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

Presentation Transcript

Speakers

Noel Albritton, MSN, RN, Lead Solutions Specialist
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor
Jennifer Witt, RN, Senior Health Informatics Solutions Coordinator
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor
Moderator
Donna Bullock, MPH, BSN, RN
Program Lead, Hospital IQR Program
Inpatient VIQR Outreach and Education Support Contractor

December 5, 2023
2:00 p.m. Eastern Time

Donna Bullock: Hello, and welcome to today's event, *Severe Sepsis and Septic Shock: Management Bundle [(Composite Measure)], Severe Sepsis Present Data Element, Version 5.14a Questions and Answers.* My name is Donna Bullock, and I will be the moderator for today's event. Before we begin, I would like to make a few announcements. If you registered for today's event, a link to the slides was emailed to you two hours ago. If you did not receive this email, you can download the slides from the Quality Reporting Center website. That's www.QualityReportingCenter.com. During the webinar, you can click the handout link. This event is being recorded. The recording and the transcript will be posted on QualityNet and on the Quality Reporting Center website in the near future. The webinar has been approved for continuing education credit, and more information about this will be provided at the end of the presentation. If you have a question, as we move through the webinar, please click the question mark and type it in. We will get to as many questions as we can at the end of the event.

Now, I would like to introduce our speakers. Noel Albritton is the Lead Solutions Specialist with the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor. Jennifer Witt is the Senior Health Informatics Solutions Coordinator, also with the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor.

The purpose of this event is to review the *Severe Sepsis Present* data element and to respond to frequently asked questions.

At the conclusion of today's event, participants will be able to understand and interpret the guidance in Version 5.14a, effective for July1, 2023, through December 31, 2023, discharges of the specifications manual, specific to the *Severe Sepsis Present* data element to ensure successful reporting for the SEP-1 measure for the Hospital Inpatient Quality Reporting Program.

These next slides are acronyms that may be used in today's presentation. I will now turn the presentation over to Noel.

Noel Albritton: Thanks, Donna. Hello everyone and thank you for joining us. For today's presentation, we will focus on the abstraction guidance and frequently asked questions pertaining to the *Severe Sepsis Present* data element and the *Severe Sepsis Presentation Date* and *Time* data elements. We will be using the abstraction guidance found in specifications manual Version 5.14a. You can find the SEP-1 algorithm and specifications manual Version 5.14a on the QualityNet website at qualitynet.cms.gov.

Before we jump into the abstraction guidance and frequently asked questions, I want to point that a new sepsis ICD-10 code was added to Appendix A.2 in manual Version 5.14a. Along with the ICD-10 codes for severe sepsis and septic shock, Appendix A includes sepsis ICD-10 codes that are also used to determine if cases meet the initial patient population for the measure. The criteria for the initial patient population, including these ICD-10 codes, are used to determine if the case is eligible for the measure. Only cases meeting these criteria are eligible for the chart abstracted process measure. You can find and review Appendix A.2 on the QualityNet website at qualitynet.cms.gov.

To begin, I want to review this portion of the SEP-1 algorithm and what it means when you select Value 1 or Value 2 for the *Severe Sepsis Present* data element. You will use the abstraction guidance included in the *Severe Sepsis Present* data element to determine if Value 1, Yes, or Value 2, No, should be selected. If you select Value 1, Yes, indicating severe sepsis was present, the case will proceed to the *Severe Sepsis Presentation Date* and *Time* data elements in the algorithm. If you select Value 2, No, which indicates severe sepsis was not present, the case will proceed to category B, and the case will be excluded from the measure. Now, let's review some of the guidance and frequently asked questions regarding the *Severe Sepsis Present* data element.

First, I want to point out that the *Severe Sepsis Present* data element can be met by either clinical criteria or physician, advanced practice nurse, or physician assistant documentation of severe sepsis. Within the *Severe Sepsis Present* data element notes for abstraction, you will find all of the criteria for using clinical criteria or physician/APN/PA documentation to

meet the data element. As we move through today's presentation, we will reference criteria A, B, and C, so I want you to be clear on what that means. The *Severe Sepsis Present* data element includes criteria A, B, and C for meeting severe sepsis by clinical criteria. Criteria A is documentation of an infection, criteria B is two or more SIRS criteria, and criteria C is one sign of organ dysfunction. Now, let's begin with looking at a portion of the abstraction guidance pertaining to criteria A.

The abstraction guidance on this slide provides instruction on which time to abstract for infection documentation. This guidance states if documentation of an infection within a physician/APN/PA, nursing, or pharmacist 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 the note opened time was not available, then you would use the priority order included in the abstraction guidance to determine the time of the infection documentation. I want to point out that this guidance applies to each documentation of an infection. For example, if there are two infections documented in a note, you would apply the guidance on this slide to each of those infection documentation to determine which time to use. Let's review a couple scenarios and frequently asked questions regarding infection documentation.

As I mentioned, we frequently receive questions regarding which time to use for the infection documentation, such as this question. Which time would you use for the infection documentation to meet *Severe Sepsis Present* criteria A, infection, based on the below documentation and meeting two SIRS criteria at 1600 and a sign of organ dysfunction at 1615? The MD documented pneumonia in the note without a specific time, but a note opened time of 1530 is available. Then, there is also physician documentation of pneumonia under the Assessment section that includes documentation of pneumonia with a specific time of 1700. In this scenario, you would use 1530 for the infection documentation time because the MD's documentation of possible pneumonia is the earliest infection documentation that is within 6 hours of criteria B and C.

Both documentation of pneumonia in the narrative note and under the Assessment could be used to establish criteria A. With two SIRS criteria at 1600 and a sign of organ dysfunction present at 1615, the note opened time of 1530 establishes the earliest severe sepsis presentation time. Let's look at a similar scenario.

This scenario is similar to the last one; however, the progress note opened time is different. This question asks: Which time would you use for the infection documentation to meet *Severe Sepsis Present* criteria A, infection, based on the documentation below and meeting two SIRS criteria at 1600 and a sign of organ dysfunction at 1615? The MD documented "likely UTI" in the note without a specific time, but a note opened time of 0900 is available. Then, there is also physician documentation of UTI under the Assessment section that includes a specific time of 1700. You would use 1700 for the infection documentation because the physician's documentation of UTI under the Assessment section is the earliest infection documentation that is within 6 hours of criteria B and C. In this scenario, the documentation of UTI in the narrative note and under the Assessment section are acceptable to establish criteria A. With two SIRS criteria met at 1600 and a sign of organ dysfunction met at 1615, you would use the infection documentation at 1700 to establish severe sepsis. You would not use the note opened time at 0900 for the infection documentation because criteria B and C were not met within 6 hours of the note opened time. Let's take a look at another portion of the abstraction guidance for establishing criteria A.

We also frequently receive questions regarding whether documentation of an inflammatory condition or a sign or symptom of an infection can be used to meet criteria A and which time to use for the infection documentation. 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. The guidance is stating this documentation of the antibiotic being ordered for the inflammatory condition or sign or symptom of infection is acceptable because, by

ordering an antibiotic, the clinician is treating the condition as an infection. Let's take a look some examples.

We also see questions similar to this scenario. This question asks: Which time would you use for the infection documentation to meet *Severe Sepsis Present* criteria A, infection, based on the below documentation? There is a PA note opened on 9/10/2023 at 1145 that states: Vanco ordered for persistent fever. Then, we can see on the MAR three doses of IV Vanco that were administered. Use 1145 for the infection documentation time because the PA's documentation states the antibiotic was ordered for the sign or symptom of infection at that time. If you recall from the abstraction guidance on the previous slide, the guidance refers to documentation of the antibiotic being ordered for the sign or symptom of infection as being acceptable. However, the abstraction guidance does not refer to using the time the antibiotic was administered based on documentation that the antibiotic was ordered for the sign or symptom of infection. Let's review another scenario.

This is another scenario we frequently see. This question asks: Would you use this documentation to meet *Severe Sepsis Present* criteria A, infection, based on the information below? There is an MD note opened on 10/15/23 at 1500 that states: Patient with c/o urinary frequency, low-grade fevers, and tachycardia. Will start on Ceftriaxone and await results of urine cultures. Then, the problem list in the note includes cystitis and type 2 diabetes. No, because the documentation does not state an antibiotic was ordered for the inflammatory condition. In the questions we receive about this scenario, abstractors seemed to be attempting to link the physician documentation referring to urinary frequency, urine cultures, and the inflammatory condition listed on the problem list with the documentation of the antibiotic. However, you should abstract the medical record at face-value. So, based on the abstraction guidance allowing documentation of an antibiotic being ordered for the inflammatory condition or sign or symptom of infection, you would only use documentation specific to the antibiotic being ordered for the inflammatory condition or sign or symptom to meet criteria A.

Otherwise, you would disregard documentation of the inflammatory condition or sign or symptom of infection and not use it to meet criteria A. Let's take a look at another question that you can participate in answering.

Would you use the PA's reason for ordering IV Vanco "cellulitis" to establish criteria A, infection, for the *Severe Sepsis Present* data element, A, Yes, or B, No? We will give you a few more seconds to select your answer. Select A, Yes, because the documentation includes an inflammatory condition as the reason or indication for ordering the IV antibiotic. In this scenario, the PA's antibiotic order includes the reason the antibiotic, which is cellulitis. Since the antibiotic was ordered for the inflammatory condition, this documentation is acceptable for establishing criteria A, infection.

Next, let's discuss the abstraction guidance related to disregarding a documented infection and a scenario we often receive questions about. The guidance on this slide allows for a documented infection to be disregarded if there was physician/APN/PA documentation indicating the infection was not present within 6 hours after the infection was documented. Let's take a look at one scenario we frequently see.

This question asks: Would you disregard this infection documentation based on the information below? On 11/27 at 1800, the physician documented possible pneumonia, ordered cultures and antibiotics. Then, we can see there is a final diagnosis of bronchitis documented on 11/27 at 2100. No, you would not disregard the initial infection documentation because there is no documentation within 6 hours after the initial documentation of possible pneumonia that indicates the pneumonia is not present. We frequently receive this question because the infection is not included in the Final Diagnosis section. Therefore, the abstractor is assuming that the infection is not present. However, as I mentioned earlier, we must abstract the documentation at face-value. Based on the abstraction guidance we reviewed on the previous slide, there must be documentation that the infection was not present within 6 hours after the infection was documented.

In a scenario such as the one on this slide, you would not disregard the infection documentation because there is no further documentation stating the infection was not present. Next, let's move on to reviewing the abstraction guidance related to organ dysfunction. This portion of the abstraction guidance in the *Severe Sepsis Present* data element addresses which time to use for the initiation of mechanical ventilation. We often receive questions asking which time to use for when criteria C, organ dysfunction, is met by initiation of mechanical ventilation. This guidance states to use the time mechanical ventilation was started. The abstraction guidance also includes the example on this slide which includes the time mechanical ventilation was placed on the patient, as well as several other times that are not used to establish criteria C. As demonstrated in the example, the time of intubation and the time the settings and alarms were set are not used to establish the start time for mechanical ventilation. You would only use the time the mechanical ventilation was started or placed on the patient. Let's take a look at a couple example scenarios.

We often receive questions like this one regarding which time to use for the mechanical ventilation to meet organ dysfunction. This question asks: Would you use the mechanical ventilation as a sign of organ dysfunction, based only on the documentation below? In the respiratory therapy note there is documentation of "Pt intubated in the ED and now in the ICU on vent. Settings and alarms checked." No, you would not use this documentation because it does not include the start time for the mechanical ventilation. As I mentioned, the abstraction guidance on the previous slide only refers to using the start time for mechanical ventilation. Therefore, you would disregard documentation referring to mechanical ventilation that does not include the start time or placed time.

Next, you can participate in the following knowledge check question. Which time would you use for the mechanical ventilation to establish criteria C, organ dysfunction, for the *Severe Sepsis Present* data element? A. ET Placed at 1730. B. Bag valve mask (BVM) at 1740. C. Ventilator placed at 1815. We'll give you a few more seconds to select your answer.

Select C, ventilator placed at 1815, because this documentation identifies when the ventilator was started on the patient. We frequently receive questions like this one asking which time to use for organ dysfunction. As we reviewed in the abstraction guidance and demonstrated on this slide, you would only use the time mechanical ventilation was started. You would disregard other time stamps, such as the intubation time, ambu bag time, or time of the vent settings because these time stamps do not identify the start time for the mechanical ventilation.

Another topic we frequently receive questions on is whether a sign of organ dysfunction should be used to meet criteria or disregarded. The abstraction guidance on this slide on the *Severe Sepsis Present* data element notes for abstraction allows for SIRS criteria or a sign of organ dysfunction to be disregard when the abnormal value is documented as normal for the patient, due to a chronic condition, or due to a medication. We will review several scenarios in a moment, but I would also 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. Often questions we receive include scenarios where an inference must be made that assumes the SIRS criteria or a sign of organ dysfunction meets this guidance. However, during abstraction, we are specifically reviewing for physician/APN/PA documentation that includes an abnormal value and documentation that it is normal for the patient, due to a chronic condition, or due to a medication. Let's take a look at some example scenarios.

We frequently receive questions and scenarios such as the one on this slide. While it is not possible to review every scenario that may occur during abstraction, let's review several scenarios that should assist with determining when to use or disregard a sign of organ dysfunction. This question asks: Would you use the abnormal bilirubin value to establish *Severe Sepsis Present* organ dysfunction based only on the documentation below? There is a lab report at 0600 of a bilirubin of 2.4. Then, there is a PA Note at 0845 that states: Bilirubin normally runs high for patient.

Yes, use the bilirubin of 2.4 to establish organ dysfunction because the PA documentation does not include the abnormal value as being normal for the patient. The abstraction guidance we reviewed on the previous slide requires the abnormal value, or term defined by the abnormal value, to be included in the physician/APN/PA documentation that considers the abnormal value to be normal for the patient, due to a chronic condition, or due to a medication. In this scenario, the PA documentation only refers to the bilirubin as high; it does not include the abnormal bilirubin value that is considered normal for the patient. So, you would use the bilirubin value of 2.4 to meet criteria C, organ dysfunction, when establishing severe sepsis.

This question asks: Would you use the abnormal INR value to establish *Severe Sepsis Present* organ dysfunction based only on the documentation below? On the lab report at 1600, there is an INR of 1.9. The APN note at 1645 that states: INR 1.9, last dose of warfarin at home this AM. No, do not use the INR value of 1.9 to establish organ dysfunction because the APN documentation includes the abnormal value and the medication in the same documentation. Let's take this another step further and look at further abstraction guidance in the *Severe Sepsis Present* data element that allows for SIRS criteria or a sign of organ dysfunction to be disregarded.

This abstraction guidance also allows for SIRS criteria or a sign of organ dysfunction to be disregarded if the SIRS criteria or sign of organ dysfunction is documented as due to an acute condition with a non-infectious source. We often receive questions related to this guidance where the abstractor is asking if an abnormal value can be disregarded if it's documented as due to a non-infectious source alone. However, it's important to point out here that this abstraction guidance is specific to documentation that the abnormal value is due to an acute condition and that acute condition has a non-infectious source or cause. Let's take a look at another scenario.

Here is an example scenario we often receive. Would you use the initiation of the BiPAP as a sign of organ dysfunction based only on the documentation below? The MD note states: BiPAP for increased work of breathing. O2 status improving.

Yes, because the BiPAP is attributed to the acute condition, the increased work of breathing, without further documentation of a non-infectious source or cause. As I mentioned on the previous slide, we often receive questions asking if the sign of organ dysfunction can be disregarded if it is documented as due to a non-infectious source. However, as demonstrated by this scenario, the BiPAP is attributed to the patient's increased work of breathing, but the documentation does not refer to the source or cause of the patient's increased work of breathing. So, the source or cause could be infectious, and you would use the initiation of the mechanical ventilation to meet criteria C, organ dysfunction. Since this same abstraction guidance applies to the SIRS criteria as well, let's take a look at another scenario involving SIRS criteria.

This question asks: Would you use the elevated heart rate as a SIRS criterion to establish *Severe Sepsis Present* if all three severe sepsis clinical criteria were met at 1800? The MD note at 1900 states: Pt. anxious and tachycardic. The MD note at 1910 states: Sedative ordered for anxiety related to PICC line placement. No, because the abnormal heart rate, defined as tachycardiac in this documentation, is documented with the acute condition, anxious, that has a non-infectious source, PICC line placement. You would disregard all the abnormal heart rate values based on this documentation because the term "tachycardic" is included in the documentation that the patient is anxious, and there is further physician documentation that the patient's anxiety is due to the PICC line placement. Based on this documentation, we can clearly establish that the abnormal heart rate is not due to an infectious source, which is why you would disregard the abnormal heart rates. Next, I will turn the presentation over to Jennifer to continue our discussion.

Jennifer Witt: Thanks, Noel. Let's continue with the guidance on this slide pertaining to when to select Value 2, No, for the *Severe Sepsis Present* data element based upon the physician/APN/PA documentation after the patient has met *Severe Sepsis*. This guidance allows for Value 2, No, to be selected when there is physician/APN/PA documentation at the same time or within 6 hours after the septic shock presentation time that indicates the patient

does not have sepsis, severe sepsis, septic shock, or that severe sepsis or septic shock was due to a viral, fungal, or parasitic infection. Often the questions we receive include documentation that severe sepsis or septic shock was not present, then the patient meets *Severe Sepsis* later. Let's take a look at several example scenarios.

We often see scenarios like this one where there is documentation reflecting the patient does not have severe sepsis documented before severe sepsis was met by clinical criteria or before the physician/APN/PA documented severe sepsis. This question asks: Would you select Value 2, No, for the *Severe Sepsis Present* data element based only on the documentation below? MD note at 1300 states: Appearing viral at this time rather than severely septic. At 1430, the physician note states: Influenza negative, possible severe sepsis. No, you would select Value 1, Yes, because the documentation indicating severe sepsis was not present is before the physician documentation of severe sepsis. As we can see in this scenario, the documentation reflects severe sepsis was not present or suspected to be present at 1300. However, at 1430, the physician's documentation reflects that severe sepsis is likely present, which is why we would not select Value 2, No, based on the documentation before the physician documented severe sepsis. Let's take a look at another scenario.

This question asks: Would you select Value 2, No, for the *Severe Sepsis Present* data element based only on the documentation below? At 2130, all three severe sepsis clinical criteria met. The MD note at 2200 states: Questionable severe sepsis. No, you would select Value 1, Yes, because the documentation after severe sepsis is met does not indicate the patient does not have severe sepsis. As I mentioned earlier, to select Value 2, No, the physician/APN/PA documentation after severe sepsis must reflect the patient does not have severe sepsis. Therefore, you would disregard the documentation reflecting severe sepsis was questionable after the patient has already met all three severe sepsis clinical criteria. Let's review one more of these scenarios.

This is a similar scenario with a slight difference. This question asks:

Would you select Value 2, No, for the *Severe Sepsis Present* data element based only on the documentation below? At 1530, all three severe sepsis clinical criteria were met. The MD note at 1800 states: Severe sepsis has been ruled out. Yes, select Value 2, No, because the documentation in the 6 hours after severe sepsis is met does indicates the patient does not have severe sepsis. As I mentioned, to select Value 2, No, you should look for physician/APN/PA documentation reflecting the patient does not have sepsis, severe sepsis, or septic shock. By stating severe sepsis was ruled out in this scenario, the documentation reflects the patient does not have severe sepsis. Now, let's move on to reviewing how to determine the *Severe Sepsis Presentation Date* and *Time*.

Another topic related to establishing the *Severe Sepsis Presentation Time* we frequently receive questions on is related to physician documentation of severe sepsis. The guidance on this slide address scenarios where severe sepsis is documented multiple times within the same note and states to use the earliest specified time. Let's take a look at another scenario.

This question asks: Which date and time would you use for the *Severe Sepsis Presentation Date* and *Time* based only on the documentation below? The MD note was opened 11/05/23 at 0900. It states: Suspect sepsis, severe at this point; antibiotics and labs ordered per protocol. Then, there is a list of current problems that includes documentation of severe sepsis. We see here severe sepsis is documented with a specific time stamp. You would use 11/05/2023 at 2215 for *Severe Sepsis Presentation Date* and *Time* because there is physician documentation of severe sepsis with a specified date and time. We are not using the note opened time of 0900 in this scenario because there is other physician documentation of severe sepsis in the note that has a specific time. Now, let's review the guidance specific to determining which time to use for narrative documentation of severe sepsis.

We frequently receive questions asking which time to abstract for the *Severe Sepsis Presentation Time* based upon physician/APN/PA documentation within a note. There are numerous possible scenarios and it's often difficult for us to determine because we do not have access to

complete medical records. However, the abstraction guidance on this slide provides a priority order for determining which time to use. I want to point out that this guidance will apply to every physician/APN/PA documentation of severe sepsis. So, if severe sepsis was documented once or multiple times within your medical record, you would determine the time for each narrative documentation of severe sepsis using this abstraction guidance. Then, you would abstract the earliest *Severe Sepsis Presentation Date* and *Time*. Let's take a look at one more scenario we frequently receive questions about that you can participate in answering.

Which date and time would you use for the *Severe Sepsis Presentation Time* if the MD note opened at 1500 and stated, "severe sepsis POA," A. Arrival Time or B. Note Opened at 1500. We'll give you a few more seconds to select your answer.

You would select B. Note Opened at 1500 because severe sepsis is documented as POA rather than documented as Present on Arrival. You would use the note opened time when severe sepsis is documented as POA because this abbreviation could refer to Present on Arrival or Present on Admission. Since this is not clear, you would use the note opened time in this scenario to establish the *Severe Sepsis Presentation Time*. Next, we are going to review one more topic that's often asked about when determining the *Severe Sepsis Presentation Time*.

We also frequently receive questions asking which date and time to use when severe sepsis or septic shock is documented as present on admission, or the documentation indicates the patient was admitted with severe sepsis or septic shock. Often the questions we receive are related to whether the physician documentation is acceptable for indicating the patient was admitted with severe sepsis or septic shock. The abstraction guidance on this slide allows for physician/APN/PA documentation that indicates the patient had severe sepsis or septic shock on admission to be acceptable for establishing the *Severe Sepsis Presentation Date* and *Time,* using the earliest of the four options included on this slide.

Let's take a look at several example scenarios. This question asks: If the MD documented, "Pt was admitted to the hospital three days ago with severe sepsis," which time would you choose for the *Severe Sepsis Presentation Time*? Is it the admit order at 0800, a disposition changed to inpatient at 0840, or arrival time to the inpatient floor at 0930? Select 0800 for the *Severe Sepsis Presentation Time* because severe sepsis is documented as present on admission, and the admit order at 0800 is the earliest of the acceptable times documented. As I mentioned when discussing the guidance on the previous slide, physician documentation indicating the patient was admitted with severe sepsis is acceptable, and you would use the earliest of the four time stamps provided in the guidance to determine the *Severe Sepsis Presentation Date* and *Time*. That is why we are using 0800 as the severe sepsis presentation time in this scenario. Let's take a look at another scenario.

This is a slightly different scenario where the physician documented the patient was admitted with septic shock, but the patient also met severe sepsis clinical criteria. The question asks: Which time would you use as the *Severe Sepsis Presentation Time* based only on the documentation below? At 1800, there is a disposition changed to inpatient. At 1830, all three severe sepsis clinical criteria were met. At 1845, there is an admit order. At 2230, the MD note says: Pt admitted with septic shock. You would use 1800 as the *Severe Sepsis Presentation Time* because the documentation indicates the patient was admitted with septic shock, and the admit order reflects the earliest presentation time available. So, although the patient met severe sepsis clinical criteria at 1830, we would continue to use the earlier time stamp for the disposition to inpatient because the physician's documentation states that septic shock was present when the patient was admitted to the hospital. Let's review another scenario.

This is another scenario that is frequently asked about because it includes documentation referring to severe sepsis, as well as the patient meeting severe sepsis clinical criteria. This question asks: Which time would you use as the *Severe Sepsis Presentation Time* based only on the documentation below?

At 0445, there is an admit order. At 0500, hospitalist note was opened, stating, "likely severe sepsis." At 0520, the hospitalist states, "impending severe sepsis." At 0530, all three severe sepsis clinical criteria were met. At 0630, the MD note states: Pt has a previous admission last year due to severe sepsis. You would use 0500 as the *Severe Sepsis Presentation Time* because this is the earliest severe sepsis presentation. So, we've established the correct answer, but let's look at this documentation in more detail. There is an admit order at 0445 and documentation at 0630 that includes the words "admission" and "severe sepsis." However, the documentation at 0630 is not stating or indicating the patient was admitted with severe sepsis. This documentation is referring to a previous hospital admission for severe sepsis which is why we did not use the time of the admit order to establish the severe sepsis presentation time. Then, there's the hospitalist note that was opened at 0500, and the note includes documentation of "likely severe sepsis" without a specific time and documentation of "impending severe sepsis" at 0520. We did not use the documentation of "impending severe sepsis" at 0520 to establish the presentation time because this is documentation of severe sepsis with a negative qualifier . Then, the severe sepsis clinical criteria were met at 0530, which would be acceptable for establishing the presentation time, except there is an earlier presentation time available based on the physician's documentation of "likely severe sepsis" at 0500. I want to point out that the documentation at 0520 stating "impending severe sepsis" is NOT similar to what we discussed earlier regarding when to select Value 2, No, for the *Severe Sepsis Present* data element. Documentation of severe sepsis or septic shock with a negative qualifier such as "impending" would simply be disregarded, meaning you would not use it. Again, the guidance for selecting Value 2, No, after severe sepsis has been met states to select Value 2, No, when there is physician documentation that the patient does not have sepsis, severe sepsis, or septic shock. While some negative qualifiers may reflect the patient does not have severe sepsis or septic shock, negative qualifiers such as "impending," "questionable," or "risk for" would not be used to select Value 2, No, for the *Severe Sepsis Present* data element.

Next, we are going to use a few scenarios to determine the *Severe Sepsis Presentation Date* and *Time* based on meeting clinical criteria. We are going to walk through several scenarios where we will determine which clinical criteria will be used to determine the *Severe Sepsis Presentation Date* and *Time*. These are the type of scenarios we frequently see in the questions submitted by abstractors. There's a lot of information on the next few slides, so feel free to go back after the presentation to review as needed. So, let's work through a few of these. This first scenario asks: What time would you use for the *Severe Sepsis Presentation Date* and *Time* based on this information? The nurse note on 12/10/2023 at 1500 states: Possible sepsis pt. The vital signs flowsheet on 12/10/2023 at 1600 has T: 101.5; HR: 112; RR: 25; BP: 84/51. Use 12/10/2023 at 1600 as the *Severe Sepsis Presentation Date* and *Time* because all three clinical criteria were met by 12/10/2023 at 1600. This scenario is straightforward because we can clearly see the infection documentation, along with the SIRS criteria and sign of organ dysfunction. So, let's look at another scenario that's slightly more complex.

This is a similar scenario, but there is further physician documentation found in the medical record regarding the organ dysfunction. This scenario asks: What time would you use for the *Severe Sepsis Presentation Date* and *Time* based on this information? The PA note on 09/10/2023 at 0700 states: Rule out PNA. The vital signs flowsheet on 09/10/2023 at 0600 has T: 101.1; HR: 88; RR: 23; and BP: 84/48. A POC lactate result at 09/10/2023 at 0730 was 2.5. The hospitalist note on 09/10/2023 at 2100 states: Hypotension related to dehydration due to poor PO intake. You would use 09/10/2023 at 0730 as the *Severe Sepsis Presentation Date* and *Time* because the abnormal blood pressure at 0600 was disregarded, and the last clinical criterion was met by 09/10/2023 at 0730. In this scenario, there is a hypotensive reading at 0600 which would allow for an earlier severe sepsis presentation time based on the other criteria met at 0600 and 0700. However, later that day, a physician documentation that the hypotension was due to an acute condition, dehydration, with a non-infectious source, poor PO intake). So, we would disregard the abnormal blood pressure reading at 0600 and continue reviewing for another sign of organ dysfunction.

That is why we are using 0730 as the severe sepsis presentation in this scenario because an abnormal lactate count is identified at that time. Keep this scenario in mind and let's look at another question.

With the last scenario in mind, where the Point of Care lactate result was used to establish the *Severe Sepsis Presentation Date* and *Time*, this question asks: If the following Point of Care lactate result times are documented, which time would you choose for the lactate result? The RN note states: POC lactate 2.5 with a note opened time of 0645. The Point of Care lactate collection time was at 0720. There is a physician note that states: Point of Care lactate 2.5 at 0730. The flowsheet has a lactate of 2.5 at 0715. Use the time from the physician note, 0730, for the Point of Care lactate result time to establish the *Severe Sepsis Presentation Time* based on the priority order listed in the *Severe Sepsis Present* data element. Let's take a look at another scenario.

This is another scenario we frequently see. I understand there's a lot of information on this slide, but this is typical for the scenarios we receive questions on. This question asks: What time would you use for the *Severe Sepsis Presentation Date* and *Time* based on this information? The ED MD note on 11/20/2023 at 1800 states: Hx COPD, A-fib. The RN note on 11/20/2023 at 2030 states: Likely infectious source causing symptoms. The EMS flowsheet on 11/20/2023 at 1745 has T: 99.5; a RR: 26; HR: 111; BP: 109/70. Lab results on 11/20/2023 at 2130 include WBC of 15 and a creatinine of 2.5. A cardiologist note on 11/21/2023 at 0800 states: A-fib with tachycardia. You would use 11/20/2023 at 2130 as the *Severe Sepsis Presentation Date* and *Time* because the last clinical criterion was met by this time. You would disregard the abnormal heart rate due to the physician documentation attributing the abnormal heart rate to the chronic condition. As I mentioned, there's a lot going on in this scenario, but we can see there is physician documentation stating A-fib is a chronic condition for the patient, and we can see there is physician documentation attributing the tachycardia to the A-fib. Therefore, we would disregard the abnormal heart rates.

Then, based on the infection documentation, other SIRS criteria met, and the sign of organ dysfunction met on 11/20/2023 at 2130, we would use that date and time to establish the severe sepsis presentation time.

That concludes our review of the *Severe Sepsis Present* and *Severe Sepsis Presentation Date* and *Time* data elements. 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 an existing question and answer, 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 the Q&A you are referencing is in agreement with the current manual guidance based on the discharge period you are abstracting. We are 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 Quality 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 will select the program. For abstraction questions for the SEP-1 measure, select Inpatient Measure 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 re-routed to the correct support team. So, for the 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 the data elements that are included in the SEP-1 measure.

The next required field is the Discharge Period. It is 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 in 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 are 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.

That concludes our presentation. Donna, I will turn it back over to you.

Donna Bullock: Thank you, Noel. We have time now for a few questions that have come in during the webinar. This is our first question: I have a patient that comes through the ED, and they do not meet for severe sepsis clinical criteria. The ED provider gives them a severe sepsis diagnosis, then the admitting hospitalist gives them a sepsis diagnosis (not severe) in their history and physical after being admitted. Does this exclude them from the severe sepsis diagnosis, or does the admitting provider have to document that severe sepsis is ruled out to be able to exclude them from severe sepsis?

Noel Albritton: Thanks, Donna. This is Noel. I'll take that. So, the physician documentation, within six hours after the severe sepsis presentation time, must refer to severe sepsis as not present to select Value 2 and exclude the case. So, if severe sepsis is met, and the ED physician only added sepsis to the final diagnosis, you would continue to select Value 1, Yes, for the *Severe Sepsis Present* data element. If the ED physician, within six hours after meeting severe sepsis, said sepsis not severe in the medical record,

then you would select Value 2, No, for the *Sepsis Present* data element because,= that's saying severe sepsis is not present after severe sepsis was already met.

Donna Bullock: Thanks, Noel. Here's another question. This one's kind of long. Regarding slide 15, the manual says that we use the administration time of the antibiotics as an infection source. It says that the administration must be within six hours; physician/APN/PA, nursing, or pharmacist documentation indicating a patient is receiving an IV or IO antibiotic for an infection; and that antibiotic is documented as administered within six hours of criteria B and C is acceptable. Example: Levaquin is documented in MAR for pneumonia, and nursing documentation within six hours of Criteria B and C, indicates the antibiotic was given. Can you clarify why the slide is asking us to use the note time of the documentation, instead of the administration time?

Noel Albritton: Yeah, This is Noel, again. I'll take that. The bullet point or abstraction guidance that was mentioned in the question is related to documentation of an infection. Slide 15, I believe, is what the question mentioned. That slide is talking about documentation of an inflammatory condition or sign or symptom of infection. So, that's the difference in which time to abstract for your infection documentation. If the antibiotic was ordered for an infection, so if it was ordered for pneumonia, UTI, whatever, infection, then you could use the time that antibiotic was administered to meet criteria A. Yet, on slide 15, that guidance is specific to inflammatory conditions and sign or symptom of an infection, with an antibiotic ordered for either of those. So, you would use the time of that documentation to meet criteria A or determine your time for criteria A infection, rather than using the time of the antibiotic administration. Hopefully, that's clear.

Donna Bullock: OK. The next question pertains to slide 12 and 13. Please explain the difference between them. Is it because the word used "likely UTI" in the first set of documentation with open note time? The positive qualifier table states for documentation of infection "likely" is a positive qualifier.

Noel Albritton: Yes. This is Noel, again.

We kind of talked about this while we were discussing that slide. The documentation of "likely" UTI would be acceptable for meeting criteria A and establishing this for sepsis presentation time, if criteria B and C were within six hours of that documentation. So, that was the issue on, I believe, slide 13. The documentation of UTI and the time associated with that was not within six hours of the SIRS criteria and sign of organ dysfunction. That's why "likely" UTI in that example wasn't used to meet criteria, just based on the timing of all three clinical criteria.

Donna Bullock: Thanks, Noel. Our next question: I have reviewed the slides, and I have a question about infections. Most of antibiotic orders include questions about why the antibiotic is being given. For example, most orders will read, "ordered for empiric treatment, suspected GU or GI, respiratory order." Is that sufficient to document suspicion of an infection?

Noel Albritton: This is Noel, again. The antibiotic ordered for, let's just say, empiric treatment without any further documentation of actual infection, so empiric treatment for GU or GI or respiratory, no, you would disregard that documentation. You would not use it to meet criteria A because an infection is not mentioned in the order. If the order included an indication, like, empiric treatment for pneumonia or empiric treatment for an infection, then you could use the documentation to meet criteria A because the indication includes an infection. Regardless of that saying empiric, it still includes the infection documentation. So, it just depends on if it's only empiric treatment documented or if it includes an infection. Hopefully, that helps.

Donna Bullock: Thank you. Next question: Is "mild lactate elevation" acceptable to use as a term word, or must I see "lactic acidosis"?

Noel Albritton: This is Noel, again. So, mild lactate elevation, you would not use that as a term defined by the abnormal value. So, if you saw a mild lactate elevation, due to whatever, you would disregard that documentation, and just continue using the abnormal lactate value.

To disregard the abnormal value, either the abnormal value itself or a term like "lactic acidosis" or a term that is defined by the abnormal value, it would need to be documented as due to the chronic condition, medication, etc.

Donna Bullock: Thank you, Noel. Someone would like to confirm that this webinar covers July 1, 2023, through December 31, 2023, not, January 1, 2024, through June 30, 2024.

Noel Albritton: Yes, that's correct. In this webinar, we're using manual Version 5.14a, which applies to discharges for July 1 through December 31, 2023.

Donna Bullock: Great, thank you. Here's our next question. If a patient has a history of HIV and they come in with an infection unrelated to HIV, for example an UTI, are they automatically excluded because of their HIV status? What about if they have PCP pneumonia?

Noel Albritton: This is Noel. No, a case would not be automatically excluded based on history or diagnosis of HIV. The measure doesn't include any exclusion based on HIV. So, you would continue, in that case, to use whatever infection documentation and clinical criteria are met to determine if severe sepsis was present and the presentation date and time. As far as you said, pneumonia, that would be the same as well. You would use documentation of pneumonia regardless of a history of HIV.

Donna Bullock: Thank you, Noel. Here's our next question. 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?

Noel Albritton: This is Noel, again. So, that's a good question. Initial hypotension was not present, then they met septic shock by a lactate of 5.8. So, to reach the *Persistent Hypotension* data element in the algorithm, you would either have to have initial hypotension or septic shock, and then administer crystalloid fluids. You can reach persistent hypotension without having initial hypotension because persistent hypotension evaluates whether

hypotension was president 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. So, in this case, you would select Value 2, No, for *Initial Hypotension*. The case would still proceed to the *Septic Shock Present* data element. Then, following that, you would evaluate *Crystalloid Fluid Administration*. Then, you would continue on to the *Persistent Hypotension* data element and determine if hypotension persisted after the patient received fluid resuscitation. So, the *Persistent Hypotension* data element is not dependent on whether initial hypotension was present or not. Those two are separate data elements. I guess, for lack of better words, they are used in different ways. They are four different things within the measure.

Donna Bullock: Great. Thank you, Noel. Our next question: What if the provider orders an antibiotic, but it does not include the reason in the order? Can that be used?

Noel Albritton: This is Noel, again. So, you just have an order for an antibiotic and no reason or indication. No. So, as far as determining criteria A, infection, you would not use an antibiotic ordered without any reason or indication for an infection to establish criteria A. So, if it just had IV Vanco with dosage and all of that, you would not use it for establishing criteria A. However, if it included IV Vanco dosage, an indication for pneumonia, or whatever infection, then that antibiotic order and antibiotic administration times could be used to determine criteria A.

Donna Bullock: OK. Here's another antibiotic question. If an antibiotic is given for prophylaxis, can it still be abstracted as infection time?

Noel Albritton: No, this would be, I guess, similar to the previous question. If there's not documentation or an indication, reason, for the antibiotic, that is an infection, or documentation that the antibiotic is being ordered for an inflammatory condition or sign or symptom of infection, then you would disregard it.

So, if the antibiotic only had an indication or reason as prophylaxis, then you would disregard that and not use it to establish criteria A.

Donna Bullock: Thanks, Noel. Someone would like to know where to get a list of all possible organ dysfunctions that would meet the criteria.

Noel Albritton: Sure. For the measure, the organ dysfunction and all the criteria used to establish severe sepsis are in the *Severe Sepsis Present* data element. If you go to the QualityNet website that we have linked here in the presentation, you can find the specifications manual. Within that, you can find the *Severe Sepsis Present* data element. That will include a list or table of all the organ dysfunction criteria that are acceptable for establishing *Severe Sepsis* for the measure.

Donna Bullock: OK. Next: In the absence of documentation of when mechanical ventilation is initiated, would you use the first time a ventilator set and the flow sheet as a start time?

Noel Albritton: This is a good question and one we see pretty often, as well. The short answer is no. Further guidance in the data element would only use the documented start time, place time, or very similar time stamp indicating when the mechanical ventilation was first started on the patient. If that time is not available, or your medical record doesn't have that time documented for whatever reason, then you would disregard the mechanical ventilation, not use it to establish organ dysfunction, and look for other criteria to establish organ dysfunction. You would not revert to the first time the ventilator settings were set or changed or any other time stamp. You would only use the document and start time, place time for that mechanical ventilation to meet Criteria C.

Donna Bullock: Thanks, Noel. Our next question: Can you speak to lab testing, with an indication of "suspected COVID"? Do we select Value 2 to *Severe Sepsis Present* for these situations?

Noel Albritton: So, if there is physician/APN/PA documentation of suspected COVID, and I assume that when you refer to lab testing that we're talking about COVID PCR test orders and that order has an indication for suspected

COVID, as long as it is physician/APN/PA documentation of suspected COVID, you would select Value 2 for the *Severe Sepsis Present* data element, which will exclude the case from the measure. If there was not physician/APN/PA documentation, for example, if it was lab, nursing, or just anything other than physician/APN/PA documentation, then you would disregard it and continue abstracting.

Donna Bullock: Thank you. OK. Got some more, another virus question. The patient has the flu, but he also has another non-viral source of infection. Can we still abstract these charts?

Noel Albritton: Yes. The short answer is yes. A diagnosis or documentation of the flu alone, or it could be RSV or any of those infections outside of COVID-19 and coronavirus, would not cause the case to be excluded from the measure. You would continue abstracting, establishing severe sepsis, per extraction guidance. The only time that it would exclude the case from the measure is if severe sepsis was met. Then, at the same time, as meeting severe sepsis, or within six hours after that, if there was physician documentation that severe sepsis or septic shock was due to the flu or whatever, other viral infection, then you would select Value 2, No, for this *Severe Sepsis Present* data element. That would exclude the case. Otherwise, you would disregard the documentation of the flu.

There is one other scenario that I can mention when you're establishing criteria A, infection. Let's say sepsis was documented and that was going to meet criteria A. Then, within six hours after, that was documented, there was physician documentation that sepsis was due to the flu. Then, you would disregard, not use that initial documentation of sepsis. That guidance is also in the *Severe Sepsis Present* data element under criteria A, if you would like to see that. Otherwise, I think that's the only places where documentation of flu or viral infection outside of coronavirus or COVID-19 would apply.

Donna Bullock: OK. Thank you, Noel. The provider documents this: "There is a concern for COVID-19." Would this case be excluded?

Noel Albritton: Yes. So, the physician documentation, physician/APN/PA documentation, of the concerns for COVID-19 would allow you to select Value 2, No, for the *Severe Sepsis Present* data element, and that would exclude the case based on reflecting that COVID-19 is possible and suspected to be present.

Donna Bullock: OK. Here's our next question. It's short. Is "sepsis, severe" the same as severe sepsis?

Noel Albritton: As far as abstracting the measure, it would be abstracted the same. So, whether the physician documentation said, "severe sepsis" or "sepsis, severe," you would abstract. You would select a Value 1, Yes, for the *Severe Sepsis Present* data element based on either of those, since both reflect that severe sepsis was present.

Donna Bullock: OK, great. If a patient meets criteria for severe sepsis, then it is documented that the patient does not have severe sepsis, would you stop abstracting, or would you continue to look for a subsequent episode of severe sepsis during the hospitalization?

Noel Albritton: This is Noel, again. So, if severe sepsis was met, then, there is physician/APN/PA documentation that the patient did not have severe sepsis within six hours after meeting severe sepsis, then you would select Value 2, No, for the *Severe Sepsis Present* data element, and that would exclude the case. So, abstraction could stop at that point. You would not continue abstracting for a later *Severe Sepsis Presentation Time* for the measure. You would only use the earliest severe sepsis presentation time, and, in that case, the patient met severe sepsis. Then, within six hours later, the physician says, "Severe sepsis was not present." You would select Value 2 and exclude the case from the measure.

Donna Bullock: Thank you, Noel. We only got time for a couple more questions. 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?

Noel Albritton: So, you would always use the earliest severe sepsis presentation time. So, if, the clinical criteria were met at 1300, and then there was physician documentation of severe sepsis at 1400, you would use 1200 as the *Severe Sepsis Presentation Time* because that's the earliest presentation time. You would just disregard that later physician documentation of severe sepsis because it wouldn't be necessary to meet severe sepsis at that point.

Donna Bullock: OK. This might be our last question. If the patient is in non-violent restraints, with the restraint justification in the order by the provider stating, "Behavior interfering with medical care" or "dislodgment of tubes, lines," would the data element *Administrative Contra Indication to Care Severe Sepsis* meet the criteria to answer Yes?

Noel Albritton: This is Noel, again. Yes. Based on the documentation in the order for the restraints, you would select Value 1, Yes, for the *Administrative Contra Indication to Care* 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. We see quite a few of those questions also that come through the QualityNet Q&A tool. For that question, if it was only a restraint order that didn't include patient non-compliance in the order, then you would not use it to select Value 1. Yet, in that case, and the question, where you have the documentation of patient non-compliance that's clearly documented, then you would select Value 1, Yes, for the *Administrative Contra Indication to Care* data element.

Donna Bullock: Thank you, Noel. That is all the time we have for questions today. If we didn't get to your question, you may send it to the sepsis team via the QualityNet Question and Answer Tool using the process Noel previously demonstrated. Next slide, please.

This webinar has been approved for 1.5 continuing education credits. If you registered for today's event, you will receive an email within two business days. This email provides a link to the webinar survey and information about how to obtain your certificate. If you did not register for the webinar, you can obtain this email from someone who did.

More information about our continuing education processes can be found on the Quality Reporting Center website. Just click the link provided on this slide. That concludes today's event. Thank you very much for attending, and we hope you enjoy the rest of your day!