Transcript
Pioneers in Quality – Expert to Expert Series
The CMS Safe Use of Opioids – Concurrent Prescribing eCQM
On-Demand Webinar
January 2020

0:02

Thank you for joining us for our Pioneers in Quality On-Demand webinar series, Expert to Expert: the CMS' Safe Use of Opioids - Concurrent Prescribing Measure Review for the 2021 reporting period.

0:15

This webinar is brought to you by The Joint Commission, the Centers for Medicare and Medicaid Services, and Mathematica Policy Research. This on-demand webinar series will offer continuing education credit. This measure is adopted by CMS for self-selection, beginning with the calendar year 2021 reporting period. This webinar series addresses the CMS' safe use of opioids, concurrent prescribing, measure intent specifications

0:40

We will also be offering a session that provides an overview for changes that occurred during the 2020 eCQM Annual Update Cycle for the STK and VTE measure sets, PC-05, and ED-2.

0:53

Each session will also include a segment during which the measure leads will respond to common questions from Jira and other sources. So make sure to stick around for the end of the session to hear all of the Q&A. You can access these sessions by visiting The Joint Commission webpage and also the eCQI Resource Center under the general eCQM and eCQI page.

1:13

Also, new to this webinar series are a series of supporting educational video shorts that address the more basic components of eCQMs and CQL. Most sessions are approximately two minutes in length.

These videos can be viewed anytime, so whether you're in need of a refresher or if you're new to the eCQM landscape, it takes less than 20 minutes to watch all five video shorts.

These videos can also be accessed on The Joint Commission website as well as on CMS's under the same general eCQM and eCQI education page.

1:46

Before we start, we'd like to offer just a few tips about webinar audio. Use your computer speakers or your headphones to listen. Feedback or dropped audio are common for streaming video.

Refresh your screen, if this occurs. You can pause the playback at any time.

2:02

If you'd like to follow along and take notes, you can access the slides now within the viewing platform. See the left side of your navigation pane and select the icon that looks like a document. 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 and save or print the PDF of today's slides. The slides will also be posted on The Joint Commission's website at this link.

2:28

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2:49

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For more information on The Joint Commission's continuing education policies visit the link shown on this slide.

3:42

At the end of this session, participants will be able to: apply concepts learned about the CMS' Safe Use of Opioids - Concurrent Prescribing eCQM, identify common issues and questions regarding the CMS' Safe Use of Opioids - Concurrent Prescribing eCQM, and prepare to implement the CMS' Safe Use of Opioids - Concurrent Prescribing eCQM adopted for the calendar year 2021 reporting period.

4:08

These staff and speakers have disclosed that neither they nor their spouses, or partners have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity: Susan Funk, Theresa Feeley-Summerl, and Mia Nievera.

4:26

I'm Susan Funk, Senior Research Associate and the lead operations staff for Pioneers in Quality, and I'm Theresa Feeley-Summerl, Measure Lead at Mathematica, and I'm Mia Nievera, Project Director for the eClinical team.

4:40

On today's session, we will review the measure logic for CMS' Safe Use of Opioids - Concurrent Prescribing eCQM. Theresa, take it away.

4:49

Thanks Mia, we'll go ahead and start with the measure rationale and intent.

So the first thing we want to look at is the unintended opioid overdose fatalities.

They are a major public health concern and 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 or the CDC, the Federal Interagency Workgroup for Opioid Adverse Drug events, and the Substance Abuse and Mental Health Services Administration.

5:21

The second point that we want to talk about is that concurrent prescriptions of opioids or of opioids and benzodiazepines place patients at greater risk of unintentional overdose due to the increased risk of respiratory depression. So eliminating concurrent use of opioids and benzodiazepines could reduce the risk of emergency room and inpatient visits related to opioid overdose by 15%.

5:43

And 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 and rates of fatal opioid overdose are 10 times higher in patients who are co-dispensed opioid analgesics than benzodiazepines and opiates alone.

6:06

The number of opioid overdose deaths involving benzodiazepines increased 14% on average each year from 2011 to 2016.

While the number of opioid analgesic overdose deaths not involving benzodiazepines didn't change significantly.

Furthermore, concurrent use of benzodiazepines with opioids was prevalent in 31 to 51% of fatal overdoses.

6:31

Studies in multiple claims and prescription databases have shown that 5 to 20% of patients received concurrent opioid and benzodiazepine prescriptions across various settings.

6:41

And one study found that eliminating concurrent use of opioids and benzodiazepines could reduce the risk of opioid overdose related emergency department and inpatient visits by 15% and potentially could have prevented an estimated 2,630 deaths related to opioid pain killer overdoses in 2015.

7:02

A study on the Opioid Safety Initiative and the Veterans Health Administration, which includes an opioid and benzodiazepine concurrent prescribing measure that this measure is based on, was associated with a decrease of over 20% overall and 0.86% patients per month. So, about 781 patients (per month) receiving two current Benzodiazepine with an opioid among all adult VHA patients who filled outpatient opioid prescriptions from October 2012 to September 2014.

7:35

And our third point is that the Safe Use of Opioids measure aligns with the CDC guidelines for prescribing opioids for chronic pain and 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.

7:56

So our intent here. given the need around prescriptions for concurrent opioid prescriptions and benzodiazepine and opioid prescriptions, the measure has two main aims.

First, identify patients with concurrent prescriptions for review and careful monitoring and also to discourage providers from prescribing two or more opioids or opioids and benzodiazepines concurrently. The measure looks at the proportion of inpatient hospitalizations for patients ages 18 and older prescribed or continued on two or more opioids, or an opioid and benzodiazepine concurrently at discharge.

For this measure a lower rate indicates higher quality care.

8:40

We'll go over each of the definitions in detail, but this is a brief overview.

8:45

The denominator includes patients 18 years of age and older with an eligible hospital encounter, which we will define shortly.

8:53

During the measurement period, you are discharged with at least one new or continuing opioid prescription or a new or continuing benzodiazepine prescription; and to clarify, prescriptions include those newly prescribed for patients at discharge, and continuing prescriptions that may have been prescribed before the hospital encounter, both of which should be included in the medication discharge list.

9:20

Note that the denominator only includes patients newly prescribed, or continuing an opioid or benzodiazepine at discharge, not all patients discharged.

I also want to add that, as you'll see on the next slide, all patients in the initial population are included in the denominator.

9:38

Excluded from the denominator are patients with a cancer diagnosis that overlaps with or happens during the eligible encounter, and patients receiving palliative or hospice care, including comfort measures, terminal care, and dying care.

9:54

The palliative and hospice care exclusions in this measure have been harmonized with other measures.

10:00

This also aligns with the CDC guideline that provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end of life care.

10:13

The numerator is formed of patients that have been prescribed two or more opioids at discharge or, an opioid and benzodiazepine.

10:23

Just to emphasize that, patients can trigger the numerator by either having prescriptions for two opioids at discharge or prescriptions for an opioid and benzodiazepine.

10:33

So again, scoring a lower rate on this measure would be an indication of higher quality care.

10:40

You'll find the value sets for the measure listed under the terminology section of the logic.

10:45

Here, I just want to pull out some of the particularly notable value sets, some of which we've gotten questions on.

The first three value sets help us define our Initial Population, which for this measure, is also the denominator.

11:00

The Encounter Inpatient set should look familiar. It's an extensional set, a value set that contains codes from only one code system. In this case, SNOMED CT codes that represent the most common inpatient encounter types and is used by several other hospital measures.

11:19

"Schedule II and III Opioid Medications" is a grouping value set containing codes for all of the opioid medications used for this measure.

A grouping value set is a list of several value sets that share a common purpose and similar clinical concepts.

11:33

This value set is restricted to Schedule II and III Opioid Medications. We're not including Schedule IV or V Opioids in the measure, in part to align with the intent of the measure to focus on opioids with high and moderate potential for abuse and in part to reduce the burden of reporting, particularly Schedule V opioids, which include cough preparations with less than 200 milligrams of codeine per 100 milliliters or per 100 grams.

So things like Robitussin AC®, Phenergan with Codeine®.

Schedule IV benzodiazepines is an extensional set containing all of the benzodiazepine medications used for this measure.

12:12

Both of the Schedule II and III opioid medications and the Schedule IV benzodiazepines are used to define the initial population in that patients should be prescribed at least one medication from at least one of these value sets.

And the same medication value sets are also used to define the numerator and that patients are prescribed two opioids from the Schedule II and III opioids medications list, or one opioid from the Schedule II and III opioid medication, and one benzodiazepine from the Schedule IV benzodiazepine value set.

12:45

So, here, we've replaced extensional value sets, palliative care, and hospice care, with a grouping value set, "palliative or hospice care," based on expert review or public feedback, to harmonize with other measures.

13:00

The "all primary and secondary cancer value set" is a grouping that contains both ICD 10 and SNOMED CT codes. This group of value sets identifies patients with a current cancer diagnosis, either primary or secondary, and excludes benign tumors, cancer in situ, unspecified or uncertain behavior neoplasms, as well as codes indicating in-remission.

13:25

Patients receiving palliative or hospice care are excluded using the "palliative and hospice care" grouping set that we chose to harmonize with other eCQMs.

13:35

So, within the grouping is the "comfort measures value set," which you may be familiar with, and harmonizes with several other hospital measures and the "palliative SNOMED set" which is more frequently used in eligible clinician measures.

13:49

Our goal here is to ensure that we're aligning with the CDC guidelines, and not applying this measure to patients receiving palliative or hospice care.

13:58

Some of you may have also seen the question about this value set on Jira, asking whether the specifications provide any mapping of the palliative and hospice care codes to discharge disposition codes, in the specifications posted on May 2020 for 2021 reporting.

They don't.

However, several of the codes in the grouping value set, palliative or hospice care are included in the SNOMED CT core problem list, which may help you correctly identify patients for exclusion on the basis of hospice or palliative care.

14:32

OK, so now we'll go ahead and take a deeper dive into the logic, understanding the CQL definitions and Quality Data Model, or QDM Data Elements.

14:42

This is the logic for the initial population, represented by the Clinical Quality Language, or CQL, and Quality Data Model (QDM) Data Elements used to create the logical expression for the initial population criteria.

14:58

So, the logic contained in this definition is represented by the narrative statement in the header for Initial population.

15:04

Now, let's walk through the logic.

The purpose of this logic is to capture inpatient hospitalizations and inpatient stay, less than or equal to 120 days, that end during the measurement period, where the patient is 18 years of age or older at the start of the encounter and filtering these encounters to include only patients with a new or continuing opioid or benzodiazepine prescription at discharge.

15:30

The first thing you'll see involved is the name of the definition. Here it's Initial Population.

The Initial Population definition also includes another definition within it.

Inpatient Encounter With Age Greater Than Or Equal To 18.

We'll take a look at the content of this statement or expression on the next slide.

15:50

The definitions in the logic can be found in the definitions list under population criteria in the measure specifications.

Also at the top of the definitions is a comment providing a summary statement of the definition. This is denoted by the /**/ Captures encounters of patients with an opioid, benzodiazepine, or combination of these medications at the discharge.

16:17

So, here, we're skipping to look at the definition we had in the last slide.

To really understand what the Initial Population means when it uses the definition "Inpatient Encounter With Age Greater Than Or Equal To 18". This definition is pretty much what it sounds like it further defines our population to look at inpatient encounters with patients 18 and older.

16:38

We focus on this inpatient population to align with other hospital measures.

At the top of this slide, we've bolded the part of the initial population definition in the header that corresponds with this part of the logic.

As clear as we try to make the name, it's always worth checking the definition to get the details. Here, it's that the patient needs to be 18 at the start of the encounter.

This CQL definition also contains a definition within it, Global.Inpatient Encounter, which we will review in further detail on the next slide, and you can look under definitions to find in the logic.

17:17

Again, we see the relationship denoted with the term "with," used here to filter and add the condition, using the term, such that, to show that the patient is 18 years or older at the start of their inpatient encounter.

You can see the QDM term and its related like-code, "Patient characteristic birthdate", birth date.

17:38

You can find that the code birthdate under terminology and the QDM term and its associated code listed again, under Data Criteria, QDM Data Elements In Logic.

17:49

So here we use a harmonized global calendar CQL function, that all eCQMs share called "Global Calendar Age in Years At" rather than relying on any notation of age in the EHR.

18:03

I also want to point out that this clarifies that the patient should be 18 at the start of their inpatient encounter rather than 18 at the time they're discharged from the hospital.

18:13

We can see that because the timing words "start of" come right before the interval representing the patient's hospital stay, InpatientHospitalEncounter.relevantPeriod.

18:24

Logic uses terms like this, .relevantPeriod to represent an interval and .birthDatetime, for example, to represent a point in time.

18:36

Finally, at the end of the statement, we have an important parameter to find, ≥18.

18:45

This definition is located within the Inpatient Encounter With Age Greater Than 18 definition, and uses the same logic, Global.Inpatient Encounter, used across many measures: hospital stays (inpatient encounters) less than or equal to 120 days that end, or result in discharge, during the measurement period.

19:06

The use of "Global" at the start of the definition here refers to a common definition available in the MAT, Measure Authoring Tool or the shared CQL Global Common Library.

19:18

The first thing you see in the definition is a QDM term, Encounter Performed, and its related value sets that define inpatient encounters.

19:27

You can see more information about the value sets in the terminology and data criteria and look up specific codes on the VSAC, or the Value Set Authority Center.

19:37

Again, we'll use "where" to filter encounters; "and" is used to indicate that both of the statements about encounters must be true to be counted so inpatient periods must be 120 days or less and they must end during the measurement period.

19:56

You can see here that there are two other definitions within the Global.Inpatient Encounter definition.

20:02

"LengthInDays" and "Measurement Period" are more global or commonly used functions to calculate the length and days and the measurement periods the same way across all the measures.

20:13

Because they are calculations, they're not further defined in the logic, but you can look them up on the eCQI Resource Center if you have questions about it.

20:22

And now, we've reached the end of definitions within definitions.

20:27

Now that we've defined "Inpatient Encounter With Age Greater Than Or Equal To 18," let's review the rest of the inpatient population definition. After the "Inpatient Encounter With Age Greater Than Or Equal To 18" you'll see that references in the logic, linking the encounter to the opioid and benzodiazepine medications, via value sets associated with the Medication Discharge QDM data type, using "with" and "union."

20:54

"Union" is a term that combines the two lists, so we can identify a prescription from one list or the other. So please note that Medication Discharge QDM data type, includes both new and continuing prescriptions at discharge.

21:10

The final two lines use "such that" to restrict the measure population to patients who had an opioid or benzodiazepine on their discharge medication list during the relevant period of an inpatient stay.

21:24

You may have noticed that, instead of the .relevantperiod, we see that .authordatetime used with opioid or benzodiazepine discharge medication.

This indicates the point in time that the discharge medications were entered into the EHR.

21:40

We can see the timing word, "during", links this point in time to the inpatient stay. Okay, that wraps up the initial population definition, on to the denominator.

21:52

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.

22:02

Denominator exclusions are applied once the denominator has been established.

The exclusions for this measure are cancer, palliative care, and hospice care.

I will break down the exclusions in the next four slides.

22:16

These exclusions align with the CDC guidelines that provide recommendations for primary care clinicians who are prescribing opioids for chronic pain, and which note that these guidelines are not for patients in active cancer treatment, palliative care, and end of life care.

22:32

So at the top, you can see the white bolded part of the exclusion that this logic speaks to.

This measure excludes cancer, if the cancer prevalence period overlaps with the inpatient encounter, or if the patient has a cancer diagnosis related to their inpatient encounter.

I bolded the two pieces of the cancer exclusion in black to highlight these two different circumstances.

22:56

In black bold is the definition statement name, denominator exclusions, followed by comment describing the logic.

23:02

You can also see the definition for "Inpatient Encounter With Age Greater Than Or Equal To 18," being re-used here.

The where statements indicate a piece of logic that we use to filter the statement.

In this case, where exists a diagnosis of cancer, as defined by the value set, all primary and secondary cancer.

That statement is filtered again, to where the cancer prevalence period "overlaps," our timing indicator, with the inpatient encounter. QDM defines "prevalence period" as an interval starting with the onset date and ending with the abatement date or the date the diagnosis ends.

23:43

If there is no abatement date, the measure assumes the diagnosis remains active.

We found that this logic wasn't capturing patients diagnosed with cancer during their relevant inpatient stay. So we added the logic for an inpatient encounter with a diagnosis that matches any of the cancers listed in the all primary and secondary cancer value set.

The "or" indicates that either of these conditions can be met to exclude the patients on the basis of cancer.

In other words, we added a second piece of highlighted logic to make sure that we exclude patients who come into the hospital and are diagnosed with cancer in the hospital stay that would otherwise qualify them for the denominator.

24:28

In yellow bold at the top, you can see the section of the logic that the slide refers to.

24:34

The measure also excludes patients who have an order for palliative or hospice care during their inpatient encounter, or anyone who receives palliative or hospice care services during the time that overlaps with their hospital stay.

This is what the "or" function, underlined and bolded, accomplishes.

24:52

So, if a patient has met any one of these conditions, then the patient is excluded from the denominator.

24:59

We use two QDM terms here to differentiate between orders and services received, though both terms use 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.

25:18

The palliative or hospice grouping value set includes orders and services for comfort measures, palliative and hospice care, and aligns with several EC measures that exclude patients receiving palliative or end of life care.

25:34

Similar to the slide before, "where" is used in conjunction with timing functions "during' and 'where", to filter orders and services that take place during the inpatient period.

We can also see that an order uses the term .authorDatetime to indicate that we used the time it was entered into the EHR, and we use .relevantPeriod to describe hospice or palliative services, which we expect to take place over a duration of time.

26:04

The numerator logic detects inpatient hospitalizations where the patient is prescribed or continuing to take two or more opioids, or an opioid and benzodiazepine at discharge.

I will break down the clauses in the next two slides.

26:21

We'll start at the top where you can see part of the numerator definition that this section of logic speaks to.

We're focusing on patients that meet the numerator because they've been prescribed two or more opioids at discharge.

26:34

So, again, you can see the definition title in bold, and a comment summarizing this logic denoted by /*

26:42

You'll note that definition "Inpatient Encounter with Age Greater Than Or Equal To 18" is re-used in the CQL logic statement, as well as the QDM Data Element "Medication Discharge," and the "Schedule II and III Opioid Medication," one of the same value sets we use to define the initial population.

27:00

So, if an opioid prescription got the patient into the denominator, it can also count towards the numerator.

The first "where" indicates the inpatient encounter needs to also have the condition in the second clause. The second clause says we need to have a count inpatient encounters where (here's the second where to filter encounters) the count of opioids in the discharge list is greater than or equal to two.

27:30

Now thanks to the count function of ≥ 2, we are looking at a list of patients that have at least two active opioid prescriptions.

27:40

And again, our timing word "during" indicates that the opioids from the discharge medication must be recorded in EHR Opioids .authordatetime during the relevant patient encounter.

27:54

And so, if there are two different authordatetimes, then we'll see it as two separate opioid medications.

28:03

In the second clause here, we see the union again between two lists.

The one defined on the last slide is two opioids on the medication discharge list. And the next one, we're about to define, an opioid and benzodiazepine at discharge. If either condition of the two lists noted by the union are met, the numerator is met.

28:24

This section of the logic defines how we identify a patient prescribed an opioid and benzodiazepine at discharge. Like the last list, we start with an inpatient encounter filtered using "with", to those patients that have an opioid on the medication discharge list.

Once we have those, we filter, again, also using the term "with" to patients that have benzodiazepine at discharge.

28:49

For both of these filters, we use the term "such that" and "during" to add the condition that we're only interested in these prescriptions that take place at a certain time, in this case, during the relevant patient encounter.

29:03

We also see the "Medication Discharge" QDM term again, listing ongoing and new prescriptions existing at the time of the patient's discharge and referring back to the value set, "Schedule IV Benzodiazepines" also used to define the initial population.

29:19

The difference here is that the numerator requires a benzodiazepine to be concurrent with an opioid prescription. To wrap things up. I want to touch on some of the ideas we want to emphasize about the measure.

29:32

First, we understand there may be some clinically appropriate times for a patient to be prescribed two unique opioids or an opioid and benzodiazepine; such as cases in which patients are taking long term stable low dose benzodiazepine therapy and experience severe acute pain.

29:50

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

30:03

Second, we've just spent a lot of time on the details of this measure.

And I want to pull us back to the difference between the denominator and numerator.

The denominator includes patients discharged from an inpatient stay with an opioid or benzodiazepine, whether it's new or continuing prescription.

30:21

For example, this would include patients discharged with 7 days of opioids after surgery, or a patient whose primary care physician prescribed benzodiazepines for anxiety, as long as those prescriptions are active.

30:35

The numerator includes patients discharged from an inpatient stay with two opioid prescriptions, or an opioid and benzodiazepine prescription.

Again, these can be new or continuing prescriptions at discharge.

30:49

A patient on benzodiazepines for anxiety and released from the hospital with an opioid prescription would be counted in the numerator.

30:57

A patient discharged with two opioid prescriptions, perhaps one for chronic pain and one for acute surgical pain would also be included in the numerator.

31:07

A patient discharged with the same opioid medication, but two different dosages, for example, at one dosage for chronic and the same medication at a different dosage for acute pain, that will count as two different opioid medications and the discharge list, and the patient would meet the numerator.

That concludes our measure review. Please stick around for the Q&A. Questions from this segment were obtained from common questions submitted to Jira and other sources.

31:40

Welcome to the Q and A.

Theresa, this is a new measure. Can you tell us a little bit about how this measure came to be, and kind of the cycle that it's gone through thus far?

31:53

Sure. Thanks for asking.

So, we actually have a slide on that, here is this slide. We focus on the implementation of the measure into the Hospital Quality Reporting Program.

But I also want to add that prior to implementation, the National Quality Forum, or NQF, Patient Safety Standing Committee reviewed and endorsed the measure in early 2018. So you can find it under number 3316E.

32:19

A new measure is introduced to a CMS quality reporting program by first submitting the measure for review by the Measures Application Partnership, or MAP, to consider suitability for inclusion in a particular program.

Second, proposing the measure or program inclusion in a Notice of Proposed Rulemaking and accepting Public Comment on the proposed measure.

Third, responding to comments and finalizing the measure and its inclusion in the program for a final rule.

And finally, fourth, measures included in the CMS payment programs go through an annual update process.

32:56

So, in November 2018, CMS sent the Measure to NQF's Measures Application Partnership, or MAP, for review, and in May 2019, issued a Notice of Proposed Rulemaking and submitted the measure for public comment.

33:11

So in response to these comments, from these processes, CMS finalized the measure with an initial population with inpatients only, so that's excluding the patients in Emergency Department or observation status.

33:25

And in August 2019, CMS announced the Inpatient Prospective Payment System Final Rule that the Safe Use of Opioids measure would be included in the Hospital Inpatient Quality Reporting program, or the IQR program, beginning with the calendar year of 2021.

Also, the fiscal year of 2023 payment year for voluntary reporting.

And beginning in 2022, all hospitals participating in the IQR program will be required to report this eCQM.

33:58

And CMS also finalized this eCQM for the Medicare and Medicaid Promoting Inoperability Program in this rule.

So you briefly mentioned the annual update cycle. Could you speak a little bit more about that?

Yes, fall 2019 through spring 2020 this measure went through the annual update process with other electronic clinical quality measures used in CMS programs.

And during that time, we solicited feedback from an expert workgroup, EHR vendors, and several other measure experts to review the measure and offer input to increase alignment with measure intent, efficiency within the logic, and harmonization with other measures.

And the final specification was published in May earlier this year, which brings us to now.

34:45

Right, that's a lot of information to take in, and so, the biggest takeaway that I hear is that the measure will be required in 2022.

Yes, voluntary in 2021, required in 2022.

Great. Onto the next question.

35:15

Okay, really good question here. If someone has a question about the measure logic or wants to provide feedback, how does one go about doing that? What's the process?

Glad you asked, that's a great question.

35:30

So throughout the life cycle of eCQMs including development, implementation, and maintenance, stakeholders can give input and ask questions about measures using a collaboration platform called Jira.

35:42

Jira is hosted by the HHS Office of National Coordinator for Health Information Technology, or ONC, which supports the implementation of health information technology, and provides internal and external users with a common place to transparently log, prioritize, and discuss issues with appropriate subject matter experts on many topics.

36:02

So here's how to use ONC JIRA.

You can create an account, and that's an optional step. You'll need to create an account to track an existing issue, or to create a new issue, but you don't need an account to search for a public issue.

36:21

If you want to search for an issue, or you have a question, search by keyword or project, and see if others have submitted the same question, and you can review the responses. You can also track an issue.

36:32

So, if you find an issue that you're interested in, you can keep track of changes or comments on a ticket by clicking "start watching this issue" on the right-hand side of the issue. And for that, you need to be logged into your Jira account.

36:47

The other thing is, you can create an issue. Can't find it?

First step is: make sure that you're logged in. You can create an issue by clicking the orange "Create Issue" button at the top of the screen.

37:00

So be sure to select the correct project and issue type from the drop-down menu in the form.

And do not include any protected health information, or PHI.

37:11

And the other thing you can do is once you've created an issue, you'll be listed as a reporter of that issue.

So you can review things: you can make comments, edits, changes, add attachments and communicate with assigned subject matter experts via the comments feature.

So, additionally, you can receive an e-mail notification of any status changes to your issue. So you can send questions to the Jira system or review at the ONC Jira learning resources. And both of those are available on the sites.

37:44

Great, thanks, Theresa.

I think this is really good information to have. Not everyone is familiar with the Jira process. So as this measure gets implemented, I'm sure people are going to have more questions and want to provide some feedback. So thank you for sharing. But I do want to go back to the slide that you had just brought up.

I'm wondering if you could go through this example and talk through what this issue ticket is in reference to.

38:17

Yeah, absolutely. So, on this slide, I want to give you an example of a commenter who asked CMS and the measure developers to consider adding "discharge status" to help exclude patients receiving palliative and hospice care.

38:29

The reporter made an excellent point: that "discharge status" reports the information the measure needs and is part of an existing workflow, and we want to take that into consideration as we update the measure during the next annual update cycle.

We appreciate your questions and input, and we use them to make the measures stronger.

You can see the impact section of the slide, and how the comment, and the solution is posted below.

38:52

The Jira page here has a lot of different options that you can take including any additional comments, history of the question or request, and where the question is in the process of being answered.

If you haven't been on Jira, I encourage you to take a look and poke around a bit.

39:10

Thanks, Theresa, for going through that. This information is very helpful, especially as people are learning this new measure.

Yes. Absolutely.

That concludes our Q&A.

The eCQI Resource Center is our one stop shop for all things eCQM. Access measure specifications, additional educational resources, and materials from this presentation.

To submit a ticket, go to the ONC Jira Tracking System. The CMS Blueprint provides additional information on eCQMs. To access information on value sets, please visit the Value Set Authority Center.

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40:04

This will launch the PDF that includes a table that has links to all of our previous webinar recordings, slides, transcript, and Q&A documents.

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We will use your feedback to inform future content and assess the quality of our content. The link to the program evaluation survey and attestation will be available after the recording finishes playing. At the end of the survey, when you click "submit," you are redirected to a page from which you can print or download a PDF CE certificate. An automated e-mail will also be sent to you that includes the link to a CE certificate, and downloadable PDF.

40:56

Thank you to our presenters and thank you for participating in this webinar.