Expert to Expert Webinar: New Measure Review – Pressure Injury for 2025 implementation
Questions and Answers
July 10, 2025

Question	Answer
Please address unavoidable pressure injuries.	While pressure injury development may be unavoidable in rare situations, it is widely accepted that the risk of developing a pressure injury can be reduced through best practices. Measuring inpatient hospitalizations for patients who develop new pressure injuries while in the hospital setting will allow hospitals to more reliably assess harm reduction efforts and modify their improvement efforts in near real-time.
Are stage 1 pressure injuries not included in numerator?	This measure assesses the number of inpatient hospitalizations for patients aged 18 and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. A patient's development of a new stage 1 pressure injury would not qualify the encounter for the numerator.
How do we decide if a pressure injury is minor, moderate, or severe?	The measure assesses the number of inpatient hospitalizations for patients aged 18 and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. The National Pressure Injury Advisory Panel staging system is widely used as a classification system for pressure injuries. This staging system is outlined below: - Stage 2: Partial-thickness loss of skin with exposed dermis - Stage 3: Full-thickness loss of skin tissue; subcutaneous skin and muscle may be visible - Stage 4: Full-thickness loss of skin tissue; tendons, bone, and joints may be visible - Unstageable: Full-thickness loss of skin tissue that is obscured by eschar or slough - Deep tissue: Skin that is persistently non-blanchable, with maroon or purple discoloration
How frequently do DTPIs turn into unstageable pressure injuries?	The frequency at which deep tissue pressure injuries (DTPIs) become unstageable pressure injuries depends on patient status, comorbidities, and measures taken to prevent or address any signs of pressure injury.
Clarify documentation source(s) for 'physical assessment' data element. Would a coded diagnosis of DTPI NPOA be in the numerator?	The ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element uses the "Physical findings of skin" LOINC code (8709-8) that may be found within the patient's electronic health record (EHR). For more information on the ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element, please reference the eCQI Resource Center's eCQM Data Element Repository: https://ecqi.healthit.gov/mcw/2025/ecqm-dataelement/physicalexamperformedphysicalfindingsofskin.html. An inpatient hospitalization for a patient with a diagnosis of deep tissue pressure injury (DTPI) not present on admission (POA = N) would meet the measure's numerator criteria if the patient develops a new DTPI or stage 2, 3, 4, or unstageable pressure injury during their inpatient hospitalization.

Question	Answer
Clarification: What are criteria for "assessment results"? Does this include physician AND nursing assessment documentation?	More information on the "Physical Exam, Performed" QDM datatype and ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element may be found on the eCQI Resource Center's Data Element Repository. "Physical Exam, Performed" QDM datatype: https://ecqi.healthit.gov/mcw/2025/qdm-dataelement/physicalexamperformed.html ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element: https://ecqi.healthit.gov/mcw/2025/ecqm-dataelement/physicalexamperformedphysicalfindingsofskin.html This eCQM pulls from patient data entered in a hospital's electronic health record (EHR) system, including diagnosis codes, test and assessment results, and present on admission (POA) indicators. We recommend that each hospital work with its EHR vendor to determine the specific data sources that are being used for eCQM reporting.
Can you explain the assessment results? Is there a standard assessment available or required for submission?	More information on the "Physical Exam, Performed" QDM datatype and ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element may be found on the eCQI Resource Center's Data Element Repository. "Physical Exam, Performed" QDM datatype: https://ecqi.healthit.gov/mcw/2025/qdm-dataelement/physicalexamperformed.html ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element: https://ecqi.healthit.gov/mcw/2025/ecqm-dataelement/physicalexamperformedphysicalfindingsofskin.html
Is this based on ICD-10 coded information when the patient is discharged?	Unlike claims-based measures, which rely on ICD-10 coding post discharge, eCQMs use codes from a variety of code systems that are recorded in the electronic health record (EHR) throughout the patient's hospitalization. This measure specifically uses ICD-10, SNOMED CT, and LOINC codes for measure score calculation.
What happens if physician judgement was that DTPI was present on admission although not visible?	In order for an inpatient hospitalization to meet the measure's denominator exclusion criteria, a patient's pressure injury present on admission (POA) must be documented within the patient's electronic health record (EHR). The documentation could include POA indicators of "Y" (diagnosis was present at time of inpatient admission) or "W" (clinically undetermined) or physical exam findings.
Are there non discrete elements collected for this measure?	The measure uses data elements and value sets to identify which electronic health record (EHR) information to collect. We recommend that each hospital work with its EHR vendor to determine the specific data sources that are being used for eCQM reporting.
For the non-technical webinar participants, what are SNOMED CT and LOINC codes?	Both SNOMED CT and LOINC are medical coding systems. For information about SNOMED CT, see: https://www.nlm.nih.gov/healthit/snomedct/snomed_overview.html. For information about LOINC, see: https://loinc.org/

Question	Answer
Does POA "indicator" mean coding from a physician?	The Present on Admission (POA) indicator is a data element in a hospital's billing/claims system that is associated with each diagnosis field and indicates whether a condition was present at hospital admission or whether it arose during the hospitalization stay. The provider type or department responsible for documenting POA indicators may vary by hospital and depend on each hospital's workflow.
Will this eCQM pull from coding ICD-10 diagnoses for DPTI and PIs AND clinical documentation to confirm whether they are present in 24 to 72 hours?	This eCQM pulls from all patient data entered in a hospital's electronic health record (EHR) system, including diagnosis codes, test, and assessment results, and present on admission (POA) indicators. Documentation related to the pressure injury diagnoses will depend on individual facility practices.
Will provider documentation impact this eCQM?	This measure pulls from all patient data entered in a hospital's electronic health record (EHR) system, including diagnosis codes, test, and assessment results, and present on admission (POA) indicators.
Does this measure capture addendums in physician notes?	This eCQM pulls from patient data entered in a hospital's electronic health record (EHR) system, including diagnosis codes, test, and assessment results, and present on admission (POA) indicators. We recommend that each hospital work with its EHR vendor to determine the specific data sources that are being used for eCQM reporting.
Can the ["Physical Exam, Performed":"Physical Findings of skin"] data element be mapped to a nurse note? Or can this only be mapped to a physician note?	This eCQM pulls from patient data entered in a hospital's electronic health record (EHR) system, including diagnosis codes, test, and assessment results, and present on admission (POA) indicators. We recommend that each hospital work with its EHR vendor to determine the specific data sources that are being used for eCQM reporting.
Is my understanding correct that many organizations have not yet implemented LOINC/SNOMED CT codes for nursing/nursing documentation? They are mostly used for physicians at this time?	This is outside the scope of the measure's reporting requirements.
Hello! What is the result of conflict in documentation --i.e., nursing vs. provider documentation	This eCQM pulls from patient data entered in a hospital's electronic health record (EHR) system, including diagnosis codes, test, and assessment results, and present on admission (POA) indicators. We recommend that each hospital work with its EHR vendor to determine the specific data sources that are being used for eCQM reporting, particularly when there is contradictory data from different sources.

Question	Answer
Is there priority given to one of the two paths in the event that they contradict one another (i.e., the POA indicator versus the skin assessment)?	This eCQM pulls from patient data entered in a hospital's electronic health record (EHR) system, including diagnosis codes, test, and assessment results, and present on admission (POA) indicators. We recommend that each hospital work with its EHR vendor to determine the specific data and data sources that are being used for eCQM reporting, particularly when there is contradictory data from different sources.
What data source or field is typically used to map diagnoses in the EHR system at hospitals where this has been tested?	Testing results for CMS826: Hospital Harm - Pressure Injury are outlined in the feasibility scorecard that is available on the CMS Consensus-Based Entity website: https://p4qm.org/measures/3498e
What were the hospital-acquired pressure injury (HAPI) rates discussed earlier in the presentation?	The global incidence of pressure injuries in hospitalized patients has been estimated at 5.4 per 10,000 patient-days, and the global rate of hospital-acquired pressure injuries has been estimated at 8.4%. The incidence and rate were determined based on a review of observational, cross-sectional, or longitudinal design studies published between 2008 and 2018. Li, Z., Lin, F., Thalib, L., & Chaboyer, W. (2020). Global prevalence and incidence of pressure injuries in hospitalized adult patients: A systematic review and meta-analysis. International Journal of Nursing Studies, Vol. 105. https://doi.org/10.1016/j.ijnurstu.2020.103546
What are best practices to prevent pressure injuries?	Please reference clinical guidelines, such as those from the American College of Physicians and The International Guideline, for details on how to prevent pressure injuries. Both of these are referenced within the measure specification.
Is the denominator counting encounters for patients age 18 years or older, or encounter days?	The denominator is counting inpatient hospitalizations for patients aged 18 and older, not days.
Is the performance rate essentially: Patients that develop hospital acquired pressure injuries (HAPIs)/ (all patients - patients admitted with community acquired pressure injuries (CAPIs)) Assuming HAPI's and CAPI's meet the stg 2, 3, 4, unstageable and DTI criteria.	This measure's performance rate is calculated by dividing the total number of inpatient hospitalizations for patients with a new deep tissue pressure injury (DTPI) or stage 2, 3, 4, or unstageable pressure injury by the total number of inpatient hospitalizations for patients aged 18 and older for a given measurement period. Inpatient hospitalizations for patients with a DTPI or stage 2, 3, 4, or unstageable pressure injury that is present on admission to the hospital are excluded from the measure calculation.

Question	Answer
Does the DTPI need to be in the same location as the pressure injury for it to be an exclusion?	No, the deep tissue pressure injury (DTPI) does not need to be in the same location as the pressure injury for it to be an exclusion.
If one patient has more than one hospital-acquired pressure injury, is each one counted?	For this measure, only one harm (new qualifying pressure injury) is counted per encounter.
If a stage 1 pressure injury is POA =Y and it worsens to a stage 2 during admission, then it is counted in the numerator?	This measure excludes inpatient hospitalizations for patients with a deep tissue pressure injury or stage 2, 3, 4, or unstageable pressure injury present on admission. It does *not* exclude inpatient hospitalizations for patients with a stage 1 pressure injury present on admission. Therefore, if the patient's stage 1 pressure injury worsens to a stage 2 pressure injury during the hospitalization period, the inpatient hospitalization for this patient may meet the numerator criteria, as this would be considered a new stage 2 pressure injury.
If a patient is admitted with a stage 1 POA Y and it progresses to a stage 3 while inpatient, does the POA change to N?	A pressure injury that is present on admission (POA = Y) does not get subsequently re-coded to not present on admission (POA = N) if the pressure injury deteriorates to a higher stage during the hospitalization. However, a second code may be assigned for the same pressure injury site but with the highest stage reported during the hospitalization. If a second code of POA = N is assigned to the stage 3 pressure injury that develops during the hospitalization, the inpatient hospitalization for this patient may meet the numerator criteria.
If only one harm is counted per encounter, how does it determine which one to use? For example, if a stage two and an unstageable are found, which one would be selected for the harm?	This measure's logic only confirms whether a new deep tissue pressure injury or stage 2, 3, 4, or unstageable pressure injury developed during an inpatient hospitalization (and was not present on admission); the specific diagnosis code is not returned. For this measure, only one new pressure injury is counted per inpatient hospitalization. If two new pressure injuries develop during a hospitalization, either will qualify the inpatient hospitalization for the numerator population, and the measure would not evaluate the other pressure injury. However, we recommend that each hospital work with its electronic health record (EHR) vendor to determine which pressure injury diagnosis is identified as the qualifying harm in an encounter where the patient develops multiple hospital-acquired pressure injuries during a hospitalization.

Question	Answer
If a patient has one or more DTPIs or pressure injuries POA but then develops a new one while admitted, are they excluded, or would that one new wound would pull them out of exclusion and put them into the numerator?	If a patient has a deep tissue pressure injury or stage 2, 3, 4, or unstageable pressure injury present on admission (identified either by Present on Admission (POA) indicators or skin exam), then the patient's hospitalization will meet the denominator exclusion criteria and will *not* be included in the measure calculation. Because this inpatient hospitalization would be excluded from the measure's denominator, the progression of this pressure injury and/or any new pressure injuries that the patient develops later in the hospitalization (either at the original pressure injury site or another site) would *not* qualify the patient's hospitalization for the measure's numerator. However, if the patient had a stage 1 pressure injury present on admission that worsens to a stage 2 during the hospitalization period, the inpatient hospitalization for this patient may meet the numerator criteria, as this would be considered a new stage 2 pressure injury. Inpatient hospitalizations for patients with a stage 1 pressure injury present on admission are *not* excluded from the measure's denominator.
Will worsening pressure injuries count in this measure? Example: Pt comes in with a stage 2, but during hospitalization it progresses to stage 3.	If a patient has a deep tissue pressure injury or stage 2, 3, 4, or unstageable pressure injury present on admission (identified either by Present on Admission (POA) indicators or skin exam), then the patient's hospitalization will meet the denominator exclusion criteria and will *not* be included in the measure calculation. Because this inpatient hospitalization would be excluded from the measure's denominator, the progression of this pressure injury and/or any new pressure injuries that the patient develops later in the hospitalization (either at the original pressure injury site or another site) would *not* qualify the patient's hospitalization for the measure's numerator. However, if the patient had a stage 1 pressure injury present on admission that worsens to a stage 2 during the hospitalization period, the inpatient hospitalization for this patient may meet the numerator criteria, as this would be considered a new stage 2 pressure injury. Inpatient hospitalizations for patients with a stage 1 pressure injury present on admission are *not* excluded from the measure's denominator.
Will stage 2 pressure injuries now be reportable events? When will the measure be required to publicly report?	This eCQM, CMS826: Hospital Harm - Pressure Injury, is currently available for voluntary, not mandatory, reporting in the Hospital Inpatient Quality Reporting (IQR) Program. Voluntary reporting began in calendar year (CY) 2025. Mandatory reporting begins in CY 2028.
When is the date that reporting starts for 2025?	CMS826v2: Hospital Harm - Pressure Injury uses a calendar year measurement period (i.e., January 1, 2025, through December 31, 2025). Implementers report required and/or selected hospital eCQMs on an annual basis. The 2025 CMS QRDA I Implementation Guide for Hospital Quality Reporting provides more information on hospital eCQM reporting requirements for the 2025 reporting period. Please visit the eCQI Resource Center at https://ecqi.healthit.gov/qrda/versions for more information.
How often is this measured and submitted?	Implementers report required and/or selected hospital eCQMs on an annual basis. The eCQM Implementation Checklist available on the eCQI Resource Center (https://ecqi.healthit.gov/ecqm-implementation-checklist) provides steps for implementers to take to successfully report eCQMs.

Question	Answer
When will the data pulls occur? (i.e., is there a set date of the month that data is pulled, only after patient discharge, etc.)	Please reference the 2025 CMS QRDA I Implementation Guide for Hospital Quality Reporting for more information on data reporting requirements: https://ecqi.healthit.gov/qrda/versions.
Did I hear correctly that this measure will be mandatory for TJC ORYX reporting in 2028?	No. The Joint Commission has not yet determined the ORYX reporting requirements for 2028. ORYX requirements are typically posted in the fall for the following year. Please reach out to The Joint Commission at HCOORYX@jointcommission.org for more information.
Where can we obtain benchmark information on performance for eCQMs?	As calendar year (CY) 2025 is the first year of voluntary reporting for this eCQM, there is not yet a national average for CMS826: Hospital Harm - Pressure Injury. For this eCQM, a lower measure score indicates higher quality.
How does this measure apply to Critical Access Hospitals under CMS Conditions of Participation?	Critical Access Hospitals (CAHs) do not report through the Hospital Inpatient Quality Reporting (IQR) program but do report through the Medicare Promoting Interoperability Program. For more information on reporting requirements, please visit the CMS Promoting Interoperability website: https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs
Are cancer hospitals excluded from reporting this measure?	This eCQM is available for reporting in the Inpatient Quality Reporting (IQR) and Medicare Promoting Interoperability programs. This eCQM is *not* available for reporting in the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.
Does this measure apply to REH (Rural Emergency Hospital) facilities also?	This eCQM is available for reporting in the Inpatient Quality Reporting (IQR) and Medicare Promoting Interoperability programs. This eCQM is *not* available for reporting in the Rural Emergency Hospital (REHQR) Program.
Are there published data present on the facilities who have trialed this measure, where can this be found if available?	Testing results for CMS826: Hospital Harm - Pressure Injury are outlined in the feasibility scorecard and other endorsement application materials that are available on the CMS Consensus-Based Entity website: https://p4qm.org/measures/3498e

Question	Answer
Can you touch base on the CMS validation for eCQMs for the upcoming FY 2028 validation cycle? Any insight on how to prepare for this new validation?	If a hospital is selected for inpatient data validation efforts, they should follow the instructions sent to them by CMS's Clinical Data Abstraction Center (CDAC). The instructions explain the necessary information for submitting requested medical records. CMS verifies that eCQM data submitted to the HQR Secure Portal in QRDA format align with measure specifications as it relates to the patient's medical record. When validating cases, the CDAC reviews data found in both discrete and non-discrete fields in the medical records submitted as PDF files. If information found in the PDF medical record does not align with data in the QRDA, it could result in mismatches. Individual elements are not validated in and of themselves, but rather validation occurs at the outcome level; selected cases are scored as either a 0/1 or 1/1. If you have further questions about CMS data validation efforts for selected hospitals, you may email the Validation Support Contractor at validation@telligen.com.
How do we report PIs on terminally ill patients?	The measure assesses the number of inpatient hospitalizations for patients aged 18 and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. The measure does not contain any exclusions for inpatient hospitalizations for patients who are terminally ill, who are receiving comfort measures, or who are discharged to hospice care.
How will PI from a medical device be treated?	The measure assesses the number of inpatient hospitalizations for patients aged 18 and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. This includes pressure injuries developed as a result of a medical device, as most medical device-related pressure injuries are preventable with appropriate care.
As patients may develop Kennedy terminal ulcers (KTUs) as part of the natural dying process, will inpatient hospitalizations for patients who develop KTUs or who are receiving end-of-life care be excluded from the measure?	For the 2025 reporting period version of this eCQM, only inpatient hospitalizations for (1) patients with a deep tissue pressure injury or stage 2, 3, 4 or unstageable pressure injury diagnosis present on admission (noted via Present On Admission indicators or by skin exam results) and (2) patients with a COVID-19 diagnosis are excluded from the measure's denominator. However, we may consider the addition of new exclusion criteria in future iterations of the eCQM.
Will diabetics be excluded in the future from the measure? Asking because of diabetic sores, and ulcers can look like pressure injuries.	Diabetic ulcers are documented using ICD-10 codes that are different from those used for pressure injuries. This eCQM relies on the accurate recording of codes in the patients' EHR, based on a comprehensive understanding of a patient's comorbidities, which is essential for the correct calculation of all eCQMs.

Question	Answer
Do you consider skin failure to be a pressure injury, or do you consider skin failure to be different diagnosis because the etiology is different?	This measure assesses the number of inpatient hospitalizations for patients aged 18 and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. The measure does *not* assess diagnoses of skin failure. The measure uses codes from the following value sets to identify diagnoses or findings of stage 2, 3, 4, deep tissue, and unstageable pressure injuries: - "Present on Admission or Clinically Undetermined" (2.16.840.1.113762.1.4.1147.197) - "Pressure Injury Deep Tissue" (2.16.840.1.113762.1.4.1147.112) - "Pressure Injury Deep Tissue Diagnoses" (2.16.840.1.113762.1.4.1147.194) - "Pressure Injury Stage 2, 3, 4 or Unstageable" (2.16.840.1.113762.1.4.1147.113) More information on the codes contained in these value sets can be found on the Value Set Authority Center (https://vsac.nlm.nih.gov/).
Will patients with skin failure diagnoses be excluded from the measure?	This measure does *not* exclude inpatient hospitalizations for patients with a diagnosis only of skin failure.
What about thermal imaging devices and identification of signs and symptoms (S/S) of DTPI present on admit. What happens if those S/S are present on admit but visual changes don't occur until 14 days later?	Deep tissue pressure injuries (DTPIs) are typically visible via skin changes between 24 to 72 hours after a precipitating pressure event. The presentation of a DTPI that is detected by skin exam 72 hours or less after the start of the inpatient hospitalization would qualify the encounter for the measure's denominator exclusion criteria, as this would indicate that the precipitating pressure event for the DTPI occurred prior to the start of the inpatient hospitalization. While it is unlikely that a DTPI would present via skin changes 14 days after detection from a thermal imaging device, a DTPI detected via thermal imaging *could* progress to a stage 2, 3, 4, or unstageable pressure injury days or weeks later in a hospitalization. However, early detection of the signs and symptoms of DTPIs through thermal imaging can facilitate timely intervention, such as pressure relief and specialized wound care, which can prevent the progression of a DTPI to a stage 2, 3, 4, or unstageable pressure injury later in a patient's hospitalization.
1. If thermal imaging shows signs and symptoms (S/S) of DTPI within 24h of admission but no visual changes present until days later, can you mark this as POA-Y?	Clinical and coding teams primarily use a patient's medical record, which includes physician notes and results of past physical exams, to record a Present on Admission (POA) indicator status for a particular diagnosis. We recommend that each hospital team works internally to determine what documentation is used to determine POA indicator statuses.

Question	Answer
If a patient remains as an observation patient are they included in the numerator?	The patient must be admitted to inpatient care in order for the encounter to qualify for the initial population. This measure uses the Global."HospitalizationWithObservation" function to determine the interval of the entire inpatient hospitalization encounter, which includes time in the emergency department and observation when the transition between these encounters and the inpatient admission are one hour or less.
When does the encounter or episode of care begin?	The inpatient hospitalization period assessed by this measure includes time in the emergency department and observation when the transition between discharge from these encounters and admission to the inpatient encounter is one hour or less.
Does the encounter start when the patient presents to the ED or when the patient is admitted?	The inpatient hospitalization period assessed by this measure includes time in the emergency department (ED) and observation when the transition between discharge from these encounters and admission to the inpatient encounter is one hour or less. For example, if a provider identifies a patient's stage 2 pressure injury through a skin exam during the first 24 hours of an ED encounter, and the transition between the patient's ED discharge and the patient's inpatient admission is one hour or less, the hospitalization would meet the measure's denominator exclusion criteria, as the patient's time in the ED would be assessed by the measure as part of the inpatient hospitalization period.
Please clarify the 1 hour interval between the ED/OBS status and to the Inpatient status. Does this mean the transition from ED to inpatient must be less than 1 hour even if there is a transition interval of less than 1 hour from the ED to OBS and then less than 1 hour interval between OBS and inpatient?	In the scenario you have provided, time in the emergency department encounter visit could count toward the inpatient hospitalization. This measure uses the Global."HospitalizationWithObservation" function to determine the interval of the entire inpatient hospitalization encounter, which includes time in the ED and observation when the transition between these encounters and the inpatient admission are one hour or less.
Can you provide a timeline example of a patient coming to ED, then becomes admitted, and when a pressure injury would be considered hospital acquired?	For example, if a patient is in the emergency department (ED) for 24 hours, and the transition between the ED discharge and the start of the inpatient encounter is one hour or less, then the patient's time in the ED counts as part of the inpatient hospitalization period. Therefore, if a skin exam detects a stage 2, 3, 4, or unstageable pressure injury after the start of the inpatient encounter, then the inpatient hospitalization for this patient would meet the measure's numerator criteria. This is because the stage 2, 3, 4, or unstageable pressure injury was found by skin exam *after* the first 24 hours of the inpatient hospitalization (which includes the time spent in the ED), indicating that it is a hospital-acquired pressure injury.
Does the encounter begin at the completion of physician evaluation or upon admission to the ER?	If the transition between discharge from the emergency department and/or observation encounter and the admission to the inpatient encounter is one hour or less, then the inpatient hospitalization begins with the admission to the emergency department or observation encounter. Otherwise, the inpatient hospitalization period assessed by this measure starts at the inpatient admission.

Question	Answer
If a patient is admitted and awaiting a transfer to inpatient location they are often in the ED for hours awaiting the transfer. If admit orders or documentation that excludes or includes patients in eCQMs are entered in the EMR during this period, does that data not get included in the inpatient encounter and essentially fail the requirements and fail the cases?	We recommend that each hospital team works internally to confirm the criteria that are used to determine the start of a patient's inpatient status, as this may vary by different hospital or payer requirements.
If patient is in the ED > 1 hour, how is the Skin Exam First 24 Hours criteria calculated/ adjusted	The inpatient hospitalization period assessed by this measure includes time in the emergency department and/or observation when the transition between discharge from these encounters and admission to the inpatient encounter is one hour or less, regardless of how much time the patient spends in the emergency department encounter and/or observation status.
If a patient is admitted as inpatient, and then later changed to observation status and discharged in observation status, would they be included in this measure?	An inpatient hospitalization that ends during the measurement period for a patient 18 or older is required to meet this measure's initial population criteria. This measure uses the ["Encounter, Performed": "Encounter Inpatient"] QDM data element to identify inpatient hospitalizations that may qualify for the measure's initial population. More information on the ["Encounter, Performed": "Encounter Inpatient"] QDM data element may be found on the eCQI Resource Center's Data Element Repository: https://ecqi.healthit.gov/mcw/2025/ecqm-dataelement/encounterperformedencounterinpatient.html
If a patient presents to a different facility within 24 hours and they document a pressure injury on admission, would the injury be assigned to the original facility?	An inpatient hospitalization for a patient admitted to a facility with a pressure injury present on admission (POA) would be excluded from the measure calculation for that facility. The measure does not attribute the pressure injury to the prior facility.
Will the timing of injuries be identified in any other way other than the POA status indicator? For example, injuries that occur after admission but before the 72/24 hour exclusion mark.	For an inpatient hospitalization for a patient to meet the denominator exclusion criteria, a deep tissue pressure injury (DTPI) must be found on exam 72 hours or less after the start of the encounter, or a stage 2, 3, 4, or unstageable pressure injury must be found on exam 24 hours or less after the start of the encounter.

Question	Answer
Should there be documentation within 24 hours or is there a margin for 72 hours?	This measure assesses the number of inpatient hospitalizations for patients with a new deep tissue pressure injury (DTPI) or stage 2, 3, 4, or unstageable pressure injury that develops during an inpatient hospitalization. The numerator looks for *new* pressure injuries as evidenced either by a Present on Admission indicator of "N" or "U" *or* by the results of a skin exam. When assessing skin exam results, an inpatient hospitalization for a patient would meet the measure's numerator criteria if a DTPI was found on a skin exam that was performed greater than 72 hours after the start of the encounter, *or* if a stage 2, 3, 4, or unstageable pressure injury was found on a skin exam that was performed greater than 24 hours after the start of the encounter. There are no requirements for the timing of documentation of the results of the skin exam as long as documentation of the timing of the exam itself and any subsequent diagnosis is accurate. When evaluating skin exam results, the measure uses the ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element, which relies on the timing of the exam, not the timing of the results. The *relevant dateTime* attribute used with this data element references the time the exam is performed when the exam occurs at a single point in time. The *relevantPeriod* attribute used with this data element references a start and stop time for an exam that occurs over a time interval. For more information on the ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element, please visit the eCQI Resource Center's Data Element Repository: https://ecqi.healthit.gov/mcw/2025/ecqm-dataelement/physicalexamperformedphysicalfindingsofskin.html
What if the coding application of not POA does not necessarily mean it was > 72 hours after admission. According to coding definitions - There is no required timeframe as to when a provider (per the definition of "provider" used in these guidelines) must identify or document a condition to be present on admission. Therefore, if only the not POA indicator is assigned, could a case with onset 24-72 hours after admission be inappropriately assigned to the numerator?	This eCQM assesses patient data from the patient's entire hospitalization period. If a Present on Admission (POA) indicator of "Y" or "W" is assigned for a deep tissue pressure injury (DTPI) or a stage 2, 3, 4, or unstageable pressure injury, the inpatient hospitalization for that patient will meet the denominator exclusion criteria, regardless of when the POA indicator status was updated by the hospital. Conversely, if a POA indicator of "N" or "U" is assigned for a DTPI or a stage 2, 3, 4, or unstageable pressure injury, and the DTPI is identified by skin exam after the first 72 hours of the encounter, or the stage 2, 3, 4, or unstageable pressure injury is identified by skin exam after the first 24 hours of the encounter, then the inpatient hospitalization for that patient will meet the numerator criteria.

Question	Answer
How are the 24-hour and 72-hour cutoffs for physical exam determined?	The National Pressure Injury Advisory Panel indicates that 24-72 hours may lapse between a precipitating pressure event and the presentation of a deep tissue pressure injury (DTPI). Therefore, the measure's numerator looks for the diagnosis of a new DTPI found by skin exam *after* the first 72 hours of the encounter to identify DTPIs that result from precipitating pressure events that occur during the hospitalization period and *not* those that occurred prior to the start of hospital care. Stage 2, 3, 4, and unstageable pressure injuries that are present on admission should be immediately visible during the initial skin exam performed within the first 24 hours of a patient's hospitalization. Therefore, the measure's numerator looks for the diagnosis of a new stage 2, 3, 4, or unstageable pressure injury found by skin exam *after* the first 24 hours of the encounter to identify only stage 2, 3, 4, and unstageable pressure injuries that result from precipitating pressure events that occur during the hospitalization period.
For the DTPI on slide 18, do you know what coding guidelines recommend for coders for POA "Y"? Not sure they code "No" if not identified at the time of admission only. Meaning, if a DTPI is identified @60 hours, based on coding guidelines, would coders code as POA "Y"? I foresee challenges with over reporting of DTPI's in this scenario if coding does not take into account the 72-hour rule for DTPI's as POA "N"	Clinical and coding teams primarily use a patient's medical record, which includes physician notes and results of past physical exams, to record a Present on Admission (POA) indicator status for a particular diagnosis. We recommend that each hospital team works internally to determine what documentation is used to determine POA indicator statuses.
Is there a separate analysis of PIs for patients under the age of 18? Thanks Syed	This measure assesses the number of inpatient hospitalizations for patients aged 18 and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. The measure does not assess inpatient hospitalizations for patients younger than 18.
Are there any analyses of the subgroup of patients with PIs from spinal cord injury?	This measure does not include strata or risk-adjustment variables for different demographics or comorbidities.