Questions and Answers – Expert to Expert Webinar Annual Updates for Hospital Harm - Pressure Injury eCQM for 2026 Reporting Year

Broadcast March 19, 2026

Question	Answer
What if the nurse noted the pressure injury and documents it, but the provider/doctor doesn't code for it. Will it still be POA?	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. The provider type that may document results for the measure's data elements depends on each hospital's workflow and scope of practice guidelines.
Are patients on pressor support or vascular/arterial insufficiency excluded from measure?	Only inpatient hospitalizations for patients with a deep tissue pressure injury (DTPI) or stage 2, 3, 4, or unstageable pressure injury that is present on admission (as indicated by POA indicators of "Y" or "W" or early skin exam results) are excluded from the measure's denominator.
Are Mucous Membrane PI included? If so, where?	Mucous membrane pressure injuries are not typically stageable using the traditional National Pressure Injury Advisory Panel system due to the anatomy affected by these pressure injuries. If a new mucous membrane pressure injury is incorrectly documented or coded as a staged pressure injury, it may qualify the inpatient hospitalization for the measure's numerator. The measure uses SNOMED CT, LOINC, and ICD-10-CM codes from the following value sets to identify diagnoses or findings of DTPIs and stage 2, 3, 4, and unstageable pressure injuries: • "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) • "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) More information on the codes contained in these value sets can be found on the Value Set Authority Center (VSAC) (https://vsac.nlm.nih.gov/).

Question	Answer
If a patient develops a Kennedy Terminal pressure injury (or ulcer) will that be considered as HH-PI?	It is recommended that Kennedy Terminal Ulcers (KTUs) be documented and coded differently than pressure injuries, as they have different etiologies. If a new KTU is incorrectly documented or coded as a new staged pressure injury, it may qualify the inpatient hospitalization for the measure's numerator. The measure uses SNOMED CT, LOINC, and ICD-10-CM codes from the following value sets to identify diagnoses or findings of DTPIs and stage 2, 3, 4, and unstageable pressure injuries: • "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) • "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) More information on the codes contained in these value sets can be found on the VSAC (https://vsac.nlm.nih.gov/).
What do you mean "we may consider the addition of new exclusion criteria in future iterations of the eCQM" regarding skin failure/Kennedy ulcer?	CMS updates each eCQM on an annual basis to align with the latest clinical guidelines and evidence. CMS may consider updates to the measure's population criteria in future iterations of the eCQM for future reporting periods.
Are patients on skilled level of care included in the population numbers?	No, encounters for patients in skilled nursing facilities (SNFs) or those admitted to swing bed services do not qualify for the initial population, as this measure is for use in the Hospital Inpatient Quality Reporting (HIQR) program. The measure's initial population and denominator include all inpatient hospitalizations that end during the measurement period for patients age 18 years and older.
What happens if a wound nurse documents a stage 2, 3, or 4 pressure injury greater than 24 hours after hospital arrival, and states present on admission within that assessment?	This eCQM assesses data from the patient's entire hospitalization period. If a POA indicator of "Y" or "W" is assigned for a stage 2, 3, or 4 pressure injury with an ICD-10-CM or LOINC diagnosis code in the "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) value set, the inpatient hospitalization for that patient will meet the denominator exclusions criteria, regardless of when the POA indicator status was updated by the hospital.

Question	Answer
Should the documentation specifically state that it is a Stage 2, 3 etc. or are the words -partial thickness, full thickness, non-blanchable, maroon, or purple discoloration acceptable?	The measure uses SNOMED CT, LOINC, and ICD-10-CM codes from the following value sets to identify diagnoses or findings of DTPIs and stage 2, 3, 4, and unstageable pressure injuries: • "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) • "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) More information on the codes contained in these value sets can be found on the VSAC (https://vsac.nlm.nih.gov/).
What if a pt has a pressure injury within the last year that has superficially healed to the naked eye, once hospitalized the scar tissue area reopens.	If a patient has a DTPI or stage 2, 3, 4, or unstageable pressure injury present on admission, identified either by POA indicators of “Y” or “W” or early skin exam results, then the patient's hospitalization will meet the denominator exclusions criteria and will be excluded from the measure calculation. However, if a pressure injury is healed at the time of inpatient admission, it is unlikely that it would be recorded as being present on admission. If the pressure injury is documented as being **not** present on admission, with POA indicators of “N” or “U”, and is identified by skin exam after the initial 24 hours (for stage 2, 3, 4, and unstageable pressure injuries) or 72 hours (for DTPIs) of the hospitalization, then the inpatient hospitalization for the patient may meet the measure's numerator criteria.
Is nursing documentation an allowable source for POA indicators or must POA indicators come from coding?	The 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.

Question	Answer
The responses to the questions in the Q&A regarding Stage 1 POAs that worsen to Stage 2 or 3 during the encounter seem to be in conflict with one of the FAQs in the slides. Can you please clarify if the patient will be excluded based on if the worsening would be considered a "new" pressure injury, as the FAQ slide presented states.	An inpatient hospitalization for a patient with a stage 1 pressure injury present on admission will **not** be excluded from the measure and remains in the denominator population. Only inpatient hospitalizations for patients with DTPIs or stage 2, 3, 4, or unstageable pressure injuries present on admission are excluded from the measure's denominator. Therefore, if a patient has a stage 1 pressure injury present on admission but then develops a DTPI or a stage 2, 3, 4, or unstageable pressure injury later in the inpatient hospitalization, either at the same site or a different site, this would be considered a new DTPI or stage 2, 3, 4, or unstageable pressure injury and may qualify the inpatient hospitalization for the measure's numerator.
What is the difference in findings between the 72 and 24 hours?	Inpatient hospitalizations for patients with a DTPI found on exam 72 hours or less after the start of the hospitalization are excluded. Inpatient hospitalizations for patients with a stage 2, 3, 4, or unstageable pressure injury found on exam 24 hours or less after the start of the hospitalization are excluded.
If a patient was admitted with POA pressure injury stage unspecified, would in the denominator but not the numerator?	A diagnosis of a pressure injury with staging qualifies inpatient hospitalizations for the denominator exclusions or numerator. The value sets used to identify findings and diagnoses of pressure injuries with staging are: • "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) • "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) Review the codes contained in these value sets on the VSAC (https://vsac.nlm.nih.gov/).

Question	Answer
If the patient is in the ED or observation for greater than 1 hour, then those times would not be used?	Time spent in the emergency department (ED) or observation **can** be included in the inpatient hospitalization period assessed by the measure if the patient is in the ED or observation for longer than one hour. However, if the patient is discharged from the ED or observation and more than one hour passes before they are admitted to an inpatient encounter, their time in the ED or observation will **not** be included in the inpatient hospitalization period assessed by the measure.
To clarify, if a patient spends 10 hours in the Obs unit before transferring to inpatient. The 24-hour window would start at time of admission to inpatient?	No. The inpatient hospitalization period assessed by this measure includes time in the ED and observation when the transition between discharge from ED and/or observation and admission to the inpatient encounter is one hour or less, regardless of how much time the patient spends in the ED encounter and/or observation status. For example, if a patient is discharged from observation status at 9:45AM and admitted to the inpatient encounter at 10AM on the same day, then the inpatient hospitalization period assessed for that patient would begin at the start of the patient's observation status, regardless of when it began, because the transition between discharge from the observation status and the start of the inpatient encounter is one hour or less. Therefore, the start of the observation status would be used as the anchor to determine the initial 24-period of the hospitalization.
If a patient spends 48 hours in the ED / or on observation stay and then admits to the inpatient unit, does the start of the encounter start from when the patient was in the ED or observation stay? The 1 hour or less transition phrase is confusing to me.	The inpatient hospitalization period assessed by this measure includes time in the ED and/or observation status when the transition between discharge from ED or observation and admission to the inpatient encounter is one hour or less, regardless of how much time the patient spends in the ED encounter and/or observation status. So, if a patient spends 48 consecutive hours first in the ED and then in observation status, and the time between the end of the observation status and the start of the inpatient encounter is one hour or less, then the inpatient hospitalization period would begin at the start of the ED encounter.

Question	Answer
Can you provide an actual example of the ER-to-hospital transition?	The inpatient hospitalization period assessed by this measure includes time in the ED and/or observation status 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 ED encounter and/or observation status. For example, if the patient's ED encounter begins at 10AM and ends at 12:15PM, and the patient is admitted to the inpatient encounter at 1PM, then the inpatient hospitalization period assessed by the measure would begin at 10AM (the ED encounter start time), as the transition between discharge from the ED encounter and the start of the inpatient encounter is less than one hour. In this case, the time anchor for the 24- and 72-hour thresholds for skin exams is the start of the ED encounter. If the patient's ED encounter begins at 10AM and ends at 11:45AM, and the patient is admitted to the inpatient encounter at 1PM, then the inpatient hospitalization period assessed by the measure would begin at 1PM (the inpatient encounter start time), as the transition between discharge from the ED encounter and the start of the inpatient encounter is more than one hour. In this case, the time anchor for the 24- and 72-hour thresholds for skin exams is the start of the inpatient encounter.
Can you clarify "start of encounter" as it relates to the emergency department. Is that start on first physical exam or when the patient is triaged?	If a patient has an ED encounter that immediately precedes an inpatient encounter, where the transition between the end of the ED encounter and the start of the inpatient encounter is one hour or less, then the inpatient hospitalization period assessed by the measure begins at the start of the ED encounter, not at the time when the provider completes the initial assessment of the patient. The start of the ED encounter will be the anchor for determining the 24- and 72-hour thresholds for skin exams.

Question	Answer
If only one new harm is counted per hospitalization, do they count the most advanced stage?	This measure's logic only confirms whether a new DTPI or stage 2, 3, 4, or unstageable pressure injury develops during an inpatient hospitalization (that was not present on admission); the specific pressure injury with the most advanced staging is not returned by the measure. For this measure, only one new pressure injury is counted per inpatient hospitalization. Therefore, if two pressure injuries develop during the same hospitalization, only one would be needed to qualify the inpatient hospitalization for the numerator population, and the measure would not evaluate the other pressure injury. We suggest working with your EHR vendor to ensure your workflow is being appropriately captured to meet specific measure criteria and to determine which pressure injury diagnosis is identified as the qualifying harm when the patient develops multiple hospital-acquired pressure injuries during the hospitalization.
If there are no numerator exclusions, does this mean that hospice/comfort care only patients are counted in this measure?	Correct, inpatient hospitalizations for hospice or comfort care only patients are included in the measure's denominator and are **not** excluded. Pressure injury prevention and monitoring are considered appropriate clinical care across all inpatient settings, including those providing hospice services.
What was the rationale for including stage 2 or partial thickness PI in this measure?	While the relative level of harm of stage 2 pressure injuries is less than with stages 3 and 4 pressure injuries, unstageable pressure injuries, and potentially DTPIs, stage 2 pressure injuries, characterized by partial-thickness skin loss, constitute a very real patient harm that should be monitored and addressed.
Is there a time from admission that the POA designation is valid?	This eCQM assesses patient data from the patient's entire hospitalization period. If a POA indicator of "Y" or "W" is assigned for a diagnosis of a pressure injury with a ICD-10-CM or LOINC code in the "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) or "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) value sets, the inpatient hospitalization for that patient will meet the denominator exclusions criteria, regardless of when the POA indicator status was updated by the hospital.

Question	Answer
If a patient refuses treatment for Pressure Injury prevention, does that exclude the patient from the numerator?	No, this measure does not have numerator exclusions criteria for patient refusal of pressure injury prevention care.
What will happen if bedside nursing documents a pressure injury but do not complete staging within the EHR? Will this chart be flagged.	In order for an inpatient hospitalization for a patient with a new pressure injury to meet the measure's numerator criteria, the hospitalization must meet the following conditions: - The patient must have a diagnosis of a DTPI or stage, 2, 3, 4, or unstageable pressure injury with a LOINC or ICD-10-CM diagnosis code in the "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) value set or "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) value set and a corresponding POA indicator of "N" or "U." OR - The provider must document findings of a stage 2, 3, 4, or unstageable pressure injury with a SNOMED CT code in the "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) value set from a skin exam that starts after the first 24 hours of the hospitalization. OR - The provider must document findings of a DTPI with a SNOMED CT code in the "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) value set from a skin exam that starts after the first 72 hours of the hospitalization. More information on the codes contained in these value sets can be found on the VSAC (https://vsac.nlm.nih.gov/).
What does the term indicator vs POA mean? I know POA stands for present on admission, but what is an indicator?	The 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.

Question	Answer
What happens if an injury is initially coded as a pressure injury by a nurse, but a subsequent clinical assessment by a doctor determines that it is not a pressure injury?	This eCQM relies on the accurate recording of codes in the patients' EHRs, which is essential for the correct calculation of all eCQMs. The process for correcting or updating codes in the EHR may vary by hospital and will depend on each hospital's workflow. A hospital-level eCQM score for a given measurement period is not final until the end of the measurement period, once data entry is complete, documentation and coding are finalized for all hospitalizations in that measurement period, and data are extracted from the appropriate EHR fields and submitted to CMS for reporting.
Many providers do not understand the difference between PI vs moisture-associated skin damage (MASD) nor proper staging. A certified wound specialty nurse often is asked to evaluate skin injuries to determine if it is indeed a PI. Can the nurse be the one to deem the type of skin injury or only providers?	This measure does not specify the provider type that must document qualifying pressure injury diagnoses or findings. The provider type that may document results for the data elements included in this measure depends on each hospital's workflow and scope of practice guidelines. If you have questions about the specific data source(s) used for each data element, we recommend that you reach out to the hospital's EHR vendor for clarification.

Question	Answer
What if a pressure ulcer is coded, but POA is not coded at all, so no POA value of Y or W or U or N. Where would this fall?	For an inpatient hospitalization to meet the measure's denominator exclusions or numerator criteria for a diagnosis of pressure injury, there must be a coded POA indicator for that diagnosis. If the patient has a diagnosis of a DTPI or a stage 2, 3, 4, or unstageable pressure injury with a LOINC or ICD-10-CM diagnosis code in the "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) or the "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) value sets with no associated POA indicator in the "Not Present On Admission or Documentation Insufficient to Determine" (OID: 2.16.840.1.113762.1.4.1147.198) or the "Present on Admission or Clinically Undetermined" (OID: 2.16.840.1.113762.1.4.1147.197) value sets (i.e., POA indicator is "null"), then the inpatient hospitalization could not meet the denominator exclusions or numerator criteria. A POA indicator is not required for findings from a skin exam. If the provider documents findings of a DTPI or stage 2, 3, 4, or unstageable pressure injury from a skin exam with a SNOMED CT code in the "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) or the "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) value set, then a POA indicator is not required for findings of a pressure injury in order for the inpatient hospitalization to meet the measure's denominator exclusions or numerator criteria. More information on the codes contained in these value sets can be found on the VSAC (https://vsac.nlm.nih.gov/).
Are any risk adjustments applied to this?	No, this measure is not risk adjusted.

Question	Answer
If a patient comes in with a stage 1 (POA) and the wound declines to a stage 3, are facilities expected to code the stage 3 as hospital acquired?	A pressure injury that is present on admission (POA indicator of “Y”) does not get subsequently re-coded to not present on admission (POA indicator of “N”) if the pressure injury deteriorates to a higher stage during the hospitalization. If another POA indicator of “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. This is because inpatient hospitalizations for patients with stage 1 pressure injuries present on admission are **not** excluded from the denominator, so this hospitalization would remain in the measure's denominator and eligible for numerator consideration.
If a patient is admitted with a stage 1 pressure injury with a POA indicator of "Y" and it progresses to a stage 3 pressure injury while inpatient, does the POA indicator change to "N"?	An inpatient hospitalization for a patient with stage 1 pressure injury present on admission is not excluded from the measure. So, if a patient has a stage 1 pressure injury diagnosis with a POA indicator of “Y”, this inpatient hospitalization will remain in the denominator population and eligible for the numerator population. If a POA indicator of “N” is assigned to the stage 3 pressure injury diagnosis, the inpatient hospitalization for this patient may meet the numerator criteria. We suggest working with your EHR vendor and clinical team to determine how new DTPIs and stage 2, 3, 4, and unstageable pressure injuries are being captured in your EHR based on your current workflow.
Will this same criteria be utilized for HAPIs per CMS? If a stage 2 was identified within 72 hours of admission during a skin assessment, will we be dinged with a HAPI since it is not counted as an eCQM	If a provider documents findings of a stage 2 pressure injury from a skin exam that starts after the first 24 hours of the hospitalization, the inpatient hospitalization for this patient would meet the measure's numerator criteria – assuming that the inpatient hospitalization does not meet the measure's denominator exclusions criteria.
If we are reporting out to CMS our HAPIs, should this number match our eCQM PIs? Is the reportable criteria the same?	The eCQM and claims measure related to pressure injury do not have the same reporting criteria. These numbers may not match.

Question	Answer
Why do the measure specifications differ from the definitions of serious reportable injuries by Joint Commission/NQF who use only stage 3, 4 or unstageable pressure injury acquired after admission?	While the CMS and Joint Commission both seek to reduce patient harm related to pressure injuries, it is important to distinguish between eCQMs and patient safety events or serious reportable events (SREs). Alignment between organizations does not mean that the measure specifications, staging thresholds, or exclusion criteria are identical. Though eCQMs may cite publicly available clinical guidelines or consensus documents to support the rationale for the outcomes evaluated, eCQMs are not intended to serve as clinical guidelines or establish a standard of medical care. Each eCQM defines its population, outcomes, and exclusions based on methodological considerations specific to quality measurement, which may differ from those used for accreditation or safety event reporting purposes.
Patients who are admitted with a diagnosis of critical limb ischemia and develop a wound on that limb - they're also included in the measure, then?	Wounds that develop in the setting of critical limb ischemia are ischemic or vascular in etiology and are clinically distinct from pressure injuries. These would not qualify an inpatient hospitalization for the measure's numerator when documented and coded appropriately. The measure uses SNOMED CT, LOINC, and ICD-10-CM codes from the following value sets to identify diagnoses or findings of DTPIs and stage 2, 3, 4, and unstageable pressure injuries: • "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) • "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) More information on the codes contained in these value sets can be found on the VSAC (https://vsac.nlm.nih.gov/).

Question	Answer
What if the patient comes in and the bedside nurse classifies the pressure injury as stage 2 but the next day a wound nurse reclassifies the injury as stage 1. Which will count?	This eCQM pulls from all patient data entered into a hospital's EHR system, including diagnosis codes, test, and assessment results, and POA indicators. The provider type that may document results for this measure's data elements depends on each hospital's workflow and scope of practice guidelines. 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.
Will this presentation be sent out?	All captioned webinar recording links, slides, and transcripts can be accessed within 2 weeks of the live event on the Joint Commission's webpage at this link https://www.jointcommission.org/en-us/knowledge-library/support-center/measurement/quality-measurement-webinars-videos, scroll down on the page and use the checkbox for the Expert to Expert series.
Is the HH-PI eCQM required for either the Joint Commission or CMS?	Joint Commission is not accepting this measure for 2026. For CMS, this is a voluntary eCQM for the 2026 reporting period in the Hospital Inpatient Quality Reporting (IQR) and Promoting Interoperability programs, as finalized by CMS in the FY 2025 Inpatient Prospective Payment System (IPPS) final rule (https:public-inspection.federalregister.gov/2024-17021.pdf). For additional information on Joint Commission's 2026 reporting requirements, see this reference. Sections of that page will explain measures available for reporting in 2026, and requirements based on hospital size and whether OB services are delivered: https://jointcommission-ddsp.atlassian.net/wiki/spaces/DCS/pages/1030619137/2026+ORYX+Performance+Measurement+Reporting+Requirements

Question	Answer
Would you please clarify eCQM measure application if a patient enters the ED at 0800 on Friday gets admitted to the hospital at 1700 and is determined to have a pressure injury 0900 Saturday, the next day (greater than 24 hours)?	The determination of the inpatient hospitalization period depends on the time that the patient's preceding ED encounter **ended**, rather than when it started. For example, if a patient enters the ED at 8:00 on March 27, leaves the ED at 16:30 on March 27, and is admitted to inpatient care at 17:00 on March 27, then the inpatient hospitalization period assessed by the measure begins at 8:00 on March 27, because the time between the end of the ED encounter and the start of the inpatient encounter is one hour or less. The start of the ED encounter will be the anchor for determining the 24- and 72-hour thresholds for skin exams. Therefore, if the hospital identifies a stage 2, 3, 4, or unstageable pressure injury on a patient through a skin exam that takes place at 9:00 on March 28, then this would be considered a new qualifying pressure injury for the measure's numerator criteria, as it was found more than 24 hours after the hospitalization period began.
Do DTPI's have a different window for being considered present on admission than Stage II, III, IV, or unstageable pressure injury? Was I reading slide 23 incorrectly or did it seem like DTPIs have a longer window (72hrs) than the others (24hrs)?	The present-on-admission window for a skin exam for stage 2, 3, 4, and unstageable pressure injuries is 24 hours, whereas the window for DTPIs is 72 hours. 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 hospitalization for the measure's denominator exclusions criteria, as this would indicate that the precipitating pressure event for the DTPI occurred prior to the start of the inpatient hospitalization.

Question	Answer
What if the etiology of pressure injury is documented, but staging is never entered? Will this factor in based on coding? Be included?	Documentation of a pressure injury's etiology alone is not sufficient for inclusion in the measure. The measure does not identify pressure injuries as documented in free text fields and instead relies on SNOMED CT, LOINC, and ICD-10-CM codes from the following value sets to identify diagnoses or findings of DTPIs and stage 2, 3, 4, and unstageable pressure injuries: • "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) • "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) More information on the codes contained in these value sets can be found on the VSAC (https://vsac.nlm.nih.gov/).
Is the START of the encounter also the time the order for inpatient admission occurs (POA)?	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.
How does this apply to nursing home reporting if a nursing home is not JC Accredited?	This measure is for use by eligible hospitals and critical access hospitals participating in eCQM reporting for the CMS Hospital IQR program or Promoting Interoperability program.
Would the bedboard order for an inpatient bed, border admission order, and/or actual admission order kick off the cascade to include the patient into the denominator?	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.
Does Joint Commission have specifics around minimal documentation expectations?	Joint Commission is not accepting this measure for 2026 and therefore there are no minimal documentation expectations to denote.
Does Joint Commission have specifics around best practices for documentation expectations, like photos, sizing, flowsheet data, diagnoses, notes, etc.?	Joint Commission is not accepting this measure for 2026 and therefore cannot comment on best practices to meet the intent of this eCQM.

Question	Answer
Will we have access to this valuable information in the questions after the webinar, like in a FAQ?	For all questions submitted during the webinar broadcast, we'll compile and release a written Q&A document. You can find this document at the following links within several weeks: • Joint Commission's Webinars & Videos page: https://www.jointcommission.org/en-us/knowledge-library/support-center/measurement/quality-measurement-webinars-videos • eCQI Resource Center's Getting Started with eCQMs page: https://ecqi.healthit.gov/ecqms/education
If a patient was admitted with POA pressure injury stage then later on during the IP stay developed a new stage 2, will this be counted as numerator?	If a patient has a DTPI or stage 2, 3, 4, or unstageable pressure injury present on admission (identified either by POA indicators or an early skin exam), then the patient's hospitalization will meet the denominator exclusions 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.
What if there's conflicting documentation during the 24-72 admission (e.g., RN documented pressure injury, but MD coded it differently)?	This eCQM pulls from all patient data entered in a hospital's EHR system, including diagnosis codes, test, and assessment results, and POA indicators. The provider type that may document results for this measure's data elements depends on each hospital's workflow and scope of practice guidelines. 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
If a patient has a pressure injury POA and develops new pressure injuries on a different body area, would they be included?	If a patient has a DTPI or stage 2, 3, 4, or unstageable pressure injury present on admission (identified either by POA indicators or an early skin exam), then the patient's hospitalization will meet the denominator exclusions criteria and will not be included in the measure calculation. Once an inpatient hospitalization is 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.
Can we use wound properties documentation by nursing that identifies a newly created EHR wound record on the patient chart as present on admission as an exclusion as opposed to the diagnosis POA documentation?	To qualify for the denominator exclusions criteria, a stage 2, 3, 4; deep tissue; or unstageable pressure injury present on admission must be identified by early skin exam results or POA indicators.
How is the PI POA recognized? Does it have to be addressed by a physician only (such as placed on the patient's problem list), or can it be noted on the nursing admission exam (that is specifically reviewing skin and wound care)	This eCQM pulls from patient data entered in fields in a hospital's EHR system, including diagnosis codes, test and assessment results, and POA indicators. This measure does not specify the provider type that must document qualifying pressure injury diagnoses or findings. The provider type that may document results for this measure's data elements depends on each hospital’s workflow and scope of practice guidelines. If you have questions about the specific data source(s) used for each data element, we recommend that you reach out to the hospital’s EHR vendor for clarification.
When does the encounter start for patients who have elective surgery and are directly admitted to Pre-Op?	If a patient did not spend time in the ED and/or in observation status prior to their inpatient encounter, then the inpatient hospitalization period assessed by this measure begins at the time of inpatient admission.

Question	Answer
If there's a discrepancy on the POA status, what would determine whether it met the exclusion criteria? For example, the nurse charts not POA, but the coding summary states POA.	This eCQM pulls from patient data entered into a hospital's EHR system, including diagnosis codes, test and assessment results, and POA indicators. This measure does not specify the provider type that must document qualifying pressure injury diagnoses or findings. The provider type that may document results for this measure's data elements depends on each hospital's workflow and scope of practice guidelines. 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.
Can you specify what "clinically undetermined" means?	CMS defines "clinically undetermined" as: "Provider unable to clinically determine whether the condition was present at the time of inpatient admission." More information on CMS definitions of POA indicators is available at: https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac/coding
If the nursing flowsheet / skin assessment documents a stage 2 pressure injury after 24 hours but it is determined to be POA and the coding sheet has a POA Y indicator, which document trumps?	This eCQM assesses patient data from the patient's entire hospitalization period. If a POA indicator of "Y" or "W" is assigned for a DTPI or a stage 2, 3, 4, or unstageable pressure injury, the inpatient hospitalization for that patient will meet the denominator exclusions criteria, regardless of when the POA indicator status was updated by the hospital.

Question	Answer
On the OBS and ED Patients, if they're in these areas >1hr. when does our 24hr-72hr time frame start?	The inpatient hospitalization period assessed by this measure includes time in the ED and/or observation status 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 ED encounter and/or observation status. For example, if the patient's ED encounter begins at 10AM and ends at 12:15PM, and the patient is admitted to the inpatient encounter at 1PM, then the inpatient hospitalization period assessed by the measure would begin at 10AM (the ED encounter start time), as the transition between discharge from the ED encounter and the start of the inpatient encounter is less than one hour. In this case, the time anchor for the 24- and 72-hour thresholds for skin exams is the start of the ED encounter. If the patient's ED encounter begins at 10AM and ends at 11:45AM, and the patient is admitted to the inpatient encounter at 1PM, then the inpatient hospitalization period assessed by the measure would begin at 1PM (the inpatient encounter start time), as the transition between discharge from the ED encounter and the start of the inpatient encounter is more than one hour. In this case, the time anchor for the 24- and 72-hour thresholds for skin exams is the start of the inpatient encounter.
With that 24 to 72 hour, does this mean that a hospital acquired pressure injury per this measure will be after 72 hours from admit?	There are two timeframes for identifying pressure injuries by skin exam, depending on the type of pressure injury. The present-on-admission window for a skin exam for stage 2, 3, 4, and unstageable pressure injuries is 24 hours, whereas the window for DTPIs is 72 hours. A new DTPI found on exam more than 72 hours after the start of the hospitalization period or stage 2, 3, 4, or unstageable pressure injury found on exam more than 24 hours after the start of the hospitalization period would be considered hospital acquired.

Question	Answer
Further question with the comment about ED-inpatient counting. So, if patient is in ED for 10 hours and then admitted to inpatient. The inpatient assessment must occur within 14 hours to be excluded from the POA?	If a pressure injury is identified through a skin exam in the first 24 hours of the hospitalization period (in this scenario, 10 hours in the ED plus 14 hours of the inpatient encounter), then the inpatient hospitalization for this patient would meet the measure's denominator exclusions criteria. For time in the ED encounter to be included, the transition between discharge from the ED encounter and the start of the inpatient encounter must be one hour or less.
If a patient has 2 new, say, stage 3 PI's during the same encounter, is it counted as 2 or is it per patient in the numerator?	This measure only counts one new qualifying pressure injury per inpatient hospitalization. Even if a patient develops multiple new qualifying pressure injuries during a hospitalization, only one new pressure injury is needed to qualify the hospitalization for the numerator, and that inpatient hospitalization will be in the numerator population only once.
When is the data flowing from the EMR to the eCQM? Is it upon discharge or at a routine interval?	Please reference the 2026 CMS QRDA I Implementation Guide for Hospital Quality Reporting for more information data reporting requirements. This can be found on the eCQI resource center: https://ecqi.healthit.gov/qrda/versions.
Do we include observation as inpatient and add the patient to the numerator?	The patient must be admitted to inpatient care in order for the hospitalization to qualify for the initial population. This measure uses the Global."HospitalizationWithObservation" function to determine the interval of the entire inpatient hospitalization period, which includes time in the ED and/or observation status when the transition between discharge from these encounters and the start of the inpatient admission is one hour or less.

Question	Answer
If a patient is admitted with a blister area and during the hospitalization the blister bursts and develops a lesion that is stage 2 is this considered an injury?	The measure does not determine inclusion or exclusion based on whether a condition originated as a blister. Inclusion and exclusion are driven by whether the injury is documented and coded in the EHR based on the below definitions and associated codes. The measure uses SNOMED CT, LOINC, and ICD-10-CM codes from the following value sets to identify diagnoses or findings of DTPIs and stage 2, 3, 4, and unstageable pressure injuries: • "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) • "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) More information on the codes contained in these value sets can be found on the VSAC (https://vsac.nlm.nih.gov/).
If there is documentation of a patient refusing care i.e., turning and repositioning, barrier cream application, etc. then develop a pressure injury is there any exclusion for this situation?	Currently, the measure does not include denominator exception criteria for inpatient hospitalizations for patients who refuse pressure injury prevention care.
Are swing bed patients considered an inpatient for this measure, as they are skilled patients?	No, swing bed encounters should not be included in episode-based hospital - inpatient eCQM calculations. We encourage you to work with your EHR vendor to remove swing bed encounters from measure calculations.
If a patient comes in with a wound that is diagnosed as clinically unknown, is there a timeframe which the wound needs to be documented whether it is a pressure injury to be excluded?	If a provider is unable to clinically determine whether any pressure injuries were present at time of inpatient admission and selects a POA indicator of “W” (clinically undetermined) for a DTPI or a stage 2, 3, 4, or unstageable pressure injury diagnosis, then the inpatient hospitalization for this patient would meet the denominator exclusions criteria and would be excluded from the measure’s denominator.

Question	Answer
Is there a timeframe for a diagnosis code to be entered for a present on admission pressure injury or is it sufficient to have it entered by time of discharge?	This eCQM assesses patient data from the patient's entire hospitalization period. If a POA indicator of "Y" or "W" is assigned for a DTPI or a stage 2, 3, 4, or unstageable pressure injury diagnosis, the inpatient hospitalization for that patient will meet the denominator exclusions 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 diagnosis, and the DTPI is identified by skin exam after the first 72 hours of the hospitalization or the stage 2, 3, 4, or unstageable pressure injury is identified by skin exam after the first 24 hours of the hospitalization, then the inpatient hospitalization for that patient will meet the numerator criteria.
My understanding is that is standard practice that coding does not code Stage 2 pressure ulcers. Is this correct?	It is **not** correct that stage 2 pressure injuries are not coded. Stage 2 pressure injuries are codable when they are appropriately documented. The measure uses codes from the following value sets to identify findings or diagnoses of stage 2, 3, 4, and unstageable pressure injuries: • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) More information on the codes contained in these value sets for findings and diagnoses of stage 2 pressure injuries can be found on the VSAC (https://vsac.nlm.nih.gov/).

Question	Answer
In the new document on sentinel events by NQF and the Joint Commission, there is a discussion of patient populations that may be unavoidable-those on ECMO--how is that being addressed with eCQM	The administration of extracorporeal membrane oxygenation (ECMO) alone would not exclude an inpatient hospitalization for the patient from the measure's denominator. While the CMS and Joint Commission both seek to reduce patient harm related to pressure injuries, it is important to distinguish between eCQMs and patient safety events or SREs. Alignment between organizations does not mean that the measure specifications, staging thresholds, or exclusion criteria are identical. Though eCQMs may cite publicly available clinical guidelines or consensus documents to support the rationale for the outcomes evaluated, eCQMs are not intended to serve as clinical guidelines or establish a standard of medical care. Each eCQM defines its population, outcomes, and exclusions based on methodological considerations specific to quality measurement, which may differ from those used for accreditation or safety event reporting purposes.
If a patient is not either an Emergency or Observation encounter, but rather an outpatient surgical encounter but unexpectedly transfers to an inpatient status, would the patient encounter be included or excluded? And if the encounter is included in the denominator, when does the clock start for assessment? At the start of the outpatient surgery, or upon inpatient admission (this is assuming patient was in outpatient surgery greater than 1 hour)?	This measure's denominator includes all inpatient hospitalizations that end during the measurement period for patients aged 18 years and older, regardless of whether a patient spent time in the ED or in observation status before the inpatient encounter. If a patient did not spend time in the ED and/or in observation status prior to their inpatient encounter, then the inpatient hospitalization period assessed by this measure begins at the time of inpatient admission. The inpatient hospitalization period assessed by this measure does **not** include time in outpatient surgery service.
Any specification regarding device-related HAPI?	The measure assesses the number of inpatient hospitalizations for patients age 18 years and older who suffer the harm of developing a new DTPI or stage 2, stage 3, stage 4, or unstageable pressure injury. This includes those pressure injuries developed as a result of a medical device, as most medical device-related pressure injuries are preventable with appropriate care.

Question	Answer
What do you mean at the end of the measurement period?	This measure uses a calendar year measurement period (i.e., January 1, 2026, through December 31, 2026). Implementers report required and/or selected hospital eCQMs on an annual basis. The 2026 CMS QRDA I Implementation Guide for Hospital Quality Reporting provides more information on hospital eCQM reporting requirements for the 2026 reporting period. https://ecqi.healthit.gov/qrda/versions
If a skin exam occurs >24 hours from the start of inpatient encounter and a stage 2/3/4 is documented as POA on the skin exam, does this exclude the patient or does POA documentation not matter in these circumstances because the skin exam occurs after 24 hours from start of encounter?	This eCQM assesses patient data from the patient's entire hospitalization period. If a POA indicator of "Y" or "W" is assigned for a DTPI or a stage 2, 3, 4, or unstageable pressure injury diagnosis, the inpatient hospitalization for that patient will meet the denominator exclusions criteria, regardless of when the POA indicator status was updated by the hospital.
Will narratives of pressure injuries be captured or do pressure injuries need to be documented in certain section of chart?	Narratives of pressure injuries are not captured by the measure. The measure requires SNOMED CT, LOINC, or ICD-10-CM codes from the following value sets to identify diagnoses or findings of DTPIs and stage 2, 3, 4, and unstageable pressure injuries: • "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) • "Pressure Injury Deep Tissue Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.194) • "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) • "Pressure Injury Stage 2, 3, 4, or Unstageable Diagnoses" (OID: 2.16.840.1.113762.1.4.1147.196) More information on the codes contained in these value sets can be found on the VSAC (https://vsac.nlm.nih.gov/).

Question	Answer
How does the logic know the 72 hrs. and 24 hrs. timeframe of PI found?	The eCQM determines the 24- and 72-hour timeframes by calculating the difference between the hospitalization start time and the earliest documented timestamp of a pressure injury based on the skin assessment time. The skin assessment time is identified using the ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element with the *relevantdateTime* and *relevantPeriod* attributes. The eCQM uses interval logic to compare that timestamp against fixed thresholds (i.e., ≤24 hours vs. >24 hours after hospitalization start, ≤72 hours vs. >72 hours after hospitalization start) to classify whether the injury was present on admission or hospital acquired.
How does the measure handle 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.
How do we decide if a pressure injury is minor, moderate, or severe?	The measure does not capture mild, moderate, or severe documentation. It assesses the number of inpatient hospitalizations for patients age 18 and older who suffer the harm of developing a new pressure injury based on documentation of stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. The National Pressure Injury Advisory Panel staging system (https://npiap.com/page/Resources) 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

Question	Answer
Are stage 1 pressure injuries not included in numerator?	A patient's development of a new stage 1 pressure injury would not qualify the hospitalization for the numerator. This measure assesses the number of inpatient hospitalizations for patients age 18 years and older who suffer the harm of developing a new pressure injury (stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury).
What happens if a physician judges that a pressure injury was present on admission, but the pressure injury was not visible?	In order for an inpatient hospitalization to meet the measure's denominator exclusions criteria, a patient's pressure injury must be documented as present on admission in the EHR. The documentation could include POA indicators of "Y" (diagnosis was present at time of inpatient admission) or "W" (clinically undetermined) or early physical exam findings where the result of the ["Physical Exam, Performed": "Physical findings of Skin"] QDM data element is in the "Pressure Injury Deep Tissue" (OID: 2.16.840.1.113762.1.4.1147.112) or "Pressure Injury Stage 2, 3, 4 or Unstageable" (OID: 2.16.840.1.113762.1.4.1147.113) value sets.