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) V5.14 Review and Updates Presentation Transcript

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Donna Bullock: Welcome to today's presentation, *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) V5.14 Review and Updates*.

Our speakers today are Noel Albritton, Lead Solutions Specialist with the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor, and Jennifer Witt, Senior Health Informatics Solutions, also with the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor. Before we begin, I would like to make a few announcements. This program is being recorded. The recording and a transcript of the presentation, along with a question-and-answer summary, will be posted to the Quality Reporting Center website in the upcoming weeks. That website is www.QualityReportingCenter.com. If you registered for this event, a link to the slides was sent out to you a few hours ago. If you did not receive that email, you can download the slides at any time from the Quality Reporting Center website. This webinar has been approved for 1.5 hours of continuing education credit. More information about this will be provided at the end of today's event.

The purpose of this event is to clarify changes and outline the rationale behind the updates to the SEP-1 measure and guidance in version 5.14 of the specifications manual and to respond to frequently asked questions.

At the end of today's presentation, participants will be able to understand and interpret the updated guidance in version 5.14 of the specifications manual to ensure successful reporting for the SEP-1 measure.

This is a list of some acronyms and abbreviations that will be used in today's presentation.

If we do not answer your question during the webinar, please submit your question to the QualityNet Inpatient Question and Answer Tool. You can access this tool using the link on this slide. If your question is about a specific slide, please include the slide number. If you have a question unrelated to this webinar topic, we recommend that you first search for it in the QualityNet Inpatient Question and Answer Tool.

If you do not find the answer, then submit your question via the same tool. I will now turn the presentation over to Noel and Jennifer.

Noel Albritton: Thanks, Donna. Hello, everyone, and thank you for joining us.

Today, we will review the guidance for the SEP-1 measure and specifications manual, version 5.14. We will review guidance that was updated in the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element and the *Crystalloid Fluid Administration* data element, as well as review some frequently asked questions. Updated guidance to manual version 5.14 is noted in yellow highlight in this presentation and in the specifications manual. Our discussion and slides today will be in order of the SEP-1 algorithm. You can find the SEP-1 algorithm and the hospital inpatient specifications manual on the QualityNet website at QualityNet.CMS.gov.

Let's begin with the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. This data element received a slight update to the first sub bullet point on this slide that indicates you would select Value 2 No for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element if Value 1 Male was selected for the *Sex* data element. This guidance was changed based on updates to the *Sex* data element. You may recall in previous manual versions where the allowable value M would be selected for the *Sex* data element if the patient was male. Based on recent updates to that data element, you would now select Value 1 if the patient was male. Therefore, if you select Value 1 Male for the *Sex* data element, you would select Value 2 No for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. Next, let's review some of the guidance in the *Severe Sepsis Present* data element.

The *Severe Sepsis Present* data element did not receive any updates in manual version 5.14. However, we will take a look at several bullet points that are frequently asked about, beginning with the guidance on this slide, regarding which date and time you would use for documentation of an infection. This guidance states: If documentation of an infection within a physician/APN/PA, nursing, or pharmacist note does not have a specific

date and time, or is documented using the acronym POA, use the date and time the note was started or opened. If a time stamp reflecting the note opened or started time is unavailable, use the following sources in priority order: 1) provider patient care-initiated time 2) scribe time 3) the earliest time at the beginning of the note, reflecting when the note was opened or started. I want to point out that you should first look for and use specific documentation indicating that an infection was present or suspected. This can be any time stamp that specifically reflects when the documentation occurred. If that is not available, you would use the guidance on this slide in the order listed. Based on questions we frequently received, let's review further guidance and examples related to documentation of an infection with a specified time.

The guidance on this slide addresses documentation of an infection, with a superscripted or footnoted time stamp, which reflects a specified time for that documentation. I would like to call out that superscripted and footnoted time stamps are specific to the EHR. Different EHRs use different functionality. If your EHR does not use superscripted or footnoted time stamps, the guidance on this slide would not apply. Other EHRs may use some variation of superscripted or footnoted time stamps, but, in general, they include a notation associated with the documentation, and that notation is associated with a time stamp, generally located elsewhere in the note or medical record. While some EHRs use superscripted or footnoted time stamps, others use hover times or similar time stamps. However, these are all specified times for the documentation. We often receive questions asking if a hover time or similar can be used as a superscripted time stamp. The hover time or superscripted time stamp are both specified times for the documentation. So, you would not need to use a time stamp, such as a hover time, as the superscripted time. You would use the hover time or superscripted time stamps as the specified time of the documentation. We will take a look at an example on the next slide, but I would also like to mention, as you're abstracting, keep in mind that the information you're abstracting should be available to an outside reviewer in the event your case was reviewed for validation.

The same information would need to be available for them. Now, let's take a look at an example.

This question asks: Which date and time would you use for the infection documentation to meet *Severe Sepsis Present* criteria a for an infection based on the below documentation? The APN note on 7/13, 2023, at 1400 states: Suspect pneumonia, awaiting chest X-ray and labs, with the superscript KM.2. We can see the time stamps associated with the superscripts and, for KM.2, the date is July 13, 2023, at 1645. So, use 7/13, 2023, at 1645 for the infection documentation date and time because the APN's documentation of pneumonia includes the superscript KM.2. Let's look at another scenario.

This question asked: Which date and time would you use for the infection documentation to meet *Severe Sepsis Present* criteria a for an infection based on the below documentation: In the EHR, the MD note opened on 7/10, 2023, at 1145 states: Possible sepsis, ordered cultures and antibiotics, Tylenol for fever, with the hover time stamp of 7/10, 2023, at 1300. However, in the exported, or PDF, version of the medical record, the hover time stamp is not available for the documentation: Possible sepsis, ordered cultures and antibiotics, Tylenol for fever. So, use 7/10, 2023, at 1145 for the infection documentation date and time because the MD's documentation of sepsis in the exported medical record does not include the hover date and time of 7/10, 2023, at 1300. Again, if your EHR does not use hover time stamps, this particular example will not apply to your abstractions. However, if your EHR uses hover time stamps, the date and time included in the hover time stamp may be used as a specified time of the documentation if the time stamp is included in the exported, or PDF, medical record. If the hover time stamp is not included, such as in the example on this slide, you would disregard the hover time and use the note open time.

We also frequently receive questions regarding whether documentation of an inflammatory condition can be used to meet criteria a of infection.

This guidance was not updated in manual version 5.14. However, we will review the guidance and an example. This guidance states: An IV or IO antibiotic ordered for a condition that may be inflammation or a sign or symptom of an infection can be considered documentation of an infection. I would like to call out that this guidance specifically refers to an IV or IO antibiotic ordered for the inflammatory condition or sign or symptom of an infection. The order of an IV or IO antibiotic for inflammatory conditions or signs or symptoms of an infection is used to support an inflammatory condition as infectious or the presence of an infection. The example demonstrates this point by concluding ceftriaxone ordered for colitis, Zosyn 3.375 grams IV, every six hours for cough. We've also received questions regarding the location of this documentation within the medical record. The abstraction guidance does not require this documentation to be in a specific location within the medical record. So, acceptable documentation may be in the antibiotic order as an indication for the antibiotic or may be in narrative documentation. However, you would not use documentation of an inflammatory condition or a sign or symptom of an infection that does not specifically reference an IV or IO antibiotic being ordered for the inflammatory condition or sign or symptom of infection. Next, let us take a look at some examples.

This question asks: Would you use this documentation to meet *Severe Sepsis Present* criteria a for an infection based on the information below. The MD note states: Patient has been taking Augmentin at home for bronchitis. No, because the documentation does not say an IV or IO antibiotic was ordered for the inflammatory condition, bronchitis. If you recall from the guidance on the previous slide, to use documentation of an inflammatory condition to meet criteria a for an infection, the documentation must reflect an IV or IO antibiotic was ordered for the inflammatory condition. The physician documentation of "patient has been taking Augmentin at home for bronchitis" in this example reflects the patient has been taking an oral antibiotic at home for the inflammatory condition. So, you would not use this documentation to meet the infection criteria for establishing severe sepsis. Let's take a look at a Knowledge Check scenario that you can participate in.

Would you use the PA documentation "fever is concerning, ordering IV Vanco now" to establish criteria a of an infection for the *Severe Sepsis Present* data element? A (Yes) or B (No). We'll give you a few more seconds to select your answer.

Select A Yes, because the documentation states that the IV antibiotic was ordered for the fever, which could be a sign or symptom of an infection. If the documentation did not refer to the IV antibiotic being ordered for the sign or symptom of an infection, you would not use the documentation to meet criteria a for the *Severe Sepsis Present* data element because the guidance requires an IV or IO antibiotic to be documented as ordered for the sign or symptom of an infection to meet criteria a.

Next, for the review of the abstraction guidance in the *Severe Sepsis Present* data element, let's take a look at the guidance related to disregarding SIRS criteria and evidence of organ dysfunction. We frequently receive questions that include various documentation and scenarios that are asking if SIRS criteria or a sign of organ dysfunction can be disregarded. Let's review the guidance on this slide, then we'll review a few scenarios.

The abstraction guidance on this slide was not updated in manual version 5.14. It continues to allow SIRS criteria or a sign of organ dysfunction to not be used if the abnormal value of the SIRS criteria or sign of organ dysfunction is documented as normal for the patient due to a chronic condition or due to a medication. I would like to point out that the abstraction guidance states to not make inferences and the abnormal value must be in the same documentation that is considering the abnormal value to be normal for the patient due to a chronic condition or due to a medication. Other questions include scenarios where an inference must be made to assume the SIRS criteria or sign of organ dysfunction meets the guidance. However, during abstraction, we're reviewing for physician/APN/PA documentation that includes the abnormal value and documentation that is normal for the patient due to a chronic condition or due to a medication. Let's take a look at the examples that are already included in the guidance, then we will review other examples.

We often receive questions that include scenarios similar to the examples include in the abstraction guidance. Since these examples are readily available in the specifications manual during your abstractions, let's review these first. This slide includes the first two examples included in the notes for abstraction for the *Severe Sepsis Present* data element. The first example states: chronic a-fib with rapid ventricular response. You would not use the heart rate readings greater than 90 because this documentation attributes the abnormal value to the chronic condition in the same documentation. The second example states in the ED note: History of A-fib, chronic anticoagulation. The admitting H&P states: A-fib with tachycardia. You would also not use the heart rate readings greater than 90 based on documentation because is a-fib is a chronic condition for the patient, and the abnormal heart rate is attributed to the chronic condition.

We often receive questions regarding this example. In this scenario, a-fib is documented as a chronic condition, based on the physician documentation history of a-fib. Then, the physician documents that the abnormal heart rate, or tachycardia, is due to the condition of a-fib, which was already identified as chronic for the patient. Therefore, the documentation stating a-fib with tachycardia is attributing the abnormal heart rate to the chronic condition within the same documentation.

These three examples are also included in the abstraction guidance. The first example includes the documentation: Post-partum 48 hours, bilirubin remains elevated at 2.5, related to chronic liver disease. It states not to use the abnormal bilirubin value, based on the documentation, including the abnormal bilirubin and the chronic condition in the same documentation. The second example includes documentation in the H&P under the renal assessment of history of CKD and a creatinine value of 3.0 HD daily. You would disregard the abnormal creatine value based on this documentation because the creatine value of 3.0 and the chronic condition are in the same documentation. The last example included in this abstraction guidance states: Hypertensive after pain meds.

It has the instruction to not use the hypertensive readings based on this documentation, attributing the hypotension to the medication. Now, let's take a look at a couple other scenarios.

This question asks: Would you use a heart rate of 112 documented in the vital signs flow sheet as a SIRS criterion based only on the documentation below? The physician's note states: Complaint of chest pain with history of a-fib. Yes, you would use the abnormal heart rate to meet SIRS criteria because the abnormal heart rate is not documented as due to the chronic condition. The documentation of a chronic condition alone, such as a history of a-fib, does not meet the guidance to disregard a SIRS criterion or sign of organ dysfunction. Further guidance, the SIRS criterion or a sign of organ dysfunction must be documented as due to the chronic condition to disregard the abnormal value. Let's take a look at another example.

This question asks: Would you use the platelet value as a sign of organ dysfunction based only on the information below? The MD notes: She has excessive bruising on both lower extremities, denies any recent falls, history of ITP, but significant thrombocytopenia. No, you would not use the abnormal platelet value because the physician's documentation includes the chronic condition and thrombocytopenia in the same documentation.

There's also one more bullet point that applies to disregarding SIRS criteria or evidence of organ dysfunction that is frequently asked. This guidance states: If SIRS criteria are a sign of organ dysfunction is due to an acute condition that has a non-infectious source or process, do not use it. We frequently receive questions asking if documentation such as hypotension not due to an infection is acceptable for disregarding abnormal blood pressure readings. However, based on the guidance on this slide, the SIRS criterion or a sign of organ dysfunction must be documented as due to an acute condition with a non-infectious source to not use the abnormal value. So, you would not disregard an abnormal value based on documentation stating it was not due to an infection. Let's take a look at a couple of scenarios related to this guidance.

This question asks: Would you use the lactate value as a sign of organ dysfunction based only on the documentation below? The MD notes states: He experienced six-minute seizure at home prior to arrival to the ED. He has a history of epilepsy, which has been difficult to control with medications. Point of care, lactate on arrival, following seizure, was 8.5. No, you would not use the abnormal lactate value because the physician documentation includes the lactate value of 8.5, and the acute condition, the seizure, with a non-infectious source, history of epilepsy. Next, you can participate in the following Knowledge Check question.

Would you use the elevated heart rate value as a SIRS criterion, based only on the documentation below. On 7/4, 2023, at 1500, the vital sign flow sheet has a MAP of 61.On 7/4, 2023, at 1700, the APN note states: Right knee arthroplasty this AM now with post-op hypotension. A (Yes) or B (No). I'll give you a few more seconds to select your answer.

Select B (No) because the term "hypotension" is documented as an acute condition post-op with a non-infectious source of right knee arthroplasty. In this scenario you would not use the hypotensive readings because the documentation states the hypotension is due to the patient being post-op from her right knee arthroplasty.

Next for the *Severe Sepsis Present* data element abstraction guidance, we will review the guidance on this slide, which was also not updated in version 5.14. However, we continue to receive questions pertaining to this guidance. This guidance states: Physician/APN/PA documentation of a term that is defined by SIRS criteria or sign of organ dysfunction is acceptable in place of an abnormal value when the term, as documented, as normal for the patient, to a chronic condition, a medication, acute condition, acute on chronic condition, or due to an acute condition that has a non-infectious source or process. This guidance includes examples, which we will look at on the next slide, but it's important to also recognize the examples are specific to *Pregnant 20 Weeks Through Day 3 Post-delivery* patients and non-pregnant patients.

The examples listed on this slide are not all inclusive. Rather, these examples demonstrate terms that are defined by an abnormal value. For example, hypotension defines a specific blood pressure value that is less than normal. It's important to note here that this guidance, in examples, do not include terms like elevated, low, or similar. We often receive questions asking if an abnormal value can be disregarded if the documentation states that the value is elevated or low. However, you would not disregard a SIRS criterion or sign of organ dysfunction if the documentation does not include the abnormal value or term defined by the abnormal value, such as the terms included on this slide. Let's take a look at a scenario to further clarify.

This question asks: Would you use the heart rate of 118 for SIRS criteria based only on the documentation below? MD note states: Patient states her elevated heart rate is due to chronic anxiety. On the vital signs flow sheet, we can see the heart rate is 118. Yes, because MD documentation does not include the abnormal value or term that is defined by an abnormal value, such as tachycardia, as due to the chronic condition. To not use the heart rate of 118, the physician documentation must include the abnormal value, such as 118, or a term as defined by the abnormal value, such as tachycardia, with the documentation of the chronic condition. Next, let's review some of the guidance related to abstracting *Severe Sepsis Presentation Date* and *Time.*

We often receive questions asking about which date and time should be used when severe sepsis is documented multiple times in a note? So, let's review this guidance. The bullet point on this slide states: If severe sepsis or septic shock is documented multiple times within the same note, use the earliest specified time. For cases where severe sepsis is documented multiple times within a note, both with and without a specified time, you would use the earliest specified time severe sepsis was documented in the note. Let's take a look at an example of this scenario.

This question asks: Which date and time would you use as a *Severe Sepsis Presentation, Date* and *Time*, based only on the documentation below?

MD note opened 8/15, 2023, at 1600. On the problem list, we can say severe sepsis is documented without a specified time. Then, in the HPI section of the note, severe sepsis is documented with a specific date and time of 8/15, 2023, at 2100. So, use 8/15, 2023, at 2100 as the *Severe Sepsis Presentation Date*, and *Time* because this is the earliest specified time that severe sepsis with documented within the note. In this documentation, severe sepsis is documented multiple times, both with and without a specified time. Based on the abstraction guidance on the previous slide, you would use the earliest specified date and time severe sepsis was documented within the note to determine *Severe Sepsis Presentation Date*, and *Time*. Next, I will turn it over to Jennifer to review new guidance for the *Crystalloid Fluid Administration* data element.

Jennifer Witt: Thank you, Noel. The *Crystalloid Fluid Administration* data element was updated in manual version 5.14 to address documentation "no fluids were ordered" because the patient was not volume or fluid responsive. The updated guidance allows for Value 4 No to be selected for the *Crystalloid Fluid Administration* data element where there is physician/APN/PA documentation meeting the updated guidance that we will discuss on the next slide.

The updated guidance for selecting Value 4 states: Physician/APN/PA or nursing documentation indicates no crystalloid fluids were ordered because the patient was not volume or not fluid responsive. Documentation must indicate that invasive or non-invasive measurements of cardiac output, cardiac index, stroke volume, or stroke volume index was used to determine, the patient wasn't volume or fluid responsive. I would like to point out a few documentation requirements for this guidance based on a few questions we have received. This guidance requires physician/APN/PA documentation indicating no crystalloid fluids were ordered based on the patient not being volume or fluid responsive. The guidance also requires physician/APN/PA or nursing documentation that the cardiac output, cardiac index, stroke volume, or stroke volume index, was used to determine the patient was not volume or fluid responsive. Let's review examples, including this new guidance.

This question asks: Which allowable value would you select based only on the documentation below? The MD progress note states: Stroke volume significantly decreased this visit, suspect due to worsening CHF. BP will not respond to IV fluids. So, no fluids ordered at this time. You would select Value 4 No because there is physician documentation indicating no crystalloid fluids were ordered because the patient was not fluid responsive based on the stroke volume. Let's take a look at another example.

This question asks: Which allowable value would you select based only on the documentation below? The nurse's note states: The patient went to cath lab this AM due to chest pain and shortness of breath. Per Dr. Smith, not giving IV fluids because cardiac output was too low for patient to respond to IV fluids. You would select Value 4 No because there is nursing documentation indicating no crystalloid fluids were ordered because the patient was not fluid, responsive based on the cardiac output. We have also received a few questions asking if the actual value of the cardiac output, stroke volume, cardiac index, or stroke volume index must be included in the documentation. To clarify, the actual value of these measurements is not required to be included in the documentation to select Value 4 No. As reflected in these two examples, acceptable documentation is only required to indicate crystalloid fluids were not ordered because the patient was not fluid or volume responsive based on those measurements.

We frequently receive questions pertaining to various scenarios related to the guidance for using a lesser volume as a target ordered volume. Let's review the documentation requirements included in this guidance for using a lesser fluid volume. Then, we will take a look at a few examples. The first portion of the guidance for using a lesser volume is included on this slide and states: A physician/APN/PA order for less than 30 milliliters per kilogram of crystalloid fluids is acceptable for the target ordered volume, if all of the following criteria were met; There's a physician/APN/PA order for the lesser volume of crystalloid fluids, as either specific volume, such as 1500 milliliters, or a weight-based volume such as 25 milliliters per kilogram. So, this portion of the abstraction guidance requires a physician/APN/PA order for the lesser volume of fluids.

Let's review the other documentation requirements on the next slide.

This part of the abstract guidance for using the lesser volume of target ordered volumes states: The ordering physician/APN/PA documented within a single source, such as a note or order, in the medical record, all of the following: volume of fluids to be administered as either a specific volume or a weight-based volume and a reason for ordering a volume less than 30 milliliters per kilogram of crystalloid fluids. The abstraction guidance also includes a list of reasons on this slide, but it does not limit the reasons for a lesser volume to only these reasons. So, along with the guidance from the previous slide that requires an order for the fluids, this guidance requires the ordering physician/APN/PA to also document within a single source specific volumes be administered and the reason for the lesser volume. If there is not an order for fluids, or physician/APN/PA documentation within a single source of the lesser volume and reason, you would not use a lesser volume as a target ordered volume during abstraction. Let's take a look at some examples.

This question asks: Which volume you use as a target ordered volume? The patient weighs 85 kilograms and 30 milliliters per kilogram is 2550 milliliters. IV fluid orders at 1530 was normal saline 0.9% IV, volume 500 milliliters over one hour. The order comments: CHF. On the MAR, 500 milliliters was started at 1545, with the stop time at 1645. You would use 500 milliliters as a crystalloid fluid target ordered volume because the fluid order includes a volume less than 30 milliliters per kilogram, 500 milliliters, and a reason for the lesser volume, CHF. Let's take a look at another example.

This question asks: Which volume would you use as a target ordered volume? The patient weighs 75 kilograms. Thirty milliliters per kilogram is 2250 milliliters. IV fluid orders include, at 0930, normal saline, 0.9%, IV, 500 milliliters at 999 milliliters an hour; at 1015, normal saline, 0.9%, 500 milliliters at 999 milliliters an hour. The MD note says: Minimize volume due to overload. Gave 500 milliliters, remained hypotensive, gave second 500 milliliters for a total of 1000 milliliters.

On the MAR: 500 milliliters with a start time of 0935 and a stop time at 1005, 500 milliliters start time at 10,20, stop time at 1050. So, you would use 1000 milliliters as a target ordered volume of crystalloid fluids because the MD note includes the lesser volume, 1000 milliliters, and the reason was overload. Let's review one more example.

This question asks: Which volume would you use as a target ordered volume? The patient weighs 115 kilograms. Thirty milliliters per kilogram is 3450 milliliters. The IV fluid orders include, at 1730, normal saline, 0.9% IV with a volume of 2000 milliliters at 999 milliliters an hour; at 1945, normal saline, 0.9% IV volume, 1500 milliliters at 999 mm an hour. The MD note says: Initial volume was 2000 milliliters due to ESRD, but increasing to sepsis, 30 milliliters per kilogram volume. On the MAR, 2000 milliliters has a start time at 1730 with a stop time of 1930 and a 1500 milliliter start time at 1945 at 999 milliliters an hour. You would use 3450 milliliters as a target ordered volume of crystalloid fluids because the MD states that the target ordered volume is 30 milliliters per kilogram. In this scenario, the ordering physician documented the lesser volume of 2000 milliliters based on ESRD and documented 30 milliliters per kilogram volume based on the patient having sepsis. Since the physician ordered the 30 milliliters per kilogram volume and the documentation clearly states that 30 milliliters per kilogram is a target ordered volume for the patient, you would use the 30 milliliters per kilogram volume as the target ordered volume, rather than the lesser volume in this case.

We often receive questions related to the guidance for using the ideal body weight to establish a target ordered volume for the patient. This guidance states: Physician/APN/PA can use ideal body weight to determine the target ordered volume if all of the following conditions are met. There must be physician/APN/PA documentation that the patient is obese, or has a BMI greater than 30, and physician/APN/PA documentation indicates that ideal body weight is being used to determine the target ordered volume. The ideal body weight must be documented in the medical record, but it's not required to be documented by the physician/APN/PA.

The same documentation is required for using the predicted weight, dosing weight, or adjusted body weight. We often receive questions asking if the abstractor should use the patient's actual weight or the dosing weight because both are documented in the medical record. However, you would only use the dosing weight to determine the target ordered volume if the documentation requirements included in the guidance on this slide were met. Let's take a look at some examples.

This question asks: Which weight would you use to determine the target ordered volume? The patient weighs 105 kilograms. Thirty milliliters per kilogram is 3150 milliliters. In the MD note, it states: Ordering 30 milliliters per kilogram normal saline based on dosing weigh 85 kilograms. BMI is 28. You would use 105 kilograms to determine the 30 milliliters per kilogram target ordered volume of crystalloid fluids because the MD note states the patient's BMI is 28. In this scenario, the physician documentation states to use the dosing weight to determine the target ordered volume for the patient. However, per the abstraction guidance we reviewed on the previous slide, you would only use the dosing way to determine the target ordered volume during the abstraction if the physician documentation states that the BMI was greater than 30 or that the patient was obese. Since a documented BMI is 28, you would not use the dosing weight to determine the target ordered volume during an abstraction. You would use the actual weight documented for the patient, which is 105 kilograms in this scenario. Next, you can participate in the following Knowledge Check question.

Which weight would you use to determine the target ordered volume based on the APN documentation? Weighs 102 kilograms with BMI 33, giving sepsis fluids per adjusted body weight of 83 kilograms. A. 102 kilograms. B. 83 kilograms. C. 71 kilograms. We will give you a few more seconds to select your answer.

Select B. 83 kilograms because the APN documented the adjusted body weight was being used to determine the target ordered volume, and the patient's BMI was greater than 30.

Finally for today's presentation, I would like to review some of the guidance from the *Septic Shock Present* data element. Guidance in the *Septic Shock Present* data element was not updated in manual version 5.14; however, we frequently receive questions related to the guidance on this slide. This guidance allows for Value 2 No to be selected when there is physician/APN/PA documentation at the same time or within six hours after septic shock presentation, indicating the patient does not have sepsis, severe sepsis, or septic shock, or that severe sepsis or septic shock was due to a viral, fungal, or parasitic infection. Questions we received often include documentation that severe sepsis or septic shock was not present, then later documentation that the patient does have severe sepsis or septic shock. Let's take a look at an example of that scenario.

This question asks: Would you select Value 1 Yes or Value 2 No for the *Septic Shock Present* data element based only on the documentation below: The PA documentation at 0600 states: Septic shock ruled out. The PA documentation at 0730 says: The patient meets septic shock based on lactate of 4.5. You would select Value 1 Yes because the documentation indicating septic shock was ruled out is before septic shock was met. Let's take a look at one more scenario that is similar to this one.

This question asks: Would you select Value 1 Yes or Value 2 No for the *Septic Shock Present* data element based only on the documentation below? In the PA note, at 0600, it states: Septic shock ruled out. At 0730, the PA note states: Patient meets septic shock and based on lactate of 4.5. The MD note at 0800 states: Lactic acidosis related to liver failure, does not appear to have septic shock. You would select Value 2 No because there's physician documentation indicating septic shock was not present within six hours after the *Septic Shock Presentation Time*.

That concludes our review of the specifications manual, version 5.14, and thank you for participating in our review of the updates. Next, I will turn it over to Noel to review how to submit questions via the QualityNet Inpatient Question and Answer Tool.

Noel Albritton: Thanks, Jennifer.

First, if we do not get to your question during the webinar, please submit your question to the QualityNet Inpatient Question and Answer Tool via the link on this slide. If your question is about a specific slide, please include the slide number.

From the QualityNet.CMS.gov website, you can search for existing questions and answers, or submit a new question. To search for existing questions and answers, type the topic or data element into the Search box, and select Search. All Q&As pertaining to that topic will appear, and you can review the existing Q&As to find your answer. The existing Q&As are for educational purposes, and it's important to ensure that the Q&A you are referencing is an agreement with the current manual guidance based on the discharge period you're abstracting. We're continually reviewing and updating the existing Q&As, so it's important to review the existing Q&As often to ensure the responses continue to apply to your questions. Also, from the QualityNet Question and Answer Tool page, you can submit your own question by selecting the Ask a Question button.

When submitting a question to the support team, you must complete the form, which includes your name and contact information. The response to your question will be sent via email to the email address you include on this form.

Next, you'll select the program. For abstraction questions for the SEP-1 measure, select Inpatient Measures and Data Element Abstraction. Questions are often submitted to other programs by mistake, and it may take longer to get a response if the question has to be rerouted to the correct support team. So, for SEP-1 abstraction questions, the program to select is Inpatient Measures and Data Element Abstraction.

After selecting the Inpatient Measures and Data Element Abstraction program, you will then select the topic. For SEP-1 abstraction questions, you can select one of the topics under Hospital Inpatient Sepsis. The topics listed are by data elements that are included in the SEP-1 measure.

The next required field is the discharge period. It's important to select the appropriate discharge period because answers to your questions may vary slightly, depending on the manual version. Next, you will add the subject for your question to the Subject field. Then, enter your question into the Please Describe Your Question field. It's important that no PII or PHI is included in your submitted questions. Also, we're unable to receive screenshots or attachments. Submitted abstraction questions should be concise and only include the information specific to the topic being questioned. After you have entered your question, you would next click the Submit Question button. The support team will respond to your abstraction question as quickly as possible. So, that's how you can review existing Q&As and submit a question to the support team. Donna, I will turn it back over to you now.

Donna Bullock: Thank you, Noel. We will now start the question-and-answer session. Here's our first question: MD documented fluids exclusion. The volume of fluids ordered was 500 milliliters. The patient did not receive a 30 milliliter per kilogram crystalloid bolus due to fluid overload. The same MD ordered Vancomycin per protocol, which the PharmD dutifully followed with a 500 milliliter IV bag, using vial-adapter system. Activate and dilute before administration. Will this meet requirements for fluid administration?

Noel Albritton: This is Noel. I can answer that one. Yes. Based on this information, the physician ordered 500 milliliters and documented a reason for giving a lesser volume, which was the fluid overload. The 500 milliliters and the dilution fluids for the antibiotics are acceptable to use as the target volume in that case.

Donna Bullock: Great. Thanks, Noel. Here's our next question. If there is documentation that the patient has "chronic low blood pressure" within six hours of SBP less than 90, would the SBP of less than 90 be excluded?

Noel Albritton: So, this is Noel again. I can take that. So, no. You would not disregard the systolic blood pressure less than 90 based on the documentation of chronic low blood pressure.

If you recall from the guidance and discussion we had during the presentation, the abstraction guidance requires the abnormal value, so the actual systolic blood pressure value or a term defined by the abnormal value, which would be like hypotension in this case, to be documented as due to the chronic condition, to disregard those hypotensive readings. So, if it's just referring to chronic low blood pressure alone, you would not disregard the hypotensive readings.

Donna Bullock: Here's our next question. POA could be present on arrival or present on admission. Does this matter?

Noel Albritton: This is Noel again. So, the abstraction guidance does refer to documentation of an infection as POA. It states, if there is documentation of infection, that's POA, or documented as POA, to use the note open time in that case. That's because POA could stand for present on arrival or present on admission, just various facilities use that in different ways. That's why the abstraction guidance addresses that by stating to use the note open time when an infection is documented with POA.

Donna Bullock: Thanks, Noel. Our next question: It is noted that the hover function time will not be accepted as a time for specific documentation. However, if our IT department can find a way to print it out for validation, will it be acceptable?

Noel Albritton: This is Noel again. So, first, the hover time stamp, if your facility does use those or your EHR uses hover time stamps, it can be acceptable as a specified time for documentation. The caveat to that is, while it's acceptable to use as a specified time, it also has to be available. So, if your EHR is capable of making that available during abstraction, and available if the case was further reviewed by a third party later on, then you would use the hover time as a specified time stamp. If the hover time stamp is not available during abstraction, or available if it was reviewed by a third party later, then you would not use that as a specified time. You would continue looking for another specified time, the note open time, or one of the lower priority time stamps that are mentioned in the abstraction guidance.

Donna Bullock: OK. Here's our next question: Regarding guidance regarding the SEP-1 algorithm listing the blood culture timing as 2880 from severe sepsis time, the abstraction guidance states the blood culture collection time, as a look-back 24 hours prior, depending on when the antibiotic was administered.

Noel Albritton: So, this is Noel again. I can also address that. I've seen quite a few of these come in today during the presentation. The SEP-1 algorithm includes a blood culture collection timing of negative 2880 minutes before the *Severe Sepsis Presentation Time*. That is based on the blood culture could be, at max, 48 hours prior to the *Severe Sepsis Presentation Time*. That is because the *Broad Spectrum or Other Antibiotic Administration* data element allows for the antibiotic to be administered up to 24 hours before the *Severe Sepsis Presentation Time*. Then, the *Blood Culture Collection* data element allows the blood culture to be collected up to 24 hours before the *Broad Spectrum or Other Antibiotic Administration* data element. So, if your antibiotic was administered 24 hours before severe sepsis, you would have 24 hours before the antibiotic to collect the blood cultures. That's the maximum timeframe of 48 hours before the *Severe Sepsis Presentation Time* to collect the blood cultures. So, that's why the algorithm lists that negative 2880 minutes before severe sepsis presentation for your blood culture collection.

Donna Bullock: Thanks, Noel. This is a long one coming up. The Q&A center has answered that, regarding exclusion due to a suspicion of COVID, we should consider "symptomatic" as synonymous with "suspected." This is a change, compared to guidance in the manual. Standard orders for COVID often have an option to answer that. The indication for testing is that the patient is symptomatic. This Q&A answer is causing many more patients to be excluded from the measure since we have to answer *Severe Sepsis Present* as No. Will a Knowledge Base be published, or will the specifications manual be updated?

Noel Albritton: This is Noel again. So, the abstraction guidance does allow for documentation of COVID-19 or coronavirus as present, suspected, possible, probable, and synonymous terms to select Value 2 No for the *Severe Sepsis Present* data element based on that documentation.

That is where, when we see physician documentation that coronavirus or COVID-19 as suspected or symptomatic for COVID-19, it becomes synonymous with suspected, or it's possible or probable. That's why, as you referred to, we've sent responses to select Value 2 No for the *Severe Sepsis Present* data element based on documentation that COVID-19, that the patient was symptomatic for COVID-19. I believe the question asked about Knowledge Base publish or updates to the specifications manual. We could possibly discuss adding a question or a scenario for the Knowledge Base that's on the QualityNet website for SEP-1 questions. I'm not aware of any updates to the specifications manual, based on this scenario.

Donna Bullock: OK. Here's our next question: What if you have a specific time for infection and infection without a specific time, in the same note?

Noel Albritton: This is Noel again. I also saw quite a few of these come in during the presentation today. So, if you have an infection documented multiple times within the notes, both with and without a specified time, the infection documentation without a specified time will use the note open time. The infection documentation with a specified time would use the specified time. When there's both present, you would use the earliest of those times, that are within six hours of the other clinical criteria, to establish the earliest for *Sepsis Presentation Time*. Unlike the *Severe Sepsis Presentation Time* data element, the guidance under criteria a in the S*evere Sepsis Present* data element does not provide a hierarchy or state that you would use a specified time, if available, rather than a note open time for documentation of an infection. Either with or without a specified time is acceptable, and you would use the earliest time associated with that infection documentation to establish the earliest of *Sepsis Presentation Time*.

Donna Bullock: Thanks, Noel. The next question is: If an antibiotic is ordered, but there is no specific information regarding suspicion of an infection in the notes, and there is no indication for the antibiotic within the order, can I still use the antibiotic order as suspicion of an infection?

Noel Albritton: This is Noel again. So, no, we would not use just the antibiotic order alone, without any documentation of infection to meet criteria a for the *Severe Sepsis Present* data element. If the antibiotic order did include an indication for an infection, or if there was other documentation that referred to the antibiotic being ordered or administered for the infection, then, of course, you could use that infection documentation. If it's an antibiotic order alone with no documentation of an infection, then you would not use that to establish criteria a.

Donna Bullock: Thank you. Here's our next question: Concerning initial hypotension time, that is, after the end of fluids, the specs do not state if we are to still include the fluids when we go back and mark No for the *Initial Hypotension*, or leave the fluids.

Noel Albritton: So, in this case, you would select Value 2 No for the *Initial Hypotension* data element based on the target volume of crystalline fluids being completed prior to the initial hypotension time. Once you select Value 2 No for the *Initial Hypotension* data element, the case will proceed to the *Septic Shock Present* data element in the algorithm. At that point, if septic shock was present, then the case would go to the *Crystalloid Fluid Administration* data element for abstraction after septic shock, after you select Value 1 for the *Septic Shock Present* data element. So, the case will continue in the algorithm after you select No for *Initial Hypotension*, and it'll later address the fluids.

Donna Bullock: All right. Here's our next question: If a physician modifies their note to exclude SIRS criteria or organ dysfunction, and the date and time they modified their note is outside the acceptable timeframes, can the exclusion be used?

Noel Albritton: No. We would not exclude the SIRS criteria or organ dysfunction if the documentation was greater than 24 hours after the *Severe Sepsis Presentation Time*. That guidance can be found in the *Severe Sepsis Present* data element, documentation that the abnormal value for SIRS criteria or organ dysfunction documented is due to a chronic condition or medication has to be documented prior to the *Severe Sepsis Presentation*

Time or within 24 hours after. So, if there's documentation greater than 24 hours after sepsis presentation, then you would just disregard that documentation and continue to use the SIRS criteria and organ dysfunction to meet *Severe Sepsis*.

Donna Bullock: Next question. This question pertains to slide 10. So, to be clear, Time Seen would take priority over Note Opened Time, regardless of which is earlier.

Noel Albritton: This is Noel again. No, so this guidance on the slide refers to using a specific time if it's available. If you don't have a specific date and time available for infection documentation, then you would use the note opened or started time. That would be your priority under a specified time. Then, if the note open time or started time is not available, then you would use one of the supporting time stamps under the priority order, which would be that seen time. Then, it would just go down in priority order. So, if the seen time wasn't available, you would use a Scribe Time and so on, but you would use the note open time, if a specified time was not available before using the seen time.

Donna Bullock: Thank you, Noel. If IV antibiotic was ordered, an indication was bacteremia, can we use that as infection?

Noel Albritton: Yes. So, the documentation of bacteremia included in the antibiotic order would be acceptable to meet criteria a. You would disregard the documentation of the fungal infection in this case, but you could use the documentation of bacteremia to meet criteria a. That's because the bacteremia was not documented is due to a fungal infection. If it was documented as due to a fungal infection, then you would disregard the documentation of bacteremia as well.

Donna Bullock: OK. Here's our next question: Just a quick question about the SIRS criteria. Is it based on the sepsis one and sepsis two definitions? Is there any talk of using QSOFA in place of SIRS.

Bob Dickerson: This is Bob Dickerson. I work with Noel on maintaining the SEP-1 measure. I can take that question.

The answer to the first part is Yes. The SEP-1 measure, the screening criteria, is based on the sepsis one, sepsis two, definition, which uses the SIRS criteria, suspected infection, and sign of organ dysfunction. At this point, there are no plans to change to the sepsis three definition for screening criteria which uses QSOFA. The primary reason for that is that the research that has been done comparing these two different ways to identify patients with potential severe sepsis or septic shock clearly reflects the SIRS-based criteria is better at identifying potential early severe sepsis and septic shock, which is the intent of the measure to identify patients early in the process and then measure what care is done, what care and interventions are provided. The QSOFA sepsis three-based criteria is better at identifying patients who are at a high risk for mortality. What that tends to do is to identify the very sickest patients. Since the intent of the measure is to identify severe sepsis and septic shock early, to initiate early treatment, to help decrease severity of illness and increased mortality risks, the measure, at this point, is remaining focused on using that. Now, that does not mean that at the bedside, a clinician cannot use another screening tool that works better for them in their setting and with the patients that they're working with. What that means is, for the measure, the criteria of identifying a patient for inclusion in the measure is based upon the SIRS criteria, so that all abstractors are using the same criteria to identify whether a patient should remain in the measure or be excluded from the measure. So, again, it's not dictating what a clinician must use at the bedside. It's more so for the early identification, providing a standard screening methodology, so that all abstractors use the same thing to determine whether patients stay in their population or not. I hope that answers the question. That was a great question. Thank you.

Donna Bullock: Thanks, Bob. Here's our next question. Does the update to the infection documentation mean that we would need to use a hierarchy for the infection element? For example, if an RN note upon arrival states: Sepsis is suspected at 0900. Then, the MD/APN/PA documents the patient is septic at 0200. Which time would you use for the element of infection?

Noel Albritton: This is Noel again. I can take that one. So, I guess, first, the guidance for the infection for determining the time of infection documentation was not updated in manual version 5.14. We were just reviewing that during the presentation. You would follow the priority order that that guidance provides, and we discussed that a little bit in the previous question, where you would use a specified time available. Then, use the note open time if a specified time was not available. Then, use the other sources in priority order if a note open time was not available. For the example of an RN who notes sepsis at 0900 and an MD who documents sepsis patient at 10, either one of those documentations would be acceptable for establishing or meeting criteria a. You would use the earliest one of those infection documentations that's within six hours of the other clinical criteria to establish for sepsis. So, if criteria b and c, SIRS and organ dysfunction, were also within six hours of 0900, then you can use the nursing documentation of sepsis at 0900 to establish or meet *Severe Sepsis*. It would be the same thing if it was at 10. You could use 10, if that was when SIRS criteria and organ dysfunction were within six hours. So, you use the priority order and then the infection guidance for each infection documentation that you have in the note and the medical record. I think that addresses all the questions in that one, Donna.

Donna Bullock: Thanks, Noel. This question pertains to slide 15. What if there is notation that patient was on IV antibiotics, three days PTA, but no specifics for which antibiotic and no documentation of date/time of doses? Could you use this for your 72 hours look-back?

Noel Albritton: This is Noel again. So, I'm going to clarify slide 15, as in regards for the *Sepsis Present* data element. As far as the 72 hours look-back being referred to in the question, that, I'm assuming as related to the *Broad Spectrum or Other Antibiotic Administration* data element. For that data element, if the documentation of the IV antibiotic prior to arrival did not include the name, route, date, and time of administration for the antibiotics, then you would not use that antibiotic to establish a *Broad Spectrum or Other Antibiotic Administration* date and time.

If it's missing name, route, date, or time, you would disregard that documentation and continue looking for IV antibiotic administration within the specified time frame that does include the name, route, date, and time of administration.

Donna Bullock: Thanks, Noel. This question pertains to slide 18. Can an RN document hypotension after dilaudid or hypotension at the low pressure, which would exclude this hypotension?

Noel Albritton: This is Noel again. So, no, you would not disregard the abnormal values, abnormal hypotensive values, based on nursing documentation, attributing the hypotension to a medication. The abstraction guidance requires physician/APN/PA documentation that the abnormal value was due to a medication to disregard the abnormal value. So, for nursing documentation, such as attributing hypotension to a medication, you would disregard that documentation and just continue abstracting.

Donna Bullock: Thank you. Our next question pertains to slide 19. Does this mean, if a patient is on an anticoagulant, and their INR/PTT is high., we are supposed to use the value until the physician specifically states the value is due to the medication?

Noel Albritton: So, this is Noel again. Yes, to generalize it, yes, you would use the abnormal INR or PTT to meet criteria, unless there is physician/APN/PA documentation that attributes that abnormal value to the medication or if there's documentation in the medical record that the patient is receiving an anticoagulant and they have the INR, an elevated INR, or PTT. There's a bullet point in the *Severe Sepsis Present* data element that does not require physician documentation to disregard the elevated INR or PTT, ff the patient was on an anticoagulant and received the anticoagulant prior to the elevated INR or PTT value.

Donna Bullock: Thank you, Noel. We'll go now to slide 20. Are we now able to discount elevated creatinine for any level CKD, not just ESRD on HD? Previously, lesser levels of CKD also had to list a baseline creatinine level and could only be discounted if the level was less than 0.5 greater than the baseline.

Noel Albritton: This is Noel again. So, let's clarify a few things here. On slide 20, it's discussing a different part of the abstraction guidance that is related to physician/APN/PA documentation that an abnormal value is due to a chronic condition. There's other guidance in the notes for abstraction that address abnormal creatinine values and documentation, like the patient has ESRD and is on dialysis or an abnormal creatinine value when there's a baseline value documented, and the patient has CKD. Those are two separate bullet points that are also in the notes for abstraction. So, the bullet point regarding documentation of CKD and having a baseline creatinine value is still in the abstraction guidance, and it does still state that you would disregard the creatinine value that is within 0.5 above the documented baseline value. So, that is still in the notes for abstraction.

Donna Bullock: OK. Back to slide 15: If the patient comes in on PO antibiotics, why wouldn't we use that for infection? For many patients, this would mean they failed home medication therapy and needed more advanced treatment.

Noel Albritton: This is Noel again. For abstraction purposes, we would abstract per the documentation in the medical record. So, during abstraction, we could not assume or infer that, because the patient was on PO antibiotics at home and then came to the hospital, that an infection was still present. So, while we're abstracting to use that as infection documentation, we would look for documentation of an infection. That's why we don't use PO antibiotics, whether there's an infection documented or not, because we're dealing with severe sepsis as well. As the guidance says, it requires IV or IO antibiotic administration. We basically cannot infer that the infection was still present because the patient was on antibiotic at home.

Donna Bullock: Thanks, Noel. Slide 28 is next. Then, what do we do with pregnant patients less than 20 weeks? Do we treat them like non-pregnant patients?

Noel Albritton: Yes, for abstracting the measure, for patients that are less than 20 weeks pregnant, you would use what is labeled as Non-Pregnant Patients criteria on this column. This slide is regarding terms that are defined by an abnormal value. For the severe sepsis present clinical criteria, if the patient was less than 20 weeks pregnant, you would still use the criteria listed

under Non-Pregnant Patients simply because they're less than 20 weeks pregnant, and those other values, under the Pregnant 20 Weeks Through Day Three Post-Delivery Patients, don't apply yet.

Donna Bullock: OK. Next question. There is no slide number provided here. Does bacteremia count as documentation of infection when listed as a reason for IV antibiotics?

Noel Albritton: Yes. This one's also come up a couple of times during the presentation, and we see it in the Q&A tool, as well. Documentation of bacteremia is acceptable for meeting criteria a, infection. The abstraction guidance in the *Severe Sepsis Present* data element does list bacteremia as an exclusion for documentation of severe sepsis. That means that we would not use documentation of bacteremia to select Value 1 Yes as physician documentation of severe sepsis, but we could still use documentation of bacteremia, similar to how we use documentation of sepsis, to meet criteria a, infection, when we're trying to meet or determine this for sepsis clinical criteria.

Donna Bullock: Thanks, Noel. Our next question relates to slide 23. What if the provider states that SIRS criteria or sign of organ dysfunction is due to an acute condition that has a non-infectious source/process but uses a qualifier like "could be due to" or "possible due to"? Any guidance for these situations?

Noel Albritton: This is Noel again. Yes. Based on the information and the question, you would continue to disregard the abnormal value that is documented as it "could be" or are "may be" due to the acute condition with a non-infectious source. It's hard to say definitively in all situations, so you can submit questions through the Q&A tool online, but the abstraction guidance does not require you to explicitly confirm the abnormal value is due to the acute condition with a non-infectious source. The physician documentation, suggesting that it could be due to that acute condition with a non-infectious source, is sufficient to disregard the abnormal value.

Donna Bullock: OK. This is our last. We don't have time, but for one more question. This question pertains to slide 46.

Would Value 2 be selected if the patient met clinical criteria for severe sepsis prior to 0600, and a PA noted "septic shock ruled out" at 0600?

Noel Albritton: This is Noel again. Yes. So, if severe sepsis or septic shock was met prior to or at 0600, and there was physician/APN/PA documentation also at 0600 reflecting the patient did not have severe sepsis or septic shock, then you would select Value 2 No for the *Severe Sepsis Present* data element. That guidance is also found on the bottom of the notes for abstraction in the *Severe Sepsis Present* data element and the *Septic Shock Present* data element, but, basically, if there is physician/APN/PA documentation indicating the patient did not have sepsis, severe sepsis, or septic shock at the same time, or within six hours after the severe sepsis presentation time, you would select Value 2 No. Then, once you select Value 2 No for the *Severe Sepsis Present* data element, it will exclude the case from the rest of the measure.

Donna Bullock: Thanks very much, Noel. That is all the time we have for questions during this presentation. Next slide, please.

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