinue home medications managed by an outpatient provider. There are some patients for which it is appropriate to order an additional short-term use opioid at discharge. CMS recognizes this and does not expect a performance rate of zero for all patients. The intent is to raise awareness of opioid co-prescribing and opioid and benzodiazepine prescribing to minimize it when there are alternatives that will meet the patient needs.

00:55:46

Okay, there are a number of more questions regarding the availability of benchmarking, which I think we've pretty much answered all of the different nuances there.

So I'm going to go to this question that reads, "Currently if the same med is dispensed but with a different dose, the reports are counting them as two different medications due to having different RxNorm codes, but it is the same medication. How should these be handled?" And the answer is that the measure considered an opioid as unique based on the RxNorm code for the opioids and would include them in the Numerator.

Next question, "Does the diagnosis of sickle cell require an onset date?"

Answer, yes, and must be active, not abated, during the inpatient encounter period interval.

Okay, I'm trying to scan through and find some different types of questions. "Can you please clarify when the new specifications will be effective?" And then the answer is that the specifications being reviewed today are for patients discharged within the 2025 calendar year.

Okay. Next question. "If the patient is admitted to inpatient, then their status changes to observation, and they are eventually discharged in the observation status. Would they be included in the measure?"

Answer, discharging to observation status is not an exclusion. If the patient meets Initial Population criteria, they would remain in the measure.

All right. Well, this one's not related to opioids. There is a question about webinars for other measures, for example, the PC-02 and PC-07 perinatal measures. And that particular measure and webinars for this year, this is actually the last webinar broadcast for the 2025 updates, but the webinars that were previously recorded are available, and you can visit the website to see all of the available recordings, the slides and follow-up documents as they become available. And that is at The Joint Commission websites under Quality Measurement webinars and videos and it's under Expert to Expert Webinar Series.

Okay, just scrolling through the questions here. We do have one comment here regarding, "The measure considerations and FAQ slides are very insightful and helpful. Is it possible to make these an integration into all future presentations?" So we do want to say thank you for this recommendation, and we'll discuss this with our Subject Matter Experts in teams, and we are glad that you found this helpful.

Great. Okay, next question. "What was the rationale for changing the Denominator Exclusion from a diagnosis of cancer to specifically cancer-related pain?"

And the answer is that the Denominator Exclusion was updated to cancer-related pain to align with the clinical practice guidelines.

Okay. So just a diagnosis of opioid use disorders does not exclude from the Denominator. Diagnosis of opioid use disorder excludes a patient from the Denominator for version seven of this measure for the 2025 reporting period. Okay, and just another question regarding the cancer diagnosis.

"So just to confirm, a standalone cancer diagnosis alone is removed as an exclusion. There must be a cancer-related pain diagnosis now instead. Is that correct?"

Yes, that is correct. Okay.

01:00:35

Here's another question regarding...

Oh, here's the next question. "Is the same opioid medication at same dose, one given as scheduled dose and route and same med dose with same route as PRN count as one or two discrete opioids?"

Answer, this would depend on whether they have the same or different RxNorm codes. If the four medication components, dose, and route are the same, the RxNorm code should be the same. Okay.

This next question asks, "Where can we find a definitive list of Schedule II, III, and IV opioid medications?"

You can find the full list of Schedule II, III, and IV codes on the Schedule II, III, and IV Opioids Medication Value Set Viewable from the Value Set Authority Center at vsac.nlm.nih.gov. And again, we will include the complete OID number within the written Q&A document when that is posted.

Next question, "Sickle cell is not identified by ICD-10 codes." Answer, sickle cell disease is identified by SNOMED CT and ICD-10 codes listed in the sickle cell disease with and without crisis value set. You can view these codes on the Value Set Authority Center, VSAC, at vsac.nlm.nih.gov website. And again, we will include the OID for the value on the written Q&A.

Okay. I see our colleagues in the background are furiously answering these questions as best they can, but I'm not seeing any that have completed answers at this time. Did I miss anything, Raquel?

I don't think so. I'm seeing the same here on my end.

Okay. All right, then we will pass it back over to Susan Funk to close us out.

Great. Just a couple that I see here that are more operational. We'll go into some of these on the slides, but since we've got a minute, I will just share a couple more. We always get asked if the session is being recorded. We do record all of these and we offer all of them, as we've mentioned, on the Expert to Expert Webinar page. We'll share that link in a moment. For anyone that has not yet downloaded the slides, the slides won't be available for another couple weeks, so make sure that you download the slides. They're in the viewer toolbar. You just need to select the icon that looks like a document. If you don't have popups enabled, you might have difficulties getting to them. Real quick, let's see if there's anything else, if any of the other questions were able to be answered during the webinar.

Oh, I have-

Go ahead.

I do have another one here that popped up with an answer, so I'll read it real quick.

Oh, that's great. Thanks.

"Does inpatient include patients in observation or swing bed status?" The patients discharged from observation are not included in the patient population, Patients who are admitted to an inpatient encounter and subsequently transferred to a skilled nursing level... Same...

Susan, I think we lost you on the tail end of that response. Could you maybe just give the response again?

The measure. eCQMs are not able to differentiate patients based on level of service. We encourage you to order for purposes. Thank you. Did you catch that? I'm sorry. I did. I was able to catch the rest of the answer.

Raquel, are there any-

Okay, very good. Thank you. I was going to say, are there any more, Raquel, that you have located that the team might have been able to respond while Susan was doing the last one?

I am scrolling through and I haven't found any new questions with responses currently.

01:05:08

Okay. Well, let me see if there are any other more operational ones that we can just use for now. I don't think there... I think we are actually coming towards the end of the ones that are not repeats or that don't have complicated responses that are taking longer to respond to. Just wait one more second. Okay, I think we've gotten to everything that we possibly can in the queue today. Thanks to everyone in the audience for your patience while we were responding to all of these.

As we've noted, all of the Expert to Expert Webinar recording links, slides, transcripts, and Q&A documents can be accessed within several weeks of the live event. We've provided the link at the bottom of this slide. If you've downloaded the slides, you'll be able to just click on that to go straight to the page.

As a reminder, the Q&A documents are usually a few weeks for us to develop and get posted. That's because they need to be reviewed and approved by CMS first.

So let's just go through as a reminder about the evaluation survey and certificate. Before this webinar concludes, just a quick reminder, we use your feedback to determine education gaps inform future content and assess the quality of our educational programs. As explained earlier, a QR code is provided on the next slide. If you prefer to take the CE survey later, an automated email also delivers that survey link. After you complete the survey, you'll be redirected to a page from which you can print or download a certificate that you would, I'm sorry, that you can print or download a certificate that you will complete by adding your own name and credentials.

In case you log off without downloading or printing your certificate, you'll also get an automated email that will include the link. And this email is sent to the address that you provide within the CE survey. Just a quick reminder that the survey is only open for two weeks, so make sure that you promptly complete the survey.

So I will pause on this slide for several moments just to permit all of those that wish to use the QR code to scan it with your mobile device. I just want to give a lot of thanks to Erin for developing and presenting the content. There were a lot of changes this year, so thank you for presenting all of those. And thank you to Susan and Raquel for facilitating the Q&A segment. I know that was... We had a bit longer for questions today, so thank you. I know that was a mouthful. And thanks to the Mathematica team that were responding to the questions as the audience was submitting them throughout the webinar. And finally, thanks to all of you that attended today. We hope that you all have a great day. I'll pause here for just a few more seconds for anyone that wishes to scan that QR code, and then we'll log off. Thanks so much.