Hospital Inpatient Quality Reporting (IQR) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) Version 5.15a Review & Updates Question and Answer Summary Document

Speakers

Noel Albritton, MSN, RN, Lead Solutions Specialist
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor

Jennifer Witt, RN, Senior Quality Improvement Facilitator
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor

Moderator

Donna Bullock, MPH, BSN, RN
Program Lead, Hospital Inpatient Quality Reporting Program
Inpatient, Value, Incentives, and Quality Reporting
Outreach and Education Support Contractor

March 12, 2024
2:00 p.m. Eastern Time (ET)

DISCLAIMER: This presentation question-and-answer summary document was current at the time of publication and/or upload onto the Quality Reporting Center and QualityNet websites. Any links to Medicare online source documents are for reference use only. In the case that Medicare policy, requirements, or guidance related to these questions and answers change following the date of posting, these questions and answers will not necessarily reflect those changes; this information will remain as an archived copy with no updates performed.

The written responses to the questions asked during the presentation were prepared as a service to the public and are not intended to grant rights or impose obligations. Any references or links to statutes, regulations, and/or other policy materials included are provided as summary information. No material contained therein is intended to take the place of either written laws or regulations. In the event of any conflict between the information provided by the question-and-answer session and any information included in any Medicare rules and/or regulations, the rules and regulations shall govern. The specific statutes, regulations, and other interpretive materials should be reviewed independently for a full and accurate statement of their contents.

This document answers the questions that providers submitted during the event and after the event to WebinarQuestions@hsag.com. Subject-matter experts developed the responses.

Severe Sepsis Present

Question 1: **Does the inclusion of a negative COVID-19 test, populated within the physician notes without narrative remark, count as documentation that COVID-19 is not present?**

Yes, the inclusion of a negative COVID-19 test result populated within the physician, advanced practice nurse (APN), or physician assistant (PA) documentation would be acceptable as physician/APN/PA documentation indicating that COVID-19 was not present or suspected.

Question 2: **How do we abstract if the physician does not document that the COVID-19 test was negative, but we can see a negative test result within six hours?**

If there is only a negative COVID-19 laboratory test result and it is not documented or noted by the physician/APN/PA, then you would disregard the negative result from the lab.

Assuming there was physician/APN/PA documentation that COVID-19 was present or suspected, you would select Value "2" (No) for the *Severe Sepsis Present* data element due to there not being physician/APN/PA documentation indicating COVID-19 was not present.

Question 3: **If COVID-19 is on active problem list but there is no date documented, can we still select Value "2" (No) to *Severe Sepsis Present* if no other criteria apply?**

Yes, you would select Value "2" (No) for the *Severe Sepsis Present* data element if COVID-19 is documented by the physician/APN/PA on the active problem list and there is not a date documented. The abstraction guidance does not require physician/APN/PA documentation that COVID-19 was present or suspected to be within a specified timeframe.

Question 4: **How would it be abstracted if the patient had a positive COVID-19 test and antibiotics were ordered for suspected pneumonia?**

It would depend upon how the positive COVID-19 test was documented. If the physician/APN/PA documented the COVID-19 test was positive, then you would select Value "2" (No) for the *Severe Sepsis Present* data element. That would apply regardless of if there was further documentation of an infection.

However, if there was only a lab report that showed that the COVID-19 test was positive, you would disregard the lab report because the abstraction guidance requires physician/APN/PA documentation that COVID-19 is present or suspected to select Value "2" (No).

Question 5: **Can the problem list be used to determine if sepsis, severe sepsis, or septic shock is present based on physician documentation?**

Yes, problem lists can be used for determining criteria A (infection) for the *Severe Sepsis Present* data element. There is specific abstraction guidance in the Notes for Abstraction, under criteria A, that requires an infection documented on an active problem list to have further documentation indicating that the infection was active or present.

For the *Severe Sepsis Present* or *Septic Shock Present* data element, physician/APN/PA documentation of severe sepsis or septic shock on an active problems list does not require further physician/APN/PA documentation to indicate that it is present or active at that time.

To determine the presentation timing for *Severe Sepsis Presentation Time* or *Septic Shock Presentation Time*, you would use the specified time that is associated with the problem list. If a specified time is not available, then you would use the note open time or one of the lower priority timestamps that are also included in the abstraction guidance for the presentation time data elements.

Question 6: **If severe sepsis was not met, and the physician documented severe sepsis resolved, should we select Value "1" (Yes) for the *Severe Sepsis Present* data element?**

No, you would select Value "2" (No) for the *Severe Sepsis Present* data element because severe sepsis was not met, either by clinical criteria or physician/APN/PA documentation.

Severe Sepsis Presentation Date and Time

Question 7: **If the patient is diagnosed with sepsis on March 12, 2024, but past medical history indicates the patient had COVID-19 on March 4, 2024, would that make a difference?**

If the documentation of COVID-19 only refers to past medical history of COVID-19 or a previous diagnosis, you would disregard that documentation regardless of when it is documented in relation to the *Severe Sepsis Presentation Time*.

The abstraction guidance states, "Do not use physician/APN/PA documentation that refers to a previous diagnosis of COVID-19 or coronavirus (e.g., recent COVID-19 or history of COVID-19)."

Question 8: **If there is a suspected COVID-19 diagnosis that is disregarded within six hours of documentation, would you go back to the initial presentation to determine *Severe Sepsis Presentation Time* or after the negative COVID-19 documentation?**

You would go back and abstract the earliest *Severe Sepsis Presentation Time* if there was physician/APN/PA documentation that indicated COVID-19 was not present within six hours following documentation that it was present or suspected.

Question 9: **If the provider only documents severe sepsis was met at presentation, would you still take the date and time of emergency department (ED) arrival?**

No, you would not abstract the time of the ED arrival based on the physician/APN/PA documentation "severe sepsis met at presentation" because the documentation does not specify severe sepsis was present on arrival. In this case, you would use the specified time for the physician documentation that includes severe sepsis was met. If the specified time for that documentation is not available, you would use the note open time or one of the lower priority timestamps included in the abstraction guidelines.

Directive for Comfort Care or Palliative Care

Question 10: **Is there any timeframe for considering documentation in the medical record of comfort care prior to *Severe Sepsis Presentation Time*?**

No, there is no time limit prior to the *Severe Sepsis Presentation Time* for the physician/APN/PA documentation meeting the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element.

Question 11: **If the palliative care consult is entered at 12:00, time 0 is 13:00, but the note from Palliative Care at 15:00 states, "Patient would like full interventions. Pain management suggestions given." Would this still be a Yes for palliative exclusion?**

Yes, you would select Value "1" (Yes) for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element based on the palliative care consult that is documented within the specified timeframe. You would disregard the documentation that patient would like to continue full interventions and select Value "1" (Yes).

Question 12: **If the physician documents that hospice is recommended but no order is placed, how would this be abstracted?**

You would select Value "1" (Yes) for the *Directive for Comfort Care or Palliative Care* data element, based on the physician/APN/PA documentation recommending palliative care, comfort care, or hospice within the specified timeframe.

Question 13: **Would documentation of "plan to order palliative care consult" exclude the case if the actual order is written outside of the timeframe?**

Yes, you would select Value "1" (Yes) for the *Directive for Comfort Care or Palliative Care* data element based on the physician/APN/PA documentation that they are planning to order a palliative care consult, as long as the documentation is within the specified timeframe.

Question 14: **If there is an order for "Consult Palliative Care" and the reason listed in the consult is "discuss goals of care," would that exclude the patient?**

Yes, the physician/APN/PA order for the palliative care consult would meet the abstraction guidance for selecting Value "1" (Yes) if it was documented within the specified timeframe. The reason for the consult would not be relevant for abstraction purposes, and you can disregard it.

Discharge Time

Question 15: **Would the time that the patient signed the discharge instructions count as the *Discharge Time* if the patient did not receive care after that time?**

No, the time that the patient signed the discharge instructions would not be used to determine the *Discharge Time* data element. If there is other documentation within the medical record indicating that the patient left at that time or was discharged at that time, you would use that documentation to determine the *Discharge Time*.

Question 16: **If the patient left against medical advice (AMA) and the documentation does not include the time the patient left, but it states that the patient was no longer found to be within the hospital, what *Discharge Time* should be used? Would you use the time of the documentation or note? If the specified time the patient left is not included, should we abstract Unable to be Determined (UTD)?**

For patients who leave AMA, the specified time for the documentation stating the "patient was no longer found to be within the hospital" is acceptable for establishing the discharge time. You would only use the specific time associated with this documentation; you would not use the note opened or started time to determine the discharge time.

If there is no documentation or you are unable to determine when the patient left AMA or was discharged, then you would select UTD for the *Discharge Time* data element.

Question 17: **Would you be able to abstract the patient's time of death as the *Discharge Time*?**

Yes**,** the documented time of death, expired time, or pronounced time would all be acceptable for determining the *Discharge Time*. The abstraction guidance refers to the expired time or pronounced time; however, other synonymous terminology would be acceptable if it reflects the time of death or expired time.

Crystalloid Fluid Administration

Question 18: **Does the colloid need to be infused at a rate greater than 125 milliliters (mL) per hour to count towards total volume? Is Albumin an acceptable colloid? Is there a list of acceptable fluids that are considered colloids?**

All fluids, whether crystalloid or colloid, must be infused at greater than 125 mL/hour to be used toward the target ordered volume.

Albumin would be considered an acceptable colloid. The Inclusion Guidelines for Abstraction in the *Crystalloid Fluid Administration* data element lists some of the fluids that are acceptable. However, this list is not all inclusive. It is acceptable to reference other resources, such a physician, pharmacist, or medical literature to confirm if the fluid is considered a crystalloid, balanced crystalloid, or colloid.

Question 19: **Is there a situation where 0 mL would be acceptable as a volume, due to an acceptable reason for a lesser volume?**

No, the abstraction guidance for using a lesser volume as the target ordered volume requires that a volume less than 30 mL/kg be ordered. There are scenarios where Value "4" (No) can be selected for the *Crystalloid Fluid Administration* data element based on no fluids ordered. However, physician/APN/PA or nursing documentation must indicate that invasive or noninvasive measurements of cardiac output, cardiac index, stoke volume, or stroke volume index were used to determine the patient was not volume or fluid responsive. Selecting Value "4" (No) would allow the case to remain in the measure.

Question 20: **If there is only one physician order that includes a note about the patient being in fluid overload or congestive heart failure (CHF), is that acceptable, or does there have to be at least two orders as indicated in the example on slide 33?**

If there is only one order that includes a reason for the lesser volume, then you would use that order and that ordered volume as the target volume. For example, if there was an order at 15:00 to give 500 mL and that order included a reason for giving the lesser volume (e.g., CHF or fluid overload) and there is another order at 19:00 to give 500 mL that does not include a reason to give the lesser value, you would use the order at 15:00 to give 500 mL because the physician documented the lesser volume with a reason.

In slide 33, we are determining the target volume to use rather than determining which allowable value should be selected for the *Crystalloid Fluid Administration* data element. In that scenario, where there are two orders for lesser volumes that both include a reason, based on the updated abstraction guidance, you would combine those two orders for 500 mL because they both have a documented reason. Once you determine what the target volume is, you will determine if the target volume was ordered and started within the specified timeframe for the data element. Then, you would determine which allowable value should be selected based on the orders and whether the target volume was started and completed.

Septic Shock Present

Question 21: **If the provider does not document that the patient met septic shock criteria, but the patient meets criteria (e.g., the lactic acid is 5.0, systemic inflammatory response syndrome criteria are met, and there is a source of infection), can you use the lactic acid value to determine septic shock?**

The *Severe Sepsis Present* data element and the *Septic Shock Present* data element can be met by physician/APN/PA documentation or by clinical criteria. For example, the *Septic Shock Present* data element can be met by physician/APN/PA documentation of septic shock, or it can be met by meeting the clinical criteria (severe sepsis with an *Initial Lactate Level Result* greater than or equal to 4 or severe sepsis with persistent hypotension).

If the *Initial Lactate Level Result* was 5.0 and the patient met **systemic inflammatory response syndrome** criteria and had a source of infection, that would meet all three clinical criteria for establishing *Severe Sepsis Present*. Then, severe sepsis with the *Initial Lactate Level Result* of 5.0 would meet the criteria for septic shock. In this scenario, you would not need physician/APN/PA documentation of septic shock to select Value "1" (Yes) for the *Septic Shock Present* data element. You would select Value "1" (Yes) based on meeting the clinical criteria of severe sepsis with an *Initial Lactate Level Result* greater than or equal to 4.

Question 22: **Would either of these scenarios meet the infection guidelines or would they be excluded?**

1. Provider documents patient has Influenza A and pneumonia. No further documentation about whether it is viral or bacterial.

2. Provider documents patient has Influenza A with bacterial pneumonia infection.

For the provider documentation of "Influenza A and pneumonia," you would disregard the viral infection documentation and use the documentation of pneumonia to meet criteria A (infection). However, it is also dependent on how this is documented in the medical record.

If the documentation reflected Influenza A with pneumonia or similar, you would disregard the documentation because it would reflect that pneumonia was due to the viral infection. For the provider documentation of "Influenza A with bacterial pneumonia infection," you would disregard the viral infection and use the documentation of "bacterial pneumonia infection" to meet criteria A because it clearly states the pneumonia is a bacterial infection.