Pioneers in Quality Expert to Expert Series: 2025 Reporting Year Annual Updates for Hospital Harm- Opioid-Related Adverse Events (HH-ORAE)

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Welcome to our Expert to Expert Webinar: Annual Updates for Hospital Harm, Opioid Related Adverse Events eCQM for 2025 implementation. I'm Susan Funk, an Associate Project Director with The Joint Commission's Engagement and Quality Improvement team. And today I'll be serving as this webinar's facilitator. Thank you for joining us.

As we get started, I'll share just a few comments about today's 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 questions and submit. The slides are designed to follow Americans with Disabilities Act rules.

Before we get started covering today's Electronic Clinical Quality Measure content, we do want to explain that this measure 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 for individuals that are new to eCQMs to comprehend. We recommend that anyone new to eCQMs visit the eCQI Resource Center at the hyperlink provided on this slide. You'll find a collection of resources to help you get started with eCQMs.

The slides are available now within the viewing platform. On the left side of your 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 the broadcast. One last note about the slides. The links are not clickable on screen within this viewing platform. However, if you download the slides, all of the links provided during the webinar are functional.

This webinar is approved for one Continuing Education Credit or Qualifying Education Hour for the following organizations: the 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 organizations that accredit Joint Commission to provide CEs, many other professional societies and state boards that are not listed except credit or will match credit from Joint Commission's educational courses.

To earn CE credit, participants must individually register for this webinar broadcast, 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, please visit the link at the bottom of this slide.

Just a few words about how to navigate to the CE survey and obtain your CE certificate. You will receive the survey link in 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 within 24 hours that includes the survey link. After you submit the online evaluation survey, you will be redirected to a link from which you can print, and download or save a PDF certificate. In case you miss the popup screen with the certificate, an automated email will also deliver the certificate link. Complete the certificate by adding your own name and credentials.

The learning objectives for this session are, locate the measure specifications, value sets, measure flow diagrams and technical release notes on the eCQI Resource Center. Facilitate your organization's implementation of the Hospital Harm Opioid-Related Adverse Events, or ORAE, eCQM Annual Updates for the 2025 calendar year. And utilize answers regarding common questions and issues regarding the ORAE 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 eCQM validation. 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, Melissa Breth and Raquel Belarmino.

The agenda for today's discussion follows. Highlight how to access eCQI Resource Center navigational demo, review the Hospital Harm Opioid-Related Adverse Events eCQM, review the measure flow and algorithm, review Frequently Asked Questions. And then we'll have a live facilitated audience Q&A segment during which we'll respond to questions you've submitted throughout the webinar.

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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 stakeholder use and provide a foundation for the development, testing, certification, implementation, reporting, and continuous evaluation of eCQMs. Melissa, when you're ready, please go ahead and start your part of the presentation. I will continue to screen share.

Thank you, Susan. For the measure specifications and other helpful documents, navigate to the eCQI Resource Center website at ecqi.healthit.gov. Click on the orange rectangle labeled Inpatient eCQMs, which leads to a 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 this selected measure. The eCQM Flow documents depicts the process flow diagrams that some may refer to as algorithms. They walk through the steps to calculate, they walk through the steps to calculate an eCQM. Value sets link out to the Value Set Authority Center or 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. I'll now turn things over to Erin Buchanan to present about the Opioid-Related Adverse Events eCQM. Erin, please proceed whenever you're ready.

Erin, I'm going to make you the presenter now, and when you're ready and have your presentation up, feel free to begin your part of the presentation.

Thanks Susan. Can you see my screen?

We can indeed. Thanks for checking.

Thank you. Now I will provide some background information for hospital harm Opioid-Related Adverse Events. This measure is an outcome measure to assess the number of inpatient hospitalizations for patients age 18 and older who have been administered an opioid medication outside of the operating room, and are subsequently administered a non-enteral opioid antagonist outside of the operating room within 12 hours, an indication of an Opioid-Related Adverse Event. This measure is intended to be used to identify and reduce unintended Adverse Events of opioid administration. This is an inverse measure in that a lower measure score indicates higher quality. This measure uses the administration of an opioid antagonist following an opioid medication as an indicator of an Opioid-Related Adverse Event.

Opioids are the most used analgesic in post-op hospitalized patients and are associated with the unintended Adverse Events such as over-sedation, delirium, and respiratory distress. Opioid-Related Adverse Events are also associated with increases in hospital length of stay, and odds of higher death, higher costs, and higher risk of 30-day readmissions. Rates of inpatient Opioid-Related Adverse Events are preventable with better monitoring and response, and are indicative of quality of care. So now I'll go over the changes from 2024 versus 2025.

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Please note that throughout this presentation the star in a circle icon will denote changes with new content as underlined text and removed content as stricken text. For this measure, the term inpatient hospitalizations includes the time in the emergency department and observation when the transition between these encounters and the inpatient encounter are within an hour of each other. Patients must be 18 years or older at the start of the inpatient encounter to be included, and they must have at least one opioid medication administered outside of the OR. The description has been updated for reporting year 2025 to specify that the opioid and antagonist must be non-enteral and administered outside of the operating room. The acceptable routes for administration of the opioid antagonist are non-enteral, meaning that it is not delivered via the gastrointestinal tract. This includes intranasal spray, inhalation, intramuscular, subcutaneous or IV injection. Routes considered enteral that are not acceptable are oral, nasogastric, and gastronomy. The Initial Population description was updated to add a timing event also, specifying that the hospitalization must end during the measurement period.

The Denominator equals the Initial Population, and no updates to the Denominator were made beyond those made to the Initial Population. The Numerator was also updated to specify the opioid antagonist must be non-enteral and to clarify the timing elements.

Next, we'll review the measure flow, which provides a high level overview of how the measure works.

The Initial Population main definition for hospital harm ORAE is encounter with opioid administration outside of the operating room. These conditions must be met to qualify for the Initial Population. One, an inpatient encounter must be present which ends during the measurement period. Two, the patient must be greater than or equal to 18 years of age at the start of the Initial Population encounter. And three, an administration of an opioid medication during the encounter that is not administered within an operating room/suite location. If the criteria is met, the patient is in the Initial Population. If not, the patient is not in the Initial Population and processing ends. Note that the Denominator is equal to the Initial Population, so if the patient is in the Initial Population, they also meet the Denominator. Also note that there are no Denominator Exclusions for this measure.

Moving on to the Numerator, which is encounter with non-enteral opioid antagonist administration outside of the operating room and within 12 hours of opioid. We've circled the area of the flow that was updated for the 2025 reporting year. The Numerator logic was updated to specify the opioid antagonist must be non-enteral and to clarify timing elements, as I noted before. We've broken this down to criteria that make up this definition, noted on the right side of the side slide. The encounter will get into the Numerator if, one, there's a non-enteral opioid antagonist administered 12 hours or less before an opioid antagonist was administered.

Two, the opioid antagonist administration starts during the encounter shown here as hospitalization with observation. Three, the opioid antagonist route of administration is one that is included in the routes of administration for opioid antagonist value set, i.e, the non-enteral routes of intranasal spray, inhalation, intramuscular, subcutaneous, or intravenous injection. And finally, four, the opioid antagonist is not administered in the operating room/suite, which is an encounter location. If all four criteria are met, the Numerator is met. If not, the Numerator is not met and the processing ends.

Oh, now that the Denominator and Numerator are defined, we can plug the quantities into the calculation formula. The performance rate aggregates the populations into a single performance rate for reporting purposes. In this example, a Numerator, C equals 10, is divided by the Denominator, A equals 100, to equal a 10% performance rate. Remember that the lower the rate, the higher the quality. The C and the A refer to the Numerator and Denominator populations identified by these letters earlier in the flow diagram.

Next, we will review the measure logic. Let's quickly level flat on the layout of this slide. At the top of the slide we have the description of the population narrative followed by the CQL measure population logic definition in the blue text box. Beneath that, will be all of the nested definitions used to create the population. Using this waterfall layout with the arrows shows how these definitions are nested within one another.

With that said, let's begin with the first criteria in the Initial Population. Beginning with the broadest criteria, we want to define the qualifying encounter nested within the encounter with opioid administration outside of the operation room definition when we follow the arrow on the left upwards. The qualifying encounter creates the inpatient hospital encounter where the patient has to be 18 years of age at the start of the inpatient hospitalization during the measurement period. Moving on, we see the opioid administration definition. Here we are looking for the administration of a medication included in the opioids all value set. Following the arrow on the right, we see opioid administration is also nested within the encounter with opioid administration outside of the operating room definition where the logic is looking to see if the opioid was given during the encounter. I want to point out two things here.

One, the measures use the global hospitalization with observation function to determine the interval of the entire inpatient hospitalization encounter, which includes the time in the emergency department or observation when these encounters are within an hour of the inpatient admission. And two, the measure uses the global normalized interval function for the medication data type as it is one of the QDM data types that has both the relevant date, time, and relevant period. The normalization interval function is meant to account for differences in EHR vendors' capture of the timings in measure criteria, and to decrease implementation burden due to variable use of the timing attributes for the same QDM data types across all measures. Continuing on, here's the logic to support the update that only opioids administered outside of the OR will be evaluated for the Initial Population. The Not Exist Clause was added to ignore occurrences where opioids are given outside of, or given in the OR. The operating room suite location is captured as an attribute or facility locations of the qualifying encounter, inpatient encounter, in the parenthesis.

The logic expresses an encounter location.code followed by operating room/suite. You see a tilde symbol in the middle there, and that is an equivalence operator. So it is essentially looking for a location code that is equivalent to one that has operating room or suite in its string description. The logic then evaluates if the opioid is given during the period of time the patient was in the OR location. So, putting all of this together, the inpatient population is looking for, the Initial Population is looking for inpatient encounters with an opioid administration during the encounter where the following situation does not exist. That situation being the opioid being given during the period of time the patient was in the OR location.

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Moving on to the Denominator. The Denominator is the same as the Initial Population, so rather than repeating everything from the previous slide again, we can simply call in the Denominator statement Initial Population, which we reviewed on the previous slide.

As a reminder, the Numerator is inpatient hospitalizations where a non-enteral opioid antagonist administration starts during the hospitalization outside of the operating room and 12 hours or less following an opioid medication administered outside of the operating room. Also, as a reminder, the route of administration for the opioid antagonist must be by intranasal spray, inhalation, intramuscular, subcutaneous, or intravenous injection. Only one Numerator event is counted per encounter.

Now, I'll provide a detailed overview of the Numerator logic. Some of this overview will include points made during the review of the measure flow. The logic still looks for an opioid antagonist administered, but uses the streamlined definition of non-enteral opioid antagonist administration, which includes the data type medication administered where the route of administration is found in the routes of administration for opioid antagonist value set. The next update is to call for the Denominator definition of inpatient hospitalization followed by the timing for the non-enteral opioid administration to ensure that the measure captures its administration during the inpatient hospitalization and outside of the operating room.

Next, I'll review the logic to support that only non-enteral opioid antagonists administered outside of the OR will be evaluated by the Numerator. Here, the not exist clause was added to ignore occurrences where the opioid antagonists were given in the OR. The logic then evaluates if the non-enteral opioid antagonist is given during the period of time the patient was in the OR location. The logic then uses non-enteral opioid antagonist given time rather than the previous logic to determine the timing for the opioid antagonist. Here you can see several lines of logic around timing of the opioid antagonist. And opioid administration was removed from the measure.

On the next slide, we'll discuss those updates. Similar to the previous year's logic, this logic states that only opioids administered outside of the OR will be evaluated for the Numerator rather than the non-enteral opioid antagonist. As noted before, the not exist clause was added to ignore occurrences where opioids were given in the OR. The logic then evaluates if the opioid is given during the period of time the patient was in the OR location. The rest of the logic supports the remaining Numerator criteria, which includes a non-enteral opioid antagonist given in the hospital and a opioid given in the hospital. And the opioid was administered at least 12 hours or less before the start of the non-enteral opioid antagonist administration. If an opioid antagonist, given outside of the OR, follows an opioid administration, this is an indication of an Opioid-Related Adverse Event, i.e, Numerator Harm Event.

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And now we will go over a Frequently Asked Question that we've received. So yeah, we've received this question a few times.

"Do opioid antagonists dispensed in the ED for community overdose reversal count towards this measure?"

And the answer is no. The intent of this measure is to identify patients who are administered an opioid antagonist outside of the operating room within 12 hours of opioid administration, as this indicates an Opioid-Related Adverse Event. The QDM data type medication administered addresses medication taken by the patient. We recognize that across the country there are programs that authorize providers and hospitals to dispense naloxone free of charge to certain individuals to prevent opioid overdose in the community. Since these patients did not require administration of the naloxone while in the hospital, which would indicate an Opioid-Related Adverse Event, these cases would not be in the Numerator.

And so that's all we have to cover today about the measure. I'll pass it back to Susan to review resources.

Excellent. Thank you so much, Erin, for presenting the updates for the eCQM and the Frequently Asked Question. We've included an additional resource slide here and provided links to direct the webinar participants out to the eCQI Resource Center, CMS eligible hospitals measure page, and to get started with eCQM links, as well as the Teach Me Clinical Quality Language video series landing page and the video shorts on Hospitalization with Observation and What is a Value Set. Our next slide. Thanks.

Continuing with the resource links, we provided a link to the Value Set Authority Center or VSAC support, the Pioneers in Quality landing page and The Joint Commission's website, the Expert to Expert series landing page, and finally, the ASTP/ONC issue tracking system where clinical and technical questions about these eCQMs should be submitted following the webinar. Our next slide.

Okay, so now we're going to go into our live Q&A segment.

So just let me reiterate real quick how to submit questions. You'll submit your questions using the question pane. Click on the question mark icon that's in the audience toolbar. A panel will open for you to type and submit your question. When possible, please include a slide reference number. And all of the questions that are not answered during the live event will be addressed in a written follow-up Q&A document. To clarify, any of them that have a typed response will also be included. But any that we don't get to today, we will always address in the written document. And that follow up document will be posted to the Joint Commission website within several weeks of the live event.

So, with that I'm going to turn it over to Melissa and Raquel to facilitate the Q&A segment. And Erin, I'll take over the screen sharing in just a moment, thanks. Great, thank you Susan. I'll kick off the Q&A segment with some pre-submitted questions from the audience.

First question is, "If a patient is transferred to a higher level of care and given an opioid agonist, would this trigger this eCQM?"

To clarify, this measure assesses opioid antagonist administration. Patients over age 18 who are transferred to a higher level of care such as the ICU within the same facility would fall into the measure. However, a patient needs to have been administered an opioid medication in the facility but outside of the operating room and subsequently administered a non-internal opioid antagonist outside of the operating room within 12 hours.

Okay. The next one is also one that was submitted prior to the webinar asking for strategies for reducing concurrent opioid or benzo at discharge. Thank you for your question. This question is not relevant to this measure and its intent is to assess Opioid-Related Adverse Events, a common and preventable inpatient adverse drug event rather than Opioid Prescription at Discharge. There is a webinar on February 27th coming up on CMS506, Safe Use of Opioids Concurrent Prescribing, which may be helpful.

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Great. Our next question here, "What about opioid addiction in the perinatal population and NAS babies?"

The intent of CMS819 is to assess Opioid-Related Adverse Events, a common and preventable inpatient adverse drug events rather than opioid addiction. Patients in the perinatal population are included in this measure. A perinatal patient over age 18 who is administered an opioid medication in the facility but outside of the operating room and subsequently administered non-enteral opioid antagonist outside of the operating room within 12 hours will qualify for the measure. A newborn who received an opiate and required administration of an antagonist would not qualify for the measure. Okay.

Next question. "What quantitative benchmarks or targets are set for this metric such as, is there a percentage institution should strive for?"

There is not yet a national average for CMS819 hospital-harm Opioid-Related Adverse Events. For this measure, a lower measure score indicates higher quality.

"Will the definition be changing in 2025?"

Thank you for your question. The definition for the measure has not changed for 2025. The measure description for CMS819 hospital harm Opioid-Related Adverse Events was updated for reporting year 2025 to specify that opioid and opioid antagonist administration must both occur outside of the operating room.

Okay, next question. "Does this also include patients in the PACU?"

Only opioid antagonists administered outside of the OR following an opioid administration would be considered for the Numerator. Opioid antagonists administered in other settings outside of the OR such as the post-op recovery unit or PACU, catheter and endoscopy lab, or interventional radiology would not be a routine component of the anesthesia plan. In those locations, opioid antagonist administration is most likely related to over-sedation and could be evaluated for the Numerator. The measure identifies an operating room by documentation of hospital location, HSLOC code 1096-7, operating room or suite.

Okay. "Can you clarify that the time in the ER and observation counts as part of the inpatient stay. What if they are in observation for two days prior to going inpatient? Does the ER visits still count?"

In the narrative definitions sections of these measures, inpatient hospitalizations are defined as including time spent in the emergency department, ED, or observation when these encounters are within an hour of the inpatient admission. In other words, if the transition time between when an ED visit ended and an inpatient admission started is one hour less then the inpatient hospitalization period would begin at the start of the ED or observation visit. If the transition time between when an observation visit ended and an inpatient admission started is more than one hour, then the inpatient hospitalization period would begin at the start of the inpatient admission.

Okay. Next question. "What programs is this measure relevant to?" This measure is in the hospital inpatient quality reporting or IQR program. "If there is more than one event during the Episode of Care, which event will be captured and reported?"

Only one Numerator event is counted per encounter. If there is more than one event, the first will be counted.

Question, "Would opioid administration in the emergency department prior to an inpatient admission be included in this measure? Would a patient with an OBS admission not an inpatient admission be included in this measure?"

An inpatient encounter is required for this measure. If the transition time between an ED visit ended and an inpatient admission started is one hour or less, then the inpatient hospitalization period would begin at the start of the ED or OBS visit. If the transition time between an ED visit ended and an inpatient admission started is more than one hour, then the inpatient hospitalization period would begin at the start of the inpatient admission.

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Next question. "Should a patient be counted in the measure if they were given buprenorphine in the ED but then needed naloxone as a result of an overdose of heroin taken prior to admission?"

The measure requires that a documented administration of an opioid by hospital staff during the encounter must proceed the opioid antagonist to be considered. Therefore, opioids taken prior to the start of the encounter such as at home would not be captured. This specification protects hospitals from being penalized for appropriately treating patients that enter the facility with opioids in their system or have taken opioids secretly while in the hospital and subsequently require a naloxone administration. "Enteral administration includes oral, sublingual, and rectal administration, as well as via nasogastric tube or gastric feeding tube. Are all of these routes not included, meaning excluded in the Numerator?" Yes, all non-enteral opioid antagonist administration is considered for this measure. All enteral administrations are excluded.

"When will this data be mandatory for public reporting?"

Mandatory reporting begins in 2027. Okay, just scanning through here. Looks like we have some folks asking the same questions, so we we'll give the staff time to answer these questions and prepare the Q&A. So back to you, Susan.

Great, thanks so much. Especially to all the folks in the background typing the responses to the questions. I know it can be complicated, the thinking on the spot and preparing responses for these. So, as we mentioned, anything that we didn't get to that's still in the Question and Answer queue, we will follow up in a written Q&A document. For now, we'll go on to the next part of the presentation, which is just some of the closeout information.

So, all Expert to Expert webinar recording links, slides, transcripts and when they're available, the Q&A documents will be accessible on The Joint Commission's webpage. The captioned recording and materials will be available at the link that's displayed here within several weeks of the webinar. In today's handouts, we've also included a PDF that provides the registration links for all of the Expert to Expert webinars that are currently open for registration. The link on this slide, as I mentioned, goes to the Expert to Expert landing page on Joint Commission's website. And that's where we will include any additional links for, additional webinar sessions as we open the registrations for them. And then this is also the location where you will go to get that written Q&A document. It does need to be approved by CMS and that's why it's not an immediate posting. We do need to prepare the responses and then get approval for them.

With that, I'm going to mention a few things about the CE survey. Before this webinar concludes, a reminder about the survey. We use your feedback to, I'm sorry, my slide just switched. One moment please. Sorry, everyone. Before this webinar concludes, just a few comments that relate to the survey. So, we use your feedback to determine any educational gaps and what your organization needs to know, inform future content, and we use it to assess the quality of our educational programs.

As we explained earlier, a QR code is provided on the next slide. If you prefer to take the CE survey later, an automated email will also deliver that survey link to you. At the end of the survey when you click submit, you will be redirected to a page from which you can print or download a certificate that you will complete by adding your name and credentials. In case you log off without downloading that popup PDF, you will also receive an automated email that includes the link. And that email is sent to the address that you provide within the CE survey.

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With that, we will pause on this slide for several moments just to permit anyone that wishes to use the QR code. You can just scan it with your mobile device and it will take you directly to the CE survey. I just want to say a few thank yous. Thank you, Erin, for developing and presenting the content today. Melissa and Raquel for facilitating the Q&A segment, and to the team in the background that has been typing the responses to the questions throughout the broadcast. And finally, thanks to all of you that attended today. We hope that everyone has a great rest of their day.