**Questions and Answers – Expert to Expert Webinar Annual Updates for Hospital Harm - Opioid Related Adverse Events eCQM for 2026 Reporting Year**

*Broadcast March 12, 2026*

| Question | Answer |
|---|---|
| A patient who was 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 an ambulatory surgery center. If the patient was administered an opioid medication during the inpatient hospitalization and subsequently required a reversal agent, they could be potentially included in the measure population. |
| Are hospitals in control of which OR/Suite use the 1096-7 code? | Yes, hospitals are in control of their documentation processes and must document the hospital location (HSLOC) code 1096-7 to designate operating room/suite. |
| Can a procedure in the cath lab be considered "OR"? | A cardiac catheterization laboratory (cath lab) is considered outside the OR. Opioids administered in a cath lab would be considered for the measure. |
| Can this measure be one of our self-selected measures for CY 2026? I thought I heard that it would not be accepted. | Joint Commission is not accepting data for this measure, but CMS has this measure as voluntary for 2026 CMS (https://qualitynet.cms.gov/inpatient/iqr/participation). |
| Can you clarify that this is an inverse measure? | Yes, this is an inverse measure, meaning a lower measure score indicates higher quality. |
| Can you send us the reporting calendar? | The reporting calendar is available on the Quality Reporting Center: https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/resources-and-tools2/ |
| Did you say that this will not be accepted for CY 2026? | The measure is available for voluntary reporting in CY 2026 for CMS (https://qualitynet.cms.gov/inpatient/iqr/participation). |
| Do we know what EHR is causing the problem of dispensed Narcan counting for the numerator? | No, we are unaware of a specific EHR causing dispensed Narcan to count for the numerator. This is generally a problem with how EHR systems define, map, or extract data, rather than being exclusive to one specific vendor. The problem could occur when EHR systems fail to distinguish between medication administration and medication dispensing or ordering. Please review with your EHR vendor if you are experiencing this. |
| If Narcan is not excluded for administration for itching--how do, we differentiate? | This measure does not distinguish the clinical intent of Narcan administration and counts all qualifying non-enteral opioid antagonist administration that meet the timing criteria for an inpatient. There is no way to differentiate these patients within the measure at this time. Inpatient hospitalizations where a non-enteral opioid antagonist administration starts during the hospitalization and 12 hours or less following an opioid medication administered outside of the operating room will be included in the numerator, regardless of reason for administration. |

| Question | Answer |
|---|---|
| For Hospitalization with observation, does it matter if its outpatient observation or inpatient observation? Is there any restriction on what kind? Or can it be either, as long as its within 1hr prior to Inpatient encounter it will be considered? Could you explain the intent of utilizing this observation visit? | The term "inpatient hospitalizations" includes time in the emergency department and observation status when the transition between these encounters and the inpatient encounter occur within one hour. The one-hour timeframe is used to determine whether any Observation Services are related to the inpatient admission. We encourage you to work with your EHR vendor to ensure the correct encounters are captured by the measure. |
| How do hospitals report this eCQM to CMS? When is it mandatory? | Mandatory reporting for this measure begins in 2027. A hospital may choose to submit the measure as one of the three self-selected eCQMs for four quarters of CY 2024 data (Q1, Q2, Q3 or Q4) to meet the eCQM reporting requirement for the Hospital IQR and Medicare Promoting Interoperability Programs. eCQMs are submitted to the Hospital Quality Reporting (HQR) System via Quality Reporting Data Architecture (QRDA) file. Please see QualityNet for more information on submission. Note that CMS evaluates measures on an annual basis to determine if submission is voluntary or mandatory. We refer you to CMS' Hospital Inpatient Quality Reporting Program website for more information: https://qualitynet.cms.gov/inpatient/iqr |
| How does the measure logic handle the situation of concurrent (simultaneous) infusion of low-dose naloxone with an opioid? Concurrent infusion is sometimes seen in clinical settings to reduce opioid-induced side effects (sedation, pruritus, respiratory depression) and to minimize the development of tolerance. | This measure does not distinguish clinical intent and counts all qualifying non-enteral opioid antagonist administration that meet the timing criteria. The measure looks for administration of an opioid medication followed by administration of a non-enteral opioid antagonist that occurs 12 hours or less following the opioid medication administration outside of the operating room. The route of administration of the opioid antagonist must be by intranasal spray, inhalation, intramuscular, subcutaneous, or intravenous. |
| I need clarification as I am not understanding- Is the Pre-op and PACU considered part of the OR? | In this measure, pre-op and PACU are not considered part of the OR. The specific location code (HSLOC Code) 1096-7 is used in the measure to identify Operating Room/Suite. Patients who receive Opioids with subsequent reversal agents administered outside of the operating room would be included in this measure. |

| Question | Answer |
|---|---|
| In some PCA situations there is charting in EHR workflows of 0 mL in MAR charting. Our understanding is that if 0 volume is administered should NOT qualify for the eCQM as an opioid administration. Can you confirm that is the correct interpretation of the eCQM specifications? | Based on the information provided, if no opioid medication was administered through the Patient-Controlled Analgesia (PCA) pump, the encounter would not qualify for the initial population. |
| Inside the Operating Room should only include medications administered in an Intraoperative setting? Or both Pre-op and Post-op should also be included? | The measure includes inpatient hospitalizations where an opioid antagonist was administered within 12 hours following administration of an opioid medication outside of the operating room (OR). The specific location code (HSLOC Code (1096-7)) is used in the measure to identify Operating Room/Suite. Pre-op and Post-op are not included. |
| Is it a proportion measure, and should the data available for this measure in the Data Catalog be considered a percentage? | Yes, this is a proportion measure. This can be found in the measure specification under Measure Scoring: Proportion. Data for this measure will be displayed in the Provider Data Catalog as a percentage. |
| Is Naloxone utilized for opioid induced pruritus excluded from the metric? | The measure does not exclude administration of opioid antagonists administered to reduce opioid-induced side effects. |
| Is Patient Controlled Analgesic (PCA) administration of morphine considered or is the measure looking at opioids given at a discrete time vs PCA administration? Making sure the measure is pulling correctly. | 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. Patient Controlled Administration (PCA) of morphine is considered by the measure. If an opioid antagonist was administered within 12 hours of the opioid medication administration via PCA, the patient would be included in the numerator. |
| Is there a way to get a copy of the Q&A as there are some valuable information? | For all questions submitted during the webinar broadcast, we'll compile and release a written Q&A document weeks after the webinar. You will find this document at this link https://www.jointcommission.org/en-us/knowledge-library/support-center/measurement/quality-measurement-webinars-videos |

| Question | Answer |
|---|---|
| Maryland law (MD SB394 STOP Act of 2022) was signed into law in May of 2022. Part of the law requires that hospitals are to dispense Naloxone free of charge to patient under certain circumstances. All of our hospitals are following this law. We must comply with MD state law and will need to provide accurate HH-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 the naloxone at discharge and still be able to report on the original intent of the measure? | 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, related to this discharge medication, since the medications were dispensed but not administered during the patient's inpatient hospitalization. If the patient is admitted inpatient and meets measure criteria for the initial population they could be included in the measure. |
| Narcan for itching- is that an exclusion? | The measure does not exclude administration of opioid antagonists administered to reduce opioid-induced side effects. We will continue to monitor the published literature on this topic and consider the appropriateness of an exclusion in a future annual update cycle. At this time, this patient could be included in the measure. |
| Our hospital will sometimes place sickle cell patients on low dose Narcan drips to mitigate severe pruritis 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, no formulation of naloxone is FDA-approved for pruritus, and its use to treat pruritus is considered off-label use. We will continue to monitor the published literature on this topic and consider the appropriateness of an exclusion in a future annual update cycle. At this time, the patient could be included in the measure. |
| PACU would be considered outside of the OR, correct? | Yes, the Post Anesthesia Care Unit (PACU) would be considered outside of the OR. The HH-ORAE measure identifies an operating room (OR) by documentation of hospital location (HSLOC) code 1096-7 Operating Room/Suite. |

| Question | Answer |
|---|---|
| Please share any benchmarks you have for this measure. Are there thresholds? National rates? | While measures are available for voluntary reporting, benchmarks (national and state comparisons) are not available. Only hospital level results are available on the Provider Data Catalog (https://data.cms.gov/provider-data/). Mandatory reporting will begin in calendar year 2027. |
| Right now, hospice and palliative care are excluded based on SNOMED codes. Is there any plan to include ICD codes for this exclusion in the future? | The HH-ORAE measure does not exclude patients based on hospice or palliative care. |
| 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. However, hospital level results are available on the Provider Data Catalog (https://data.cms.gov/provider-data/). Mandatory reporting will begin in calendar year 2027. |
| So, a patient seen in the emergency department (ED) and given and opioid and an opioid antagonist in the ED but is then admitted into the hospital, they qualify for the measure population and would quality for numerator and denominator? | This patient would qualify for the measure if they are discharged from the ED within one hour of being admitted inpatient. For the purpose of the measure, inpatient hospitalization includes ED and observation encounters within the inpatient hospitalization timeframe when the transition between those encounters (if present) and the inpatient encounter occur within one hour. Example: A patient in the ED is administered an opioid medication at 10:00 and an opioid antagonist at 10:45. The patient is discharged from the ED at 14:25 and admitted inpatient at 15:00. Time in the ED would count for this patient because less than one hour passed between discharge from the ED and admission to the inpatient encounter. |
| Speaking of off-label use, our facility uses Narcan for itching related to epidurals. It would be helpful if this could be considered as an exclusion in the future. | Currently, no formulation of naloxone is FDA-approved for pruritus, and its use to treat pruritus is considered off-label use. However, we will continue to monitor the published literature on this topic and consider the appropriateness of an exclusion in a future annual update cycle. |
| So, can this be a self-selected measure for CMS for CY 2026 then? | Yes, this measure is available as a self-selected measure for calendar year 2026. |
| The 2026 ORAE data will be mandatory reporting for 2027, right? | The measure becomes mandatory for CMS reporting beginning in CY 2027, meaning the data will be collected during CY 2027. |
| This measure is self-selected for CMS AND Joint Commission for 2026? | This measure is not being accepted by Joint Commission for 2026. For CMS, reporting this eCQM is voluntary for 2026. |

| Question | Answer |
|---|---|
| To be clear CY 2026 is voluntary but its mandatory reporting in 2027? | Correct, the measure is available for voluntary reporting for calendar year 2026. Mandatory reporting will begin in calendar year 2027. |
| 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 stay. We have reviewed this with our EHR vendor and there is not a way to separate out a "dispensed to home" medication from "administered inpatient". We are in several western states. | The intent of this measure is to identify patients who are *administered* an opioid antagonist within 12 hours of opioid administration outside of the operating room during the inpatient hospitalization, as this indicates an opioid related adverse event. The QDM datatype, "Medication, Administered" is used to capture medication administration in the measure logic. Patients who are dispensed opioid antagonists that were not administered during the inpatient hospitalization would not meet the measure numerator. |
| What about opioid patches, such as Fentanyl patches, are these 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? | Transdermal opioid patches, including fentanyl patches, are included in the opioid medication value set and its administration could count towards the denominator of the Hospital Harm – Opioid Related Adverse Events eCQM. |
| 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. | The measure requires that a documented administration of an opioid medication occurs during the inpatient hospitalization, which includes time in the emergency department and observation when the transition between these encounters (if they exist) and the inpatient encounter are within an hour or less of each other. Therefore, opioids taken prior to the start of the encounter (such as at home), or opioids taken without medical supervision or guidance, would not be captured or included in the Initial Population. This protects hospitals from being penalized for appropriately treating patients with an opioid antagonist that enter the facility with opioids in their system or have taken opioids secretly while in the hospital and subsequently require naloxone administration. |

| Question | Answer |
|---|---|
| What is the determining factor of an ED/Obs "end time" in regards to "inpatient hospitalizations" time frame? Is this considered the admit to inpatient order start time? | We use a function called 'Global.HospitalizationWithObservation' 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 because patients may receive care during these encounters. If one or both exist, then the logic will incorporate them into the inpatient hospitalization timeframe if the transition between discharge from these encounters and admission to the inpatient encounter is one hour or less. Any opioid or opioid antagonist administrations given during the ED or Observation encounter would be evaluated against the numerator criteria. |
| What is the difference between CMS506 vs HHORAE? | CMS506, or Safe Use of Opioids-Concurrent Prescribing, addresses the concurrent prescription of two or more opioids, or an opioid and a benzodiazepine, at discharge. The Safe Use measure does not capture the use of Naloxone/reversal agent, or the use of opioids during an inpatient admission |
| When will the measure stewards consider the whole hospitalization (outpatient or observations encounters) for surgery start and stop date & times within the measure logic? | The initial population for the measure is inpatient hospitalizations for patients age 18 and older during which 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. 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. Opioids and opioid antagonists administered in the operating room should not count towards the measure. The measure team will consider future updates to the measure logic to account for operating room encounter times throughout the entire hospitalization period. |
| Will Critical Access Hospitals be required to mandatory report for calendar year 2027? | Since critical access hospitals are not required to participate in the Hospital Inpatient Quality Reporting (IQR) Program, they are not required to report this measure in 2027 when mandatory reporting begins.<br><br>Critical access hospitals reporting through the Promoting Interoperability Program may be required to report the measure once reporting becomes mandatory. For more information on the Promoting Interoperability program see: https://qualitynet.cms.gov/inpatient/PI. |
| Will these questions/answers be available for download as well? | For all questions submitted during the webinar broadcast, we'll compile and release a written Q&A document weeks after the webinar. You can find this document at this link: https://www.jointcommission.org/en-us/knowledge-library/support-center/measurement/quality-measurement-webinars-videos |

| Question | Answer |
| --- | --- |
| Would a naloxone drip be considered an acceptable method of administration? | Yes, a naloxone drip is considered an acceptable intravenous method of administration. The route of administration of the opioid antagonist must be by intranasal spray, inhalation, intramuscular, subcutaneous, or intravenous injection. |