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) *Severe Sepsis Present* Data Element Version 5.14a Questions and Answers

Question and Answer Summary Document

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Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Severe Sepsis Present

Question 1: **Does this webinar cover July 1, 2023, through December 31, 2023, discharges, not January 1, 2024, through June 30, 2024, discharges?**

Yes, that is correct. In this webinar, we are using manual Version 5.14a, which applies to discharges from July 1 through December 31, 2023.

Question 2: **The patient does not meet the severe sepsis clinical criteria; however, the emergency department (ED) provider gave a severe sepsis diagnosis. The admitting hospitalist then gave a sepsis diagnosis but did not include "severe." Does this exclude them from the severe sepsis diagnosis, or does the admitting provider have to document that severe sepsis is ruled out to exclude the patient from severe sepsis?**

The physician documentation within six hours after the *Severe Sepsis Presentation Time* must refer to sepsis or severe sepsis as not being present to select Value "2" (No) and exclude the case. If severe sepsis is met and the physician only added sepsis to the final diagnosis, you would still select Value "1" (Yes) for the *Severe Sepsis Present* data element because the physician did not indicate that severe sepsis was not present. If the physician documentation within six hours after meeting severe sepsis indicated sepsis was not severe, then you would select Value "2" (No) for the *Severe Sepsis Present* data element because that documentation indicates severe sepsis is not present after severe sepsis criteria was already met.

Question 3: **Please explain the difference between slide 12 and slide 13. Is it due to the documentation of "likely urinary tract infection (UTI)" and the first set of documentation with "Open Note" time? Per the positive qualifier table in the specification manual, it states that "documentation of infection likely" is a positive qualifier.**

The documentation of "likely UTI" would be acceptable for meeting criterion A (infection) and establishing the presence of severe sepsis if criteria B (two or more systemic inflammatory response syndrome [SIRS] criteria met) and C (organ dysfunction) were met and all three were within six hours of each other. The scenario on slide 13 includes documentation of "likely UTI," but the time associated with that documentation was not within six hours of the SIRS criteria and sign of organ dysfunction. That is why the documentation of "likely UTI" in the example on slide 13 was not used to meet criteria A.

Question 4: **If the patient meets *Severe Sepsis* by all the criteria (SIRS, infection, and organ dysfunction) at 1300, but the physician documents at 1400 that the patient has severe sepsis, do you use the time the criteria are met or the time the physician documented severe sepsis?**

You would always use the earliest *Severe Sepsis Presentation Time* available. If the clinical criteria were met at 1300 and then there was physician documentation of severe sepsis at 1400, you would use 1300 as the *Severe Sepsis Presentation Time* because that is the earliest presentation time.

Question 5: **The manual guidance states to use the administration time of the antibiotics as an infection source and states that the administration must be within six hours. If there is documentation indicating a patient is receiving an intravenous (IV) or intraosseous (IO) antibiotic for an infection, and that antibiotic is documented as administered within six hours of Criteria B and C, is that acceptable? Example: Levaquin is documented in the Medication Administration Record for pneumonia and nursing documentation, within six hours of Criteria B and C, to indicate that the antibiotic was given. Can you clarify why you would use the note time of the documentation instead of the administration time?**

If an IV or IO antibiotic was ordered for an infection, for example Levaquin for pneumonia, either the time of the infection documentation or the time that the antibiotic was administered can be used to meet criterion A. If there was infection documentation without a specified time in a note, you would use the note opened time for that infection documentation. If there are multiple times reflecting an infection is present, you would use the time within six hours of criteria B and C that results in the earliest severe sepsis presentation time. You would use the note opened time along with criteria B and C if it established the earliest *Severe Sepsis Presentation Time.*

Question 6: **If the order reads, "ordered for empiric treatment, suspected gastro urinary (GU) or gastrointestinal (GI), respiratory order," is that sufficient to document suspicion of an infection?**

No, you would not use an antibiotic ordered for empiric treatment without further documentation of an infection. Similarly, you would not use an antibiotic ordered for a body system (for example, GU, GI, or respiratory) to meet criterion A. If the antibiotic order included an indication with an

infection such as empiric treatment for a urinary tract infection (UTI), or pneumonia, then you would use the documentation to meet criterion A.

Question 7: **What if the provider orders an antibiotic, but it does not include the reason in the order? Can we use that order?**

No, you would not use an antibiotic ordered without a reason or indication to establish criterion A. For example, if IV Vancomycin (Vanco) with dosage was ordered without an indication, you would not use it for establishing criterion A. If the order included the IV Vanco dosage and an indication for pneumonia or another infection, then that antibiotic order and antibiotic administration times can be used to meet criterion A.

Question 8: **If an antibiotic is given for prophylaxis, can it still be abstracted as infection time?**

No, you would not use an antibiotic administration to meet criterion A unless the antibiotic was ordered for an infection. If the antibiotic had an indication or a reason of prophylaxis, you would not use that documentation to establish criterion A.

Question 9: **Is "mild lactate elevation" acceptable to use as a term, or must I see "lactic acidosis"?**

You would not disregard the abnormal lactate value based on the documentation "mild lactate elevation" because this does not include a term defined by an abnormal value. To disregard the abnormal lactate value, either the abnormal value or a term like "lactic acidosis" defined by the abnormal value must be documented and identified as due to a chronic condition, medication, or other condition included in the *Severe Sepsis Present* data element Notes for Abstraction.

Question 10: **The patient does not meet the criteria for *Initial Hypotension.* Due to elevated lactate of 5.8, the patient falls in the category of septic shock, and *Persistent Hypotension* is highlighted. How do we answer a question for *Persistent Hypotension*, even though the patient was not initially hypotensive?**

In this scenario, if Value "2" (No) was selected for the *Initial Hypotension* data element, the case would proceed to the *Septic Shock Present* data element in the algorithm. You would select Value "1" (Yes) for the *Septic Shock Present* data element based on the case meeting *Severe Sepsis Present* and having an *Initial Lactate Level Result* of 5.8. Then, the case

will proceed to the *Crystalloid Fluid Administration* and *Persistent Hypotension* data elements. *Initial Hypotension* is not required for the case to reach the *Persistent Hypotension* data element because it evaluates for the presence of persistent hypotension or new onset of hypotension after fluid resuscitation. The measure uses the *Initial Hypotension* data element and the *Septic Shock Present* data element as triggering events for *Crystalloid Fluid Administration* and fluid resuscitation.
As such, the *Persistent Hypotension* data element is not dependent on whether *Initial Hypotension* was present or not.

Question 11: **Would we select Value "2" (No) for *Severe Sepsis Present* if there is documentation of "suspected COVID"? Would the case be excluded if the provider documented this? "There is a concern for COVID-19."**

Yes, you would select Value "2" (No) for the *Severe Sepsis Present* data element based on physician/Advance Practice Nurse (APN)/physician assistant (PA) documentation of "suspected COVID" or "there is a concern for COVID-19," because the documentation reflects COVID-19 is present, suspected, or possible. Selecting Value "2" (No) for the *Severe Sepsis Present* data element will exclude the case from the measure.

Question 12: **If the patient has the flu, and he has another non-viral source of infection, do we still abstract these charts?**

The diagnosis or documentation of the flu, respiratory syncytial virus (RSV), or any viral infection outside of COVID-19 would not automatically result in the case being excluded from the measure. You would disregard the documentation of the viral infection and continue abstracting to determine if severe sepsis was met per abstraction guidance. If an infection was documented and within six hours after the initial infection documentation there was physician/APN/PA documentation that the infection was due to a viral source, you would disregard the initial infection documentation and not use it to meet criteria A.

You would select Value "2" (No) for the *Severe Sepsis Present* data element, which will exclude the case, if severe sepsis criteria were met and, at that same time or within six hours after meeting severe sepsis criteria, there was physician documentation indicating severe sepsis or septic shock was due to a viral infection.

Question 13: **If a patient has a history of human immunodeficiency virus (HIV) and they come in with an infection unrelated to HIV, for example a UTI,**

are they automatically excluded because of their HIV status? What if they have pneumocystis pneumonia?

No, a case would not be automatically excluded based on history or diagnosis of HIV. You would use documentation of the infection that is not viral, fungal, or parasitic and clinical criteria B and C to determine if severe sepsis was present and the presentation date and time.

The documentation of pneumocystis pneumonia would also not exclude the case from the measure. Since pneumocystis pneumonia is a fungal infection, you would disregard this documentation and continue reviewing for severe sepsis clinical criteria or physician/APN/PA documentation of severe sepsis.

Question 14: **In the absence of documentation of when mechanical ventilation is initiated, would you use the first time a ventilator was set and the flow sheet as a start time?**

No. Based on the abstraction guidance, you would not use the first time the ventilator settings were set or changed or any other time stamp that is not specific to the mechanical ventilation start time. You would only use the documented ventilator start time, ventilator placement time, or similar time stamp indicating when the mechanical ventilation was first started on the patient to meet criterion C. If a start time is not available, you would disregard the mechanical ventilation and not use it to establish organ dysfunction.

Question 15: **The patient is in non-violent restraints, and the provider stated the restraint justification in the order as "behavior interfering with medical care" or "dislodgment of tubes, lines." Does this meet the criteria to answer Yes to the data element *Administrative Contraindication to Care, Severe Sepsis*?**

Yes, you would select Value "1" (Yes) for the *Administrative Contraindication to Care*, *Severe Sepsis* data element because the indication or reason for the restraints reflects patient non-compliance with care that could result in not being able to draw blood, administer IV antibiotics, or administer IV fluids. If there was only a restraint order that did not include documentation of patient non-compliance, then you would not select Value "1" (Yes) for the *Administrative Contraindication to Care* data element.

Question 16: **Is "sepsis, severe" the same as severe sepsis?**

Yes, physician/APN/PA documentation of "severe sepsis" or "sepsis, severe" is acceptable for selecting Value "1" (Yes) for the *Severe Sepsis Present* data element.

Question 17: **Where can I locate a list of all possible organ dysfunctions that would meet the criteria?**

The organ dysfunction criteria and all the criteria used to establish severe sepsis are located in the *Severe Sepsis Present* data element in the Alphabetical Data Dictionary of the Specifications Manual for National Hospital Inpatient Quality Measures on QualityNet.