Transcript – Expert to Expert Webinar - Annual Updates for Opioid Related Adverse Events eCQM for 2026 Reporting Year

Broadcast March 12, 2026

Slide 1

[00:00:02] [Susan Funk] Welcome and thank you for joining us for this Joint Commission Expert to Expert webinar addressing the 2026 annual updates for the Hospital Harm Opioid-Related Adverse Events electronic clinical quality measure. The Expert to Expert webinar series is offered in partnership with the Centers for Medicare and Medicaid Services and eCQM stewards. CE credit is available for this webinar for the live broadcast attendance only. I'm Susan Funk, Associate Project Director for Engagement on Quality Improvement Programs at Joint Commission, and today, I'll be serving as this webinar's moderator. Next slide, please.

Slide 2

[00:00:51] Before we begin the webinar content, we would like to offer just a few tips about webinar platform functionality. Audio is by voice over internet protocol or VOIP only; use your computer speakers or headphones to listen. There are no dial in lines. Participants are connected in listen-only mode. Feedback or dropped audio are common for live streaming events. Refresh your screen/rejoin. We will not be recognizing the Raise a Hand or Chat features. To ask a question, click on the Question Mark icon in the audience toolbar. A panel will open for you to type your question and submit. The slides are designed to follow Americans with Disabilities Act rules. Next slide.

Slide 3

[00:01:47] The slides are available now. There are many links provided throughout this webinar, but they are not clickable on screen. By downloading the slides, you'll be able to access links and also take notes. To access the slides now, within the participant navigation pane, select the icon that represents a document. A new pop-up window will open, and you can select the name of the file. A new browser window will open, and from it, you can download or print the PDF of the slides. Slides will also be available within 2 weeks of the webinar on Joint Commission's website at the link included at the bottom of this slide and they will also be posted on the eCQI Resource Center. Next slide please.

Slide 4

[00:02:34] I'm sure that many of you attending today's webinar will wish to receive continuing education credit or qualifying education hours. All relevant information about continuing education credit is available within a handout we've included within the webinar resources and has also been communicated on the webinar registration page. The attachment includes the list of entities that will provide credit, the requirements for participants to earn credit, and information about how to complete the survey and obtain a certificate. So -- be sure to download that attachment to learn more.

Credit is available for attendance during this live webinar broadcast only. For information on Joint Commission's continuing education policies, visit the link provided on the bottom of this slide. Next slide, please.

Slide 5

[00:03:26] The participant learning objectives are: locate eCQM resources on the eCQI Resource Center. Facilitate your organization's implementation of the Opioid-Related Adverse Events eCQM annual updates for the 2026 reporting

year and utilize answers to common issues and questions regarding the Opioid-Related Adverse Events eCQM to inform 2026 use and implementation. Next slide.

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[00:04:03] This webinar does not cover these topics: Basic eCQM concepts, Topics related to chart abstracted measures, and process improvement efforts related to these measures. While we will not address how to validate eCQM data during this webinar, before submitting eCQM data to CMS, please ensure your data is validated. Specifically, please ensure that extreme outlier results are verified. For example, extreme outliers may include reporting 0% or 100%. Joint Commission is not accepting data in 2026 for this eCQM. Next slide.

Slide 7

[00:04:49] All staff and subject matter experts have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with, or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content. Next slide.

Slide 8

[00:05:15] During this webinar, we will review the annual updates and changes to the Hospital Harm Opioid-Related Adverse Events eCQM for the 2026 reporting year. We'll then provide an overview of the measure flow and algorithm and then we'll address some Frequently Asked Questions. Finally, we'll have a live Q&A segment. Next slide, please.

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[00:05:42] Before we transition to the discussion about the changes for the 2026 reporting year, we wanted to point you to a PDF handout that includes directions to locate and access eCQM specifications, value sets, measure flow diagrams, and technical release notes. The link to the eCQI Resource Center landing page is provided on this slide. However, be sure to download the PDF Handout that has additional links. You can locate that PDF within the Resource Section of the audience navigation pane. We explained how to access documents within the Resource pane earlier in the presentation. Next slide, please.

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[00:06:26] Alright, I will now turn the webinar over to our speaker for today, Erin Buchanan from the Mathematica team. Erin, please introduce yourself, and when you're ready, start your presentation.

[Erin Buchanan] Thank you, Susan, and thank you all for joining us today. As Susan mentioned, my name is Erin Buchanan, and I am with Mathematica. And I'll be going over some background information on the Hospital Harm - Opioid-Related Adverse Events Measure. Next slide, please.

Slide 11

[00:07:00] 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 is an inverse measure in that a lower measure score indicates higher quality. This

measure is intended to be used to identify and reduce unintended adverse events of opioid administration. The measure uses the administration of an Opioid Antagonist following an opioid medication as an indicator of an Opioid-Related Adverse Event, or ORAE. Opioids are the most-used analgesic in post-op hospitalized patients and are associated with unintended adverse events, such as oversedation, delirium, and respiratory distress. Opioid-Related Adverse Events are also associated with increases in hospital Length of Stay, odds of death, higher costs, and higher risk of 30-day readmissions. Opioid-Related Adverse Events are preventable with better monitoring and response. And rates are indicative of quality of care. Next slide, please.

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[00:08:39] This measure assesses 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 Inpatient hospitalizations that end during the measurement period for patients age 18 and older and at least one opioid medication administration starts during the hospitalization outside of the operating room - For this measure, the term “i npatient hospitalizations” includes time in the emergency department and observation when the transition between these encounters and the inpatient encounter are within an hour 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. - There were no changes to the description or initial population. - 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 gastrostomy.

Slide 13

[00:30:37] The Denominator equals the Initial Population shown on the previous slide. 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 the opioid medication administered outside of the operating room. The route of administration of the Opioid Antagonist must be intranasal spray, inhalation, intramuscular, subcutaneous, or intravenous injection. Only one Numerator event is counted per encounter. As you can see, there are no changes to the Denominator or Numerator. Next slide, please.

Slide 14

[00:35:09] On this slide, you can find a link to the Measure Specifications and to the Technical Release Notes, which show each change for 2026 reporting. Next slide, please.

Slide 15

[00:42:27] Next, we'll review the measure flow, which provides a high-level overview of how the measure works and have a more detailed look at the measure update. Next slide, please.

Slide 16

[00:44:27] So before I dive into the details here, we know the display on the screen is quite small. I would recommend that you download the PDF of the slides so that you can zoom in to enlarge this image. So, the Initial Population's main definition for Hospital Harm ORAE is "Encounter with Opioid Administration Outside of Operating

Room." On the right-hand side are the conditions that must be met to qualify for the Initial Population, which includes one, the 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 here 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. Next slide, please.

Slide 17

[00:44:27] Moving on to the Numerator, which is Encounter with Non-Enteral Opioid Antagonist Administration outside of the operating room and within 12 hours after opioid. We've circled the area of the flow that was updated for the Reporting Period. So, the Numerator logic title was updated to "Encounter with NonOperating Room Opioid and Antagonist Administration". We've broken this down to the criteria which make up this definition, noted on the right side of the slide. The encounter will get into the Numerator if, one, there is a Non-Enteral Opioid Antagonist administered 12 hours or less before an Opioid Antagonist is 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., a Non-Enteral route 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, then Numerator is met. If not, the Numerator is not met, and the processing ends. Next slide, please.

Slide 18

[00:44:33] Here you'll see the Numerator logic, and we'll go into more detail about the update that I mentioned on the previous slide. Please note that the removed text is green with strikethrough and new text is bold with underlines. Also, please note that some of this overview that I'm going to describe was reviewed during the measure flow slide. So, as we noted before, the only update here is to the definition title, which was updated to "Encounter with NonOperating Room Opioid and Antagonist Administration." This 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 remaining logic stayed the same for the Numerator, so we don't need to review that. Slide, please.

Slide 19

[00:47:39] Now that the Denominator and Numerator are defined, we can plug the quantities into the calculation formula. The performance rate aggregates the population into a single performance rate for reporting purposes. In this example, a Numerator c = 10 is divided by the Denominator a = 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 the Denominator Population identified by these letters earlier in the flow diagram. Next slide, please.

Slide 20

[00:47:39] And now I'm going to review a question we get very frequently and that I've sort of been talking about throughout this presentation. The question we get a lot is, what are the Routes of Administration for Opioids and Opioid Antagonists? For Opioid Antagonists, the Routes of Administration are intranasal spray, inhalation, and intramuscular,

subcutaneous, or IV injection. For opioids, no route of administration. There's no requirement for the route of administration. And just to clarify as well, routes considered enteral that are not acceptable for the Opioid Antagonists are oral, nasogastric, and gastric. And now I will pass the floor back to Susan. And now I will pass the floor back to Susan.

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[00:47:41] [Susan Funk] Oh, this is such a quick webinar today. Erin, you did a great job. Thanks for leading us through all those annual updates. We're getting a lot of questions, so I'll speak a little slowly to give everybody more time to get your questions into the question and answer pane, and Erin, just catch your breath, because we'll be back with you in just a moment. So, everyone, we've included a couple resource slides here. This first slide provides the links to the eCQI Resource Center, the CMS Eligible Hospital Measures page, and the Get Started with eCQMs links. We've linked to the Teach Me Clinical Quality Language Video Series and specifically to the video shorts that cover the Hospitalization with Observation and "What is a Value Set?" Next slide.

Slide 22

[00:47:48] This slide continues with some additional resource links. We've provided the link for the Value Set Authority Center, or VSAC Support. We've also provided a link to the Expert to Expert Webinar Series on Joint Commission's website. And finally, the ASTP/ONC Issue Tracking System. And this is where clinical and technical questions about these eCQMs should be submitted that you might have after this webinar concludes. Next slide, please.

Slide 23

[00:47:51] We will now move into our live Q&A segment. Please submit questions via the question pane. Click the Question mark icon in the audience toolbar. A panel will open for you to type and submit your question. All questions not answered during the live event will be addressed in a written follow-up Q&A document. The follow-up document will be posted to Joint Commission’s website several weeks after the live event – after CMS review and approval.

Our subject matter experts have been busy during the presentation responding to many questions as they’ve been submitted. We’ll now share some of the questions and answers. We’ll welcome back Erin to facilitate this Q&A segment. Erin, when you’re ready, please jump in with the first question.

All right, I'm just going to give some reminders here about how to ask questions as we start to move into our live Q&A segment. Please submit questions via the question pane. You will click on the question mark icon in the audience toolbar. A panel will open for you to type and submit your question. And all questions not answered during the live event will be addressed during a written follow-up Q&A document or *within* a written follow-up Q&A document. The follow-up document will be posted on Joint Commission's website within several weeks after this live event, and that's after CMS reviews and approves it. Our subject matter experts have been busy as Erin was delivering the annual updates for the webinar, so they've been responding to many of these questions as they've been submitted. So, let's see here. We'll now share some of these questions and answers. We'll welcome back Erin to facilitate this Q&A segment. So, Erin, when you're ready, please jump in with the first question that you'd like to address within the queue.

[Erin Buchanan] Sure thing. Thanks, Susan. And I guess just a disclaimer before I get started on these questions, if you have that are very specific situations to your facility, I would encourage you to submit the question to the ASTP/ONC

issue tracking system that Susan shared on a couple slides ago, and our team will be able to take more time to respond to your question that way. With that said, I'll jump right into the questions that has been submitted today.
So, our first question is, "How do hospitals report this eCQM to CMS? When is it mandatory?" This is to everyone, so you should be able to see this question as well. Mandatory reporting for this measure begins in 2027. A hospital may choose to submit the measure as one of three self-selected eCQMs for four quarters in calendar year 2024 data, so Q1, 2, 3, or 4, to meet the eCQM reporting requirements for the Hospital IQR, so Inpatient Quality Reporting Program, and the Medicare Promoting Interoperability Programs. eCQMs are submitted to the Hospital Quality Reporting System, or HQR, via Quality Reporting Data Architecture, or QRDA files. Please see QualityNet for more information on submitting. Note that CMS evaluates measures on an annual basis to determine if submission is voluntary or mandatory. We refer you to CMS's Hospital Inpatient Quality Reporting website for more information.

The next question is, "Please share any benchmarks you have for this measure. Are there thresholds or national rates?" Benchmarks are established using historical measure performance data. Benchmarks may be set once mandatory reporting begins in calendar year 2027.

"Can you clarify that this is an inverse measure?" Yes, this is an inverse measure because it is a measure in which a lower performance rate is better. The goal is to have the Numerator equal to or very close to zero.

"Maryland law MD SB394, STOP Act of 2022, was signed into law in May of 2022. Excuse me. Part of the law requires that hospitals are to dispense Naloxone free of charge to patients under certain circumstances. All of our hospitals are following this law. We must comply with Maryland state law and will need to provide accurate Hospital Harm ORAE metrics in the future. Can the specifications be reviewed and updated to provide an avenue for hospitals that are required by law to provide Naloxone at discharge and will be able to report on the original intent of the measure?" So, in response... so patients with Opioid Antagonists on the report due to the Maryland STOP Act of 2022 should not be included in the Numerator population for this measure since the medications were dispensed but not administered. We will consider updating the measure to provide clarification around the Maryland STOP Act of 2022 for the next annual update. And I'll also add that we're aware that other states have similar laws, and this question would apply in those situations as well.

"Is patient-controlled analgesic, PCA, administration of morphine considered, or is the measure looking at opioids given at a discrete time versus PCA administration?" And they wrote that they're making sure the measure is pulling correctly. This measure assesses the number of inpatient hospitalizations for patients 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. As a result, patient-controlled administration is considered by the measure. If the Opioid Antagonist was administered within 12 hours of the opioid, the patient would be included in the Numerator.

And then we have another PCA question here. "In some PCA situations, there's charting in EHR workflows of zero milliliters in MAR charting. Our understanding is that if zero volume is administered, it should not qualify for the eCQM as an opioid administration. Can you confirm that is the correct interpretation of the eCQM specifications?" So based on the information provided, no opioid was administered, therefore the encounter would not qualify for the Initial Population.

Okay. "Our hospital will sometimes place sickle cell patients on low-dose Narcan drips to mitigate severe pruritus and nausea while on narcotics for vaso-occlusive crisis. This is not an adverse event or hospital harm event, as it is a planned therapy for the patient, but it is showing in the Numerator for this measure. Please clarify how this situation is handled by the measure." Currently, the use of Naloxone to treat pruritus is considered off-label use. However, we'll

continue to monitor the published literature on this topic and consider the appropriateness of an Exclusion in a future annual update.

So, we do have a question, a few. I guess I'll pause. Susan, should we also respond to webinar questions?

[Susan Funk] You know what? Let's save those for the last. Let's try to get through as many of the clinical ones as we can, and then maybe when you're rounding out towards the end, I can jump in with a few of those. That's good.

[Erin Buchanan] Okay, great. Thank you. All right. So, let's see. "Can a procedure in the cath lab be considered OR?" So, in response to this one, 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 in the post-op recovery unit or PACU, catheter or endoscopy lab, or interventional radiology, would not be a routine component of an anesthesia plan. In these 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/Suite. So, you'd be using that code for the location.

All right, we have this a few times. I guess another, we have another point here, I think, that one of our team members added. So, just to add to that previous response, Just to add to that, the measure does not include all OR locations listed in CDC Locations And Descriptions and Instructions for Mapping Patient Care Locations document, which some of you may be familiar with. So, the measure intent does not consider the procedural areas I mentioned before or all the locations that may be available to code for. We are specifically looking for that hospital service location code 1096-7 to identify the operating room/suite.

"When will the measure steward consider the whole hospitalization, outpatient or observations/encounters, for surgery start and stop date and times within the measure logic?" Thank you for your question. The Initial Population for the measure is inpatient hospitalizations for patients age 18 years and older where at least one opioid medication was administered outside of the operating room. As indicated in the measure's header section, the definition of inpatient hospitalizations includes time in the emergency department and observation when the transition between these encounters, if they exist and the Inpatient Encounter are within one hour or less of each other.

"Speaking of off-label use, our facility uses Narcan for itching related to epidurals," so, similar to a previous question. "It would be helpful if this could be considered as an Exclusion in the future." Thank you for that feedback. We will consider this update in a future iteration of the measure.

"Is Naloxone utilized for opioid-induced pruritus excluded from the measure?" So just to be completely clear, based off of the past few questions we've had, there is no Exclusion for opioid-induced pruritus in the current version of the measure.

"PACU would be considered outside of the OR, correct?" Only Opioid Antagonists administered outside of the operating room, OR, following an opioid administration would be considered for the measure, or for the Numerator. Opioid Antagonists administered in other settings outside of the OR, so the post-op recovery unit, catheter and endoscopy lab, or interventional radiology, would not be considered a routine component of an 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 OR by documentation of that hospital location code that I mentioned before. So, yes.

"Would a Naloxone drip be considered an acceptable method of administration?" Yes, a Naloxone drip is considered an acceptable method of administration.

Okay. "What happens when a patient comes from home with a suspected overdose? The Naloxone is given in the ED, the patient is admitted on a Naloxone drip, but the hospital did not administer the original opioid causing the admission or need for the reversal agent." And to clarify this, 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, or opioids taken secretly while in the hospital 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 required Naloxone administration.

Okay. Gone over that. "Right now, hospice and palliative care are excluded based on SNOMED codes. Is there any plan to include ICD-10 codes for this Exclusion in the future?" Thank you for your question. This measure does not exclude patients based on hospice or palliative care orders or procedures performed.

Oh. One second. "What about," oh. Sorry, my question disappeared. Oh, where'd it go? Sorry. Oh, okay, here it is. "What about opioid patches, such as fentanyl patches that are counted as part of the Numerator if not placed within the 12-hour window but do remain on the patient at the time of Naloxone administration?" Patients who are 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 are included in this measure, so those patches would qualify for the measure.

Someone is following up on their previous question regarding Narcan not being excluded for itching and are asking how do we differentiate? And there's no way to differentiate these patients within the Numerator.

"We are finding that Naloxone that is dispensed to home is being picked up by the measure and putting patients in the Numerator although the medication was not administered during the patient's stay. We've reviewed this with our EHR vendor, and there is not a way to separate a dispense-to-home medication from administered inpatient." Excuse me, "We are in several Western states." Thank you for this feedback. We will look into that.

"What is the determining factor of an ED/OBS end time in regards to inpatient hospitalization timeframe? Is this considered the admit to inpatient order start time?" The term inpatient hospitalization is used to include ED and Observation Encounters into the inpatient hospitalization timeframe since we know that patients are treated prior to being admitted to inpatient, which should count towards their care during their hospitalization. Therefore, we use a function called Global Hospitalization with Observation to determine the start of the inpatient hospitalization. This function looks to see whether an ED encounter or Observation Encounter exists prior to the Inpatient Encounter. If one or both exist, then the logic will incorporate them into the inpatient hospitalization timeframe and use the earliest encounter start time to be the start of the inpatient hospitalization. And any opioid and Opioid Antagonist Administrations given during the ED or Observation Encounter would be evaluated against the Numerator criteria. The function also references a timing constraint of one hour or less between any transition that exists during the hospitalization. This is used to determine whether the ED or observations encounters are related to the inpatient admission.

All right. Mm. Similar question. "Did you say that this will not be accepted for calendar year 2026?" And just to clarify there, the measure is available for voluntary reporting in calendar year 2026. It becomes mandatory in 2027.

[Susan Funk] Just to jump in one second to clarify that, though. They did hear correctly. Joint Commission is not accepting data for this measure, but CMS is.

{Erin Buchanan] Thanks, Susan. Okay, already checked that. "Since the measure will be available for voluntary reporting for 2026, will we have access to the data that is voluntarily submitted for national comparisons?" While measures are

available for voluntary reporting, national comparisons are not available. Hospital-level results are available on the Provider Data Catalog.

Okay. Think we've covered that. Oh, we do have a question. "What is the difference between CMS 506 versus Hospital Harm ORAE?" So, this webinar is just about Hospital Harm ORAE, so please focus your questions on this measure, but I would encourage you to check out the calendar of webinars because there will be a webinar on CMS 506.

Okay, what else do we have? Another observation. A patient who is seen in the ASC and then was transferred to inpatient and received Narcan. Would this patient be considered in the cohort?" This measure does not consider time spent in the ambulatory surgery center. And I'll add to that. There are measures for the ASC Program that are completely separate from this measure, which is an inpatient measure. So, I would encourage you to check out the ASC website to see if there's a measure that would apply there.

Okay. We have PACU questions, I've already gone over.

Oh. And I think I've reached the end of the list, Susan.

[Susan] Great. I think, I'm scanning through, too, as well, and I think some of the other ones don't have written responses yet and would probably take a little longer for the team to be able to respond to. So, to Erin's point earlier, if your question either was not answered today or if you require a kind of immediate response, please do use that ASTP/ONC issue tracking system. The same team that's answering questions today will be responding to questions via that platform. And anything that's taking longer to respond to is probably a really specific question that pertains to a specific organization.

I'm just scanning through to see some of these operations questions that I might be able to respond to. I think I saw a couple that were related to getting copies of the Q&A, and I was going to cover that in my script in just a moment. And other than that, we've clarified the reporting, voluntary versus mandatory. And the timeframes, that was also covered within the questions that Erin already responded to.

So, with that, I think we're ready to move onto the closeout for the webinar. Erin, thanks so much. You spent a lot longer than we normally do on all these questions and responses, and that's, I know, very valuable to the audience, so thanks for your time for doing that. Just to remind everyone, any of the questions we didn't address today during the broadcast will also be included in a written Q&A document. And that Q&A document will be posted on the Joint Commission website within several weeks. But that needs to be reviewed and approved by CMS, so it won't be immediate. As I've noted, if you need an immediate response, you'll want to go to ASTP/ONC issue tracking to submit your question there. All right. Jessica, next slide, please.

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[00:47:54] All right, so let's start with some of these closeout slides. So previous Expert to Expert webinar recording links, slides, and transcripts can all be accessed on Joint Commission's webpage. And that link is displayed on this slide. You'll need to scroll down and use the checkbox to sort for Expert to Expert Webinars. Within a couple weeks, the recording and materials will be posted on that site, and we're also sharing those documents with the eCQI Resource Center, where they'll also be posted. After this webinar, if you have any questions about webinar operations or obtaining your CE credit, please submit them via email to tjcwebinarnotifications@jointcommission.org. And for those that wish to attend any of our future webinars in this series, we've included a handout that has the registration links for all of the scheduled webinars that are going to be happening through April. Please share that document with your colleagues so they, too, can take advantage of the educational opportunities. Next slide, please.

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[00:47:54] Before this webinar concludes, we wanted to share just a few words about the CE survey. We use your feedback to inform future content, determine education gaps, and assess the quality of our educational programs. A QR code will appear on the final slide. You can use your mobile device to scan and access the survey. If you prefer to take the survey later, we also send an automated email from the webinar platform that will include that link to the survey. After you complete and submit your survey responses, you'll be redirected to a page from which you can print or download a blank certificate that you complete by adding your own name and credentials. In case you miss that opportunity to download, an automated email will also be sent to you that includes the link to the certificate. Next slide, please.

Slide 26

[00:47:59] All right, we have reached the end of the webinar. I will leave this slide up for a few moments so that participants can scan the QR code. Thank you, Erin, for presenting today and for getting through so many of those questions and answers. Many thanks to the Mathematica team that was in the background responding to those questions throughout the queue and throughout the webinar. And thanks to the operations staff that supported this webinar today. Finally, thanks to everyone in the audience that joined today. This concludes our presentation, but as I noted, we'll leave this slide up for just a few more moments for anyone that wishes to go directly into the CE survey. Have a great day, everyone.