



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) v5.13 Review & Updates
Presentation Transcript**

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Donna Bullock: Welcome to today's presentation: *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.13 Review & Updates.*

My name Donna Bullock, and I will be your moderator. 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 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. A transcript of the presentation, along with a question-and-answer summary, will be posted to the website, QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a link to the slides was sent out a few hours ago. If you did not receive that email, you can download the slides. Again, that website is www.QualityReportingCenter.com. This webinar has been approved for 1.5 hours of continuing education credit. At the end of today's event, we will display a survey link in the chat section.

The purpose of today's event is to clarify the changes and outline the rationale behind the updates to the SEP-1 measure and guidance in version 5.13 of the specifications manual and 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 5.13 of the specifications manual to ensure successful reporting for the SEP-1 measure.

This is just 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 & Answer Tool](#) at the link on this slide. If your question is about a specific slide, please include the slide number.

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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. Thank you for joining us. Today, we will review the guidance for the SEP-1 measure in specifications manual version 5.13. We will review guidance that was updated in manual version 5.13, as well as review guidance that is frequently asked about. Updated guidance to the manual is noted in yellow highlight throughout the 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 by reviewing the abstraction guidance for the *Transfer From Another Hospital or ASC* data element. We often receive questions asking if Yes should be selected for this data element if the patient was received as a transfer from an outside free-standing drug or alcohol rehab or treatment facility. The guidance on this slide provides the acceptable locations for a patient to transfer from to select Yes for the data element. All of these facilities reflect locations that may initiate treatment for severe sepsis or septic shock that may impact the ability of the hospital receiving the patient to pass the measure, which is why patients received as a transfer from these facilities are excluded from the measure. Since treatment for severe sepsis and septic shock is generally not initiated in drug or alcohol treatment facilities, these facilities are not included in the guidance on this slide. Therefore, you would select No for the *Transfer From Another Hospital or ASC* data element if the patient was received from an outside free-standing drug or alcohol treatment facility.

Next, let's take a look at the abstraction guidance in the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. This guidance was not updated in manual version 5.13. However, we are reviewing this guidance because we often receive questions about whether patients documented as pregnant should be excluded from the measure or whether the clinical

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criteria should be disregarded when establishing severe sepsis. Selecting Value “1” (Yes) for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element does not exclude the case from the measure. The measure does not exclude patients based on pregnancy or post-partum status. Rather, the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element is used to determine which clinical criteria to apply when determining if severe sepsis was present. If you select Value “1” (Yes) based on the patient being 20 or more weeks pregnant or within 3 days post-delivery at the severe sepsis presentation time, you would use the specific clinical criteria included in the *Severe Sepsis Present* data element for these patients. Similarly, if you select Value “2” (No) for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element, you would use the clinical criteria in the *Severe Sepsis Present* data element that is specific to non-pregnant patients. Next, we are going to look at the updates for the *Severe Sepsis Present* data element in version 5.13.

The *Severe Sepsis Present* data element received several updates in manual version 5.13 that we will review. Let’s begin with the updated abstraction guidance on this slide which states, “If documentation of an infection is ‘superscripted’ or footnoted, use the specified time of the ‘superscript’ or footnote.” Based on this guidance, if you find an infection documented within a note that is superscripted or footnoted, you would use the specified time associated with the superscript or footnote for the time of the infection documentation. This guidance was added to the *Severe Sepsis Present* data element for clarification as well as to make it more readily available during abstraction of specific data elements. The Introduction to the Data Dictionary has included similar guidance which has allowed superscripted and footnoted time stamps to be used. However, we found that many abstractors continued to question the specific use of superscripts and footnotes. Therefore, this guidance was added to multiple data elements which we are reviewing during today’s presentation. Let’s take a look at an example scenario.

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This question asks: Which date and time would you use for the infection documentation to meet *Severe Sepsis Present* criteria A (infection) based on the below documentation? In the MD note that was opened on 01/13/2023 at 1800, there is documentation: “Pending labs and cultures, pt continues to have fever, deep cough, tachycardia, suspected sepsis.” There is a superscript for TS.3. We can see the time stamps associated with the superscripts, and, for TS.3, the date is January 13, 2023, at 1912. So, use 01/13/2023 at 1912 as the specified date and time for the infection documentation because the physician’s documentation of sepsis includes the superscript TS.3.

Also updated in manual version 5.13 was the abstraction guidance for using an antibiotic ordered for an inflammatory condition or sign or symptom of an infection. The updated 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 updated guidance now includes IV and IO antibiotic orders because the measure is specific to inpatient severe sepsis and septic shock patients and does not use oral antibiotic administration when meeting the criteria of the measure. This guidance also specifies an antibiotic ordered for these conditions or signs or symptoms of an infection because criteria A for the *Severe Sepsis Present* data element is attempting to establish the presence of an infectious source for severe sepsis. The order of an IO or IV antibiotic for inflammatory conditions or signs or symptoms of an infection is used to support the presence of an infection. Next, you can participate in following Knowledge Check question.

Would you use this APN documentation: “Appendicitis, ordered IV Unasyn, awaiting OR consult” to establish criteria A (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. The documentation states the antibiotic was ordered for the appendicitis which could be an infectious or non-infectious inflammatory condition. The antibiotic order establishes that the APN considers this to be infectious.

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If the documentation did not refer to the antibiotic being ordered for the inflammatory condition, 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 ordered for the condition to establish criteria A. Again, the order for an IV or IO antibiotic for inflammatory conditions or signs or symptoms of an infection is used to support the inflammatory condition is infectious or the presence of an infection.

Next, let's review the clinical criteria for establishing severe sepsis when Value "1" is selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. As I mentioned earlier, patients that are pregnant or post-partum are not excluded from the measure. Rather, you would use the guidance on this slide to determine which clinical criteria to apply when determining if severe sepsis was met by clinical criteria. The table on this slide from the *Severe Sepsis Present* data element provides SIRS criteria values based on non-pregnant patients and pregnant 20 weeks through day 3 post-delivery patients. You can see, for example, you would use a respiratory rate greater than 20 for non-pregnant patients, but, if the patient was 20 weeks or more pregnant or within 3 days post-delivery at the time of severe sepsis presentation, you would only use the respiratory rate if it was greater than 24.

Let's review a couple scenarios that include a pregnant patient. This question asks: "Would you use the heart rate as a SIRS criterion based only on the information below?" The MD note states the patient is 28 weeks pregnant. On the vital signs flowsheet, we can see the heart rate is 122. Yes, because the patient is 28 weeks pregnant which qualifies them for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element that includes the high heart rate threshold greater than 110, and the heart rate of 122 in this scenario exceeds the threshold.

Let's review another similar scenario. This documentation is similar, and the question also asks: "Would you use the heart rate as a SIRS criterion based only on the information below?" The MD note states the patient is 28 weeks pregnant. On the vital signs flowsheet, we now see the heart rate is 109.

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In this scenario, the answer is No. We would not use the heart rate because the patient is more than 20 weeks pregnant, and the heart rate of 109 is less than 110. So, we did not exclude the patient due to pregnancy, rather we used the clinical criteria specific to patients 20 weeks pregnant through day-3 post-delivery to establish severe sepsis by clinical criteria. Although the heart rate of 109 is acceptable for meeting SIRS criteria for non-pregnant patients, you would not use the heart rate of 109 in patients 20 or more weeks pregnant or post-partum.

Similar to the guidance for the SIRS criteria, the organ dysfunction criteria also distinguishes which values to use based on non-pregnant versus pregnant 20 weeks through day 3 post-delivery patients. As we discussed with the SIRS criteria guidance, you would use the columns for non-pregnant and pregnant 20 weeks through day 3 post-delivery containing the organ dysfunction values. Again, pregnant patients are not excluded from the measure, rather you would use the values in the table on this slide to determine if criteria C, organ dysfunction, was met.

This slide contains the remainder of the table that includes criteria for establishing organ dysfunction. Again, you will notice some of the values for pregnant 20 weeks through day 3 post-delivery patients are different, such as the creatinine value. A creatinine value greater than 1.2 in pregnant 20 weeks through day 3 post-delivery patients would be acceptable for criteria C, but you would continue to only use creatinine values greater than 2 in non-pregnant patients. Let's review another scenario regarding these criteria.

This question asks: "Would you use the systolic blood pressure reading as a sign of organ dysfunction based only on the information below?" The progress note states the patient is 30 weeks pregnant. On the vital signs flowsheet, we can see the systolic blood pressure is 87. The answer is No. The patient is 30 weeks pregnant which qualifies them for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* criteria; therefore, the hypotension threshold is less than 85, and this systolic pressure of 87 is above that threshold. Let's take a look at another scenario.

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This question asks, “Would you use the creatinine value as a sign of organ dysfunction based only on the documentation below?” The PA notes: “Patient is a 34-year-old female, presents 36 weeks pregnant, complains of lower back pain and fevers.” In the lab results, there is a creatinine result of 1.5. Yes, because the patient is 36 weeks pregnant which qualifies them for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* criteria. The elevated creatinine threshold is greater than 1.2, and this creatinine result of 1.5 exceeds the threshold.

We frequently receive questions regarding documentation of A-fib and whether the abnormal heart rate should be used to meet severe sepsis clinical criteria in those cases. So, let’s review a couple examples involving documentation of A-fib. First, the abstraction guidance on this slide continues to allow you to disregard an abnormal SIRS or organ dysfunction value if the abnormal value is documented by the physician/APN/PA as normal for the patient, due to a chronic condition, or due to a medication. The example on the slide is also included in the *Severe Sepsis Present* data element and includes documentation of chronic A-fib with RVR, along with the instruction to not use the abnormal heart rate based on this documentation. Let’s review another example.

This question asks: “Would you use a heart rate of 120 documented in the vital sign flowsheet of a SIRS criterion based only on the documentation below?” The physician note states, “History of chronic A-fib and prostate cancer.” Yes, you would use the elevated heart rate to meet SIRS criteria because the elevated heart rate is not documented as due to the chronic condition. The documentation of chronic A-fib alone does not meet the guidance to disregard the abnormal heart rate. Per the guidance, SIRS criterion or sign of organ dysfunction, in this case the abnormal heart rate, must be documented as due to the chronic condition to disregard the abnormal value.

Next, you can participate in following Knowledge Check question. Would you use the elevated heart rate value as a SIRS criterion based only on the documentation below?

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On 1/5/22 at 0500, H&P states a history of A-fib. At 1300, on the vital signs flowsheet, there is a heart rate of 137. Then, at 1600, the APN note states, “EKG A-fib with RVR.” A. Yes or B. No. We’ll give you a few more seconds to select your answer.

Select B. No. The term RVR is documented as due to A-fib, and A-fib is a chronic condition for the patient. In this scenario, A-fib is a chronic condition for the patient based on the physician/APN/PA documentation in the H&P. Then, the APN documents the abnormal heart rate is due to A-fib at 1600. So, you would not use any of the abnormal heart rates based on this documentation.

Next for the *Severe Sepsis Present* data element, another non-invasive form of mechanical ventilation was added for manual version 5.13. The guidance now includes initiation of average volume-assured pressure support, or AVAPS, as acceptable for meeting criteria C, organ dysfunction.

Additionally, for the guidance pertaining to mechanical ventilation, a new example was added to assist with clarifying frequently asked questions related to determining the time of organ dysfunction based on mechanical ventilation. This new example states: “Intubation Flowsheet: ET placement at 0800. Respiratory Flowsheet: Parameters and vent settings/alarms documented at 0815. Respiratory Therapist note at 0840: Patient intubated and placed on mechanical ventilation at 0830.” Use 0830 as the time when mechanical ventilation was started. The intubation time or time of the vent settings would not be used as the time mechanical ventilation was started or initiated. It’s important to call out here that the guidance on this slide states to use the time mechanical ventilation was started. We frequently receive questions asking about using the time of intubation to establish organ dysfunction. However, you would not use the time of intubation to establish criteria C, organ dysfunction, because the guidance specifically refers to using the start time of mechanical ventilation.

Also, from the *Severe Sepsis Present* data element, the example on this slide received a slight update in manual version 5.13.

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Previously, the example stated, “Cr elevated secondary to dehydration...” However, the guidance requires the SIRS criteria or sign of organ dysfunction be documented as due to the acute condition with a non-infectious source. So, the updated example now includes the abnormal value that is documented as due to the acute condition with a non-infectious source.

The guidance on this slide was not updated in version 5.13. However, we continue to receive questions pertaining to this guidance. This guidance states: “Physician/APN/PA documentation of a term that is defined by a SIRS criteria or sign of organ dysfunction is acceptable in place of an abnormal value when the term is documented as normal for the patient, due to a chronic condition, a medication, acute condition, acute on chronic condition, or due to an acute condition that has a non-infectious source/process.” The examples are included on the next slide.

The examples are split into non-pregnant and pregnant 20 weeks through day-3 post-delivery, but the important thing to note here is that all of these terms are defined by a specific abnormal value. For example, tachycardia defines a specific heart rate that is greater than normal. However, we often receive questions asking if the heart rate can be disregarded if the documentation states “elevated heart rate due to medication” or similar. 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. Let’s take a look at an example scenario to clarify.

This question asks: “Would you use the systolic blood pressure reading for organ dysfunction based only on the documentation below?” MD note states, “Patient’s daughter states her mom’s blood pressure runs low.” On the vital signs flowsheet, we see the blood pressure of 79/43. Yes. The documentation does not include the abnormal value or a term that is defined by an abnormal value, such as hypotension, is normal for the patient. To not use the systolic blood pressure of 79, the physician’s documentation must include the abnormal value, such as 79, or a term that is defined by an abnormal value, such as hypotension.

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Next, the guidance for conflicting documentation was updated in manual version 5.13 to address scenarios where the SIRS criterion or sign of organ dysfunction is documented as normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source and documented as due to an acute condition, acute on chronic condition, infection, severe sepsis, or septic shock. This update was based on questions received from abstractors pertaining to cases with conflicting documentation that specifically included an acute condition or acute on chronic condition. Let's take a look at an example of this scenario.

This question asks: "Would you use the blood pressure of 82/57 documented at 1500 to establish organ dysfunction based on the physician documentation below that is within 24 hours after the *Severe Sepsis Presentation Time*?" The H&P at 1700 states, "Chronic hypotension on PO midodrine at home." The consult note at 1930 states, "Upon arrival to the ICU, she was hypotensive with systolic readings in the 80s. Impression is acute on chronic hypotension." Yes. There is conflicting documentation in separate sources, and the latest documentation attributes the hypotensive readings to an acute on chronic condition. From the previous slide, when there is conflicting documentation in separate sources, you would use the latest documentation before the *Severe Sepsis Presentation Time* or within 24 hours after the *Severe Sepsis Presentation Time*. As you can see on this slide, there are separate pieces of documentation. One states the hypotension is chronic, and the other states hypotension is due to an acute on chronic condition. Based on the updated guidance on the previous slide, you would use the hypotensive readings because the later documentation at 1930 attributes the hypotension to an acute on chronic condition.

The guidance on this slide provides the order of priority and the updated primary source to use. It states the laboratory test value result time from lab. Other time stamps intended to identify the result time from the lab are acceptable with a terminology reference such as a policy, key, or legend. Many of you have submitted questions asking if a verified time stamp can be used as the result time from the lab to meet this primary source.

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The guidance intentionally does not include the verified time stamp, specifically because we have received feedback that hospitals use this time stamp in various ways other than specifically for the lab result time. However, some of you have mentioned in your questions that your facility uses a verified time stamp, or similar, as the result time from the lab. Based on that information, this guidance was updated to allow for other time stamps your facility may use to identify when a lab resulted. Since time stamps, such as a verified time, may have other implications, this guidance allows you to use that time stamp during abstraction of the labs if there is a terminology reference.

New guidance was also added to the *Severe Sepsis Present* data element in manual version 5.13 to address physician/APN/PA documentation of severe sepsis and septic shock. This new guidance states, “Do not use physician/APN/PA documentation of a severe sepsis or septic shock exam or assessment being performed.” Examples include: “Severe sepsis exam completed.” “Septic shock reassessment done.” Based on this new guidance, you would not use physician/APN/PA documentation of severe sepsis or septic shock to select Value “1” (Yes) when the documentation only refers to the exam or assessment being performed. This guidance was added because this type of physician/APN/PA documentation of severe sepsis or septic shock is referring to the exam or assessment being performed, rather than referring specifically to severe sepsis or septic shock as being present or possibly present.

You will also notice in manual version 5.13 that updates were made to the positive and negative qualifiers table. “Suggestive of” and “presumed” were added to the positive qualifiers. “Monitor,” “query,” and “less likely” were added to the negative qualifiers. The guidance for this table continues to state, ‘For documentation of an infection, severe sepsis, or septic shock accompanied by a qualifier, use the table. Use documentation containing a positive qualifier to meet criteria. Do not use documentation containing a negative qualifier to meet criteria. Do not use documentation containing both a positive and negative qualifier to meet criteria.’”

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Lastly, for the updates to the *Severe Sepsis Present* data element, sepsis with shock was added to the inclusion guidelines for abstraction of severe sepsis. Moving forward, physician/APN/PA documentation of sepsis with shock is acceptable for selecting Value “1” (Yes) for the *Severe Sepsis Present* data element.

Moving onto the *Severe Sepsis Presentation Date and Time* data elements, new guidance was added to the notes for abstraction to clarify the abstraction of documentation with a superscript or footnoted time stamp. This guidance states, “If documentation of severe sepsis or septic shock is ‘superscripted’ or footnoted, use the specified time of the ‘superscript’ or footnote.” Like I mentioned earlier, it’s important to note that the Introduction to the Data Dictionary has included guidance for some time that allows for superscripted or footnoted documentation to be acceptable. However, the addition of this guidance to the *Severe Sepsis Presentation Date and Time* data elements makes this guidance more readily available during abstraction. Let’s review another scenario related to superscripted documentation.

This question asks: “Which date and time would you use for the *Severe Sepsis Presentation Date and Time* data elements based on the below documentation?” MD note opened on 03/04/2023 at 0600 includes documentation, “Pt in critical condition, severe sepsis, initiating fluids,” with the superscript JD.6. We can see in the time stamps associated with the superscripts, and, for JD.6, the date is March 4, 2023, at 0845. Use 03/04/2023 at 0845 as the specified date and time because the physician’s documentation of severe sepsis includes the superscript. Next, I will turn the presentation over to Jennifer.

Jennifer Witt:

Thanks, Noel. The *Initial Lactate Level Result* data element was also updated in version 5.13 to address conflicting documentation. Similar to our discussion earlier regarding conflicting documentation for the *Severe Sepsis Present* data element, this guidance also addresses scenarios where the abnormal lactate value is documented as normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source and documented as due to an acute condition, acute on

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chronic condition, infection, severe sepsis, or septic shock. You would use the latest documentation within 24 hours after the *Severe Sepsis Presentation Time* to determine if the abnormal lactate value would be used or disregarded.

Next, we will discuss the updates for the *Initial Hypotension* data element.

The *Initial Hypotension* data element received a couple updates that we will discuss. First, the bullet point that includes the specified time frame for *Initial Hypotension* was updated to include “and prior to the completion of the target ordered volume of crystalloid fluids.” Although the abstraction guidance in the initial hypotension data element already directed to select Value “2” (No) if the target ordered volume of crystalloid fluids was completely infused before the hypotensive readings, we continued to receive questions regarding various scenarios related to initial hypotension and completion of the target ordered volume. Therefore, this updated guidance was added to clarify the specified time frame for *Initial Hypotension* is before the target ordered volume of crystalloid fluid is completely infused. Let’s review a common question and scenario we received regarding this.

This question asks, “Would you use the blood pressure readings to establish *Initial Hypotension* based only on the scenario below?”

Severe sepsis presentation time was 0600. You would assess for initial hypotension from: 0000 to 1200. The target ordered volume is 1800 mL, and 1800 mL was started at 0500 and completed at 0645. The blood pressure at 0430 was 95/68; at 0530, 88/55; and at 0700, 83/49. No, because the second hypotensive reading at 0700 is after the completion time of the target ordered volume of crystalloid fluids.

Last for the initial hypo *Initial Hypotension* data element, the guidance regarding conflicting documentation was also updated. Similar to our discussions earlier regarding conflicting documentation, this guidance also addresses scenarios where the abnormal blood pressure value is documented as normal for the patient, due to a chronic condition or

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medication, or due to an acute condition with a non-infectious source and documented as due to an acute condition, acute on chronic condition, infection, severe sepsis, or septic shock. You would use the latest documentation within 24 hours after the *Severe Sepsis Presentation Time* to determine if the abnormal blood pressure value would be used or disregarded. Now, let's review the updates for *Crystalloid Fluid Administration*.

This first update addresses the physician/APN/PA documentation requirements for using a lesser volume. The updated guidance 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, such as 1500 mL, or a weight-based volume, such as 25 mL/kg, and a reason for ordering a volume less than 30 mL/kg of crystalloid fluids." This guidance was updated to address questions submitted by abstractors and clarify that the required physician documentation must be in one source rather than stating a "single note" as previous manual versions stated. To further clarify, let's take a look at a few examples.

This first example is included in the guidance and was stated in version 5.13. It states, "Physician documentation: Heart failure concerns, 20 mL/kg normal saline start now. The orders were for normal saline 0.9% IV, 20 mL/kg over 2 hours. On the MAR, there is normal saline 0.9% IV 20 mL/kg with a start time of 1500 and a completion time of 1700." The clarification is given to select Value "1" because the physician documented a reason for ordering less than 30 mL/kg, for heart failure, and identified 20 mL/kg as the target ordered volume of crystalloid fluids for this patient. Let's review another example: Physician documentation: Renal failure, give 1500 mL normal saline. The orders are for 1500 mL normal saline IV at 1000 mL/hr. On the MAR, there is a IV normal saline 1500 mL at 1000 mL/hr with a start time of 0800. The patient weight is 74 kg, and 30 mL/kg is 2220 mL. The updated bullet point states to select Value "1" because the physician documented a reason for ordering less than 30 mL/kg, renal failure, and identified 1500 mL as the target ordered

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volume of crystalloid fluids for this patient, rather than 2220 mL. Let's take a look at one more scenario that is not included in the manual.

This question asks, "Which volume would you use as the target ordered volume?" The patient weighs 70 kg, and 30 mL/kg is 2100 mL. The IV fluid orders at 0800 are normal saline 0.9% IV with a volume of 1,000 mL over one hour. Within the order, the comments say, "fluid overloaded." The MAR at 0805 has a new bag of 1000 mL with a stop time of 0905. You would use 1000 mL as the target ordered volume of crystalloid fluids because the fluid order includes the lesser volume, 1000 mL, and the reason of "fluid overloaded."

Next, for the *Crystalloid Fluid Administration* data element, the examples under the guidance on this slide were updated. This guidance addresses how to calculate a weight-based volume. First, if the weight in your medical record is already documented in kilograms, use the weight as it is documented to determine the target ordered volume. In this case, you would not round the weight that is documented in kilograms. Next, if the weight was documented in pounds, you would use the guidance here to convert the weight from pounds to kilograms. Let's look at the updated examples.

This first example demonstrates the weight already documented in kilograms in the medical record. So, the weight of 72.72 kilograms is documented. You would multiply the documented weight, 72.72 kilograms, by 30 mL/kg to get 2,181.6 mL. Then, you would round the 2,181.6 mL to the nearest whole number, which would give you the target ordered volume of 2182 mL.

These two examples demonstrate converting the weight in pounds to kilograms, then multiplying the weight in kilograms by 30 mL/kg to determine the target ordered volume. In the first example, the weight is converted to kilograms, then multiplied by 30 mL/kg to get 2190 mL. Then, if the physician ordered 2400 mL of saline, the target ordered volume of 2190 mL would be met by that fluid order.

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In the second example, the weight is converted to kilograms, then multiplied by 30 mL/kg to get 2190 mL as the target ordered volume again. However, this time the physician only ordered 1000 mL of lactated ringers. So, the target ordered volume of 2190 mL would not be met by this order for 1000 mL. If more fluids were not ordered in this case, you would select Value “2” (No) for the *Crystalloid Fluid Administration* data element. Now, let’s take a look at the updates for the *Persistent Hypotension* data element.

Next, let’s review the updated guidance for the *Persistent Hypotension* data element along with reviewing a couple other bullet points that were not updated. Like our earlier discussions regarding conflicting documentation, this guidance was also updated in the *Persistent Hypotension* data element to address scenarios where the abnormal blood pressure value is documented as normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source and documented as due to an acute condition, acute on chronic condition, infection, severe sepsis, or septic shock. Again, you would use the latest documentation within 24 hours after the *Severe Sepsis Presentation* time to determine if the abnormal blood pressure value would be used or disregarded. The guidance and example on this slide were not updated in manual version 5.13. However, we frequently receive questions involving these scenarios. So, let’s review this guidance and a scenario.

First, this guidance states, “Select Value “1” if the only blood pressure within the hour is low, and a vasopressor was administered.” In the example on the slide, we have the one-hour time frame as 1300 to 1400. The only blood pressure documented at 1325 was 87/53. On the MAR, we have Levophed started at 1500. It says to select Value “1” because there is only one blood pressure reading, it is low, but a vasopressor was administered. As we can see in this example, there’s a single hypotensive reading documented in the one-hour time frame to assess for persistent hypotension, but a vasopressor was administered. Notice the vasopressor was not administered within the one-hour time frame to assess for persistent hypotension.

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This is still acceptable to select Value “1” (Yes) because the guidance here does not include a specified time frame for the vasopressor to be administered. The last two bullet points on this slide also address which allowable value to select when only one or no blood pressure readings were documented within the hour to assess for *Persistent Hypotension*. First, select Value “2” if the only blood pressure within the hour is normal. If there are no blood pressure readings or if there is only one blood pressure reading documented in the hour to assess for *Persistent Hypotension*, you would select Value “3.” Next, you can check your knowledge with the following question.

Which allowable value would you select for *Persistent Hypotension* if the hour to assess for *Persistent Hypotension* is from 1500 to 1600, no blood pressure readings were documented during the one-hour time frame, but Vasopressin was started at 1730? A. Value “1” (Yes) Persistent hypotension present; B. Value “2” (No or UTD) Persistent hypotension not present; or C. Value “3” (No) Persistent hypotension not assessed. We’ll give you a few more seconds to select your answer.

Select Value “3” (No) Persistent Hypotension Not Assessed because there were no blood pressure readings documented in the hour to assess for *Persistent Hypotension*. As we reviewed on the previous slide, the guidance allows for Value “1” (Yes) to be selected when there is only a single hypotensive reading documented in the hour, and a vasopressor was administered, and other guidance allows for Value “1” (Yes) to be selected when there is a normal blood pressure followed by a hypotensive reading in the hour and a vasopressor was administered. However, if no blood pressures were documented during the one-hour time frame to assess for persistent hypotension, you would select Value “3” (No), regardless of whether the vasopressor was administered because a blood pressure reading was not documented. Now, let’s take a look at the updates to the *Septic Shock Present* data element.

New guidance was also added to the *Septic Shock Present* element in version 5.13 to address physician/APN/PA documentation of severe sepsis and septic shock.

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This new guidance states, “Do not use physician/APN/PA documentation of a severe sepsis or septic shock exam or assessment being performed. Examples: Severe sepsis exam completed. Septic shock reassessment done.” Like we discussed earlier for the *Severe Sepsis Present* data element, based on this new guidance, you would NOT use physician/APN/PA documentation of severe sepsis or septic shock to select Value “1” (Yes) when the documentation only refers to the exam or assessment being performed.

The updates to the positive and negative qualifiers table were also made in the *Septic Shock Present* data element. The same qualifiers were updated to include “suggestive of” and “presumed” as positive qualifiers, and “monitor,” “query,” and “less likely” as negative qualifiers. This guidance also continues to state, “For documentation of septic shock accompanied by a qualifier, use the table below. Use documentation containing a positive qualifier to meet criteria. Do not use documentation containing a negative qualifier to meet criteria. Do not use documentation containing both a positive and negative qualifier to meet criteria.”

Also, for the *Septic Shock Present* data element, “sepsis with shock” was added to the inclusion guidelines for abstraction. Moving forward, physician/APN/PA documentation of “sepsis with shock” is acceptable physician/APN/PA documentation for selecting Value “1” (Yes) for the *Septic Shock Present* data element. Finally for today’s presentation, we’re going to look at the updates for the *Septic Shock Presentation Date and Time* data elements.

The final update for manual version 5.13 we will discuss today is the inclusion of the guidance, “If documentation of septic shock is ‘superscripted’ or footnoted, use the specified time of the ‘superscript’ or footnote.” Similar to our discussion for the *Severe Sepsis Presentation Date and Time* data elements, if physician/APN/PA documentation of septic shock is superscripted or footnoted, you would use the superscripted or footnoted date and time as the specified date and time for establishing the *Septic Shock Presentation Date and Time*.

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That concludes our review of specifications manual, version 5.13. 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 & Answer Tool. Noel?

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.

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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 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 question as quickly as possible. So, that is how you can review existing Q&As and submit a question to the support team. Donna, I will turn it back over to you.

Donna Bullock: Thanks, Noel. Now, we do have time for a few questions. The first one is regarding Slide 8: When [does] an outpatient chemo therapy unit transfer to ED qualify as a transfer?

Noel Albritton: This is Noel. I can answer that. Yes, you would select Yes for the *Transfer from Another Hospital or ASC* data element if the patient was received as a transfer from the outpatient department of another hospital. So, an outpatient chemo unit or department of another hospital received by your hospital would be Yes for the transfer data element.

Donna Bullock: Thank you. Here is our next question, also regarding Slide 8. Would a same day surgery or cath at your hospital count as a transfer?

Noel Albritton: This is Noel again. No. If the patient was already at your hospital, in a unit of your hospital, you would select No for the transfer data element because they would not be coming from an outside acceptable facility.

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Donna Bullock: All right. Thank you. Here is our next question: If there is no documentation of infection in a provider note, but there is documentation of a sepsis exam completed, would this be considered documentation of infection?

Noel Albritton: This is Noel again. I can answer that one, as well. For establishing criteria A infection for the *Severe Sepsis Present* data element, yes, you can use the documentation of the sepsis exam being completed, as long as it was physician/APN/PA or nursing documentation that would be acceptable for criteria A.

Donna Bullock: Okay. Thank you. Moving on to the next question: If you have time, can you please clarify? I no longer see the manual where it states [we] would need two blood cultures. Do you pass the measure if you only have one blood culture?

Noel Albritton: This is Noel again. So, the *Blood Culture Collection* data element only requires one blood culture, and that's just to establish the blood culture collection time. The guidance has not previously, or does not currently, required two blood cultures to pass the data element. If there were two collected, you would still just abstract the time of the first one or the earliest one collected within the time frame.

Donna Bullock: Thanks, Noel. Our next question: Is this acceptable for Value "1" of crystalloid fluids? Provider documents: Will hold IV sepsis bolus because of anemia.

Noel Albritton: This is Noel again. No, that documentation would not be acceptable for using a lesser volume to meet the *Crystalloid Fluid Administration* data element. To use a lesser volume, the volume and the reason would need to be included in the physician's documentation as well as the volume needing to be ordered. In the documentation that was in the question, holding the bolus due to anemia doesn't meet the guidance because it doesn't include the lesser volume that is going to be used as the target volume for the patient. In that case, you would select Value "2" or "3," depending on whether any fluids were ordered during that time period or not.

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Donna Bullock: Thanks, Noel. Here is our next question: For those of us on EPIC, would dates and times displayed by the hover function be considered superscripts and footnotes?

Noel Albritton: This is Noel again. The hover time would most likely be considered the specified time for particular documentation itself. So, whether it is a hover time, a superscripted time, or a footnoted date and time, those could all potentially be used as the specified time for a particular documentation. The hover time, like I said, can be used as a specified time as long as it is included in the medical records abstracted, and that would be submitted in cases of validation. The hover time would not be available. If the case was validated in a PDF version of a medical record, then you would not use the hover time because it would not be available. Otherwise, it would be used as a specified time, just like the other time stamps.

Donna Bullock: Thanks, again. Here is our next question: In Slide 12, would the order have to contain the condition that is being treated with antibiotic to meet the requirement of suspected infection?

Noel Albritton: Donna, can we go to Slide 12?

Donna Bullock: Jamie is taking us to Slide 12.

Noel Albritton: Thank you. Then, will you repeat that question one more time for me?

Donna Bullock: Yes, I will. In Slide 12, would the order have to contain the condition that is being treated with antibiotic to meet the requirement of suspected infection?

Noel Albritton: So, to meet this guidance and to use an inflammatory condition or sign of infection to meet criteria A, the inflammatory condition or sign or symptom can be included as an indication for the antibiotic or the documentation can state the antibiotic is ordered for the inflammatory condition or sign or symptom, somewhere to the example that is on the slide where it says for ceftriaxone or colitis. It doesn't have to be in the antibiotic order, but the documentation must refer to the antibiotic being ordered for the inflammatory condition or sign or symptom of condition.

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Donna Bullock: Okay. Here is our next question: If there is an ARPN/APN documentation of a suspected infection before the doctor's note of infection with a time stamp and specific documentation of infection and antibiotic started, do we take the doctor's note and time stamp or the APN note suggesting an infection during the initial screening at triage?

Noel Albritton: So, the APN infection documentation or the physician documentation of an infection are both acceptable. So, in that case, you would determine which of those infection documentation times are the earliest that is within six hours of criteria B and C. Then, you would use the earliest of those infection times to establish *Sepsis Presentation Time*. If the APN time or APN infection documentation doesn't have a specified time, and the doctor, physician documentation does have a specified time, you would continue to use the earliest infection time to establish the *Severe Sepsis Presentation Time*.

Donna Bullock: Thanks, Noel. Here is the next question: Are pregnant patients in active delivery or with an epidural excluded?

Noel Albritton: This is Noel again. No, pregnant patients in active delivery or receiving epidural are not excluded on either of those bases. As we talked about in the presentation, you would use the criteria in the *Severe Sepsis Present* data element specific to nonpregnant or pregnant 20 weeks through 3-day post-delivery patients to establish severe sepsis, rather than exclude from the measure.

Donna Bullock: The next question pertains to Slide 22: If a single physician documents chronic A-fib was likely worsened by infection, can the heart rate be used?

Noel Albritton: This is Noel again. Yes, you would use the heart rate because the documentation of the chronic A-fib and "worsened by infection" does not attribute the abnormal value to the chronic condition. So, you would not disregard the abnormal heart rate based on that documentation. So, on the slide on the screen, the abnormal heart rate, RVR, defined by an abnormal heart rate, is included with the chronic condition in this example.

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If it was just the chronic condition, of A-fib documented, you would not disregard the abnormal heart rate based on that documentation.

Donna Bullock: Thank you. This question also pertains to Slide 22: So, to be clear, the diagnosis of A-fib with RVR is enough to exclude the elevated heart rate; the actual heart rate is not required to be in the documentation.

Noel Albritton: This is Noel again. First, as long as A-fib is documented as a chronic condition for the patient, then, yes, you would disregard the abnormal heart rate based on the documentation such as the example on Slide 22. The term RVR, included with the documentation of A-fib, is a term that is defined by the abnormal heart rate value. So, you would exclude the abnormal heart rate based on the term defined by an abnormal heart rate being included or being documented due to the chronic condition. It could say chronic A-fib with heart rate of 150, and that would also work to disregard the heart rate of 150 in less severe values, or you say chronic A-fib with tachycardia or RVR, and that would be acceptable for disregarding all of the heart rates because they are documented as due to the chronic condition.

Donna Bullock: Okay. Here is our next question: What about patients who use CPAPs at home? Since it indicated chronic use, do they fall in the severe sepsis category?

Noel Albritton: This is Noel again. So, if there is documentation that the patient is already on a CPAP at home, then starting the CPAP in the hospital would not be considered a new need for the noninvasive mechanical ventilation. If it is not a new need for the patient, you would not use that to establish criteria C, organ dysfunction, for *Severe Sepsis Present*. You would disregard the documentation of the CPAP because it is not a new need. If they were on a CPAP at home, and there's documentation they are now on a BiBAP or they were placed on a vent, then you can use the initiation of the BiBAP or the ventilator as the new need for organ dysfunction.

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Donna Bullock: Thank you. The next question is: Is it true that if a patient has been on IV antibiotics for 24 hours or more before the *Severe Sepsis Presentation*, the case is excluded from the measure?

Noel Albritton: This is Noel again. I can answer that one as well. So, if the patient received an IV or IO antibiotic in the 24 hours before *Severe Sepsis Presentation*, or within three hours after *Severe Sepsis Presentation*, and that antibiotic was also received greater than 24 hours before the *Severe Sepsis Presentation Time*, then the case would be excluded in the algorithm. You would abstract Value “1” (Yes) for the *Broad Spectrum or Other Antibiotic Administration* data element, and then abstract the date and time of the earliest antibiotic administered within 72 hours before the *Severe Sepsis Presentation* time. Then, the case would be excluded in the algorithm based on the antibiotic date and time being greater than 24 hours before the *Severe Sepsis Presentation Date and Time*.

Donna Bullock: Thanks again, Noel. Our next question is: What if there is documentation “shock with sepsis.” Does this meet criteria?

Noel Albritton: This is Noel again. Yes, for version 5.13, the new guidance added to *Severe Sepsis Present* data element allows for documentation “sepsis with shock,” or, in this case, “shock with sepsis,” to be acceptable for establishing your sepsis or septic shock. You would use that documentation, the same as physician/APN/PA documentation of septic shock, and select Value “1” Yes, and determine the date and time for that documentation for *Septic Shock Presentation Date and Time*.

Donna Bullock: Our next question is: Can you explain what “superscripted” and “footnoted” means?

Bob Dickerson: This is Bob Dickerson, and I work with Noel on the sepsis measure. I would be happy to take that one. I see there have been a number of questions coming in about the superscript, and how that counts, and what it counts as. Essentially, the superscript and the subscript refer to some type of a symbol next to the documentation, and that can be referenced down to another piece in the medical record, in the EHR that explains it further.

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So, that superscript or subscript, if you think about a printed document, sometimes you see a little symbol like a 1 or 2 at the end of the line. It is kind of elevated above the line. It references back to something else in the record. What I believe we have seen a lot of with some of the EHRs is they make use of that, and then there is a reference section that you can trace that symbol down to that maybe will have the time it was documented, or who it was documented by, or some additional explanations. So, I hope that explains that a little bit more.

Donna Bullock: Thanks very much, Bob. Our next question is: Is sepsis with shock adequate as documentation of septic shock?

Noel Albritton: This is Noel. I can take that. Yes, and that is similar to one a couple of questions ago. The documentation physician/APN/PA documentation of sepsis with shock will be treated the same as documentation of septic shock. You can use that to select Value “1” (Yes), and determine *Septic Shock* or *Severe Sepsis Presentation*.

Donna Bullock: Thanks, Noel. Our next question is: Since the target volume cannot be 0, some providers have asked what happens if I order a 1 mL bolus. Will that pass? FYI, I don't condone this practice, but I agreed to ask the question.

Noel Albritton: This is Noel again. So, requirements to meet the *Crystalloid Fluid Administration* data element and specifically the lesser volume requirement, the lesser volume can be ordered and documented with the reason for ordering the lesser volume. It also includes guidance for meeting the remaining requirements of the data element, which includes administering at greater than 125 mLs per hour. The 1 mL volume could meet most of those requirements. It would need to be documented as administered greater than 125 mLs per hour, which would likely be difficult to document that it was administered at that rate. Off the top of my head, I am not coming up with a way that could be documented as administered at a rate greater than 125 mLs per hour. So, it most likely would not be acceptable for meeting the *Crystalloid Fluid Administration* data element.

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Bob Dickerson: This is Bob. The other thing I would like to add on to that is, in March, we had a presentation with Dr. Bobby Redwood, who is an ED physician, does a lot with sepsis care. To the point of the person that submitted the question, the thing he pointed out is that there are very, very few patients that do not need some volume of fluid. Now, 1 mL, just to try to meet a measure, is not treating a patient. That aside, as Noel pointed out, in terms of abstraction, there are other criteria that need to be met in order to count that the volume is an appropriate volume that's being given. At the same time, the measure doesn't specify a minimum volume because we recognize that there are some patients for which the volume is going to be very dependent upon what they respond to and what their needs are. So, we hope that helps answer that question. It gets in kind of a tricky area.

Donna Bullock: Thanks, Bob and Noel. The next question is: When does 5.13 guidance go into effect?

Noel Albritton: This is Noel. I can help on that. Manual version 5.13 began with discharges January 1, 2023, and goes through June 30, 2023. We are right in the middle of version 5.13 discharge period abstractions.

Donna Bullock: Thank you, Noel. What is the time frame for the repeat lactate? Is it within six hours of severe sepsis presentation time or initial lactate time?

Noel Albritton: This is Noel again. The repeat lactate collection time frame is within six hours after the severe sepsis presentation time and after the initial lactate level collection time. So, it must be collected within the six hours after severe sepsis presentation, but it is also collected after the initial lactate level collection has been performed.

Donna Bullock: Thank you. Here is our next question: Can you go back to the question regarding the hover feature? I am not clear as to when it can be used versus not used. In EPIC, you have to hover over documentation for a date and time to appear.

Bob Dickerson: Noel, maybe we can work together on this one because I have also seen them in a number of questions related to hover and additional questions on the footnote, you know the superscript, subscript, and those types of things.

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So, I think one of the things. I will start, and, Noel, please supplement. I think one of the things that Noel had referenced in terms of being able to use, and it really gets to the features that the different EHRs have and being able to use those to identify the times. You want to make sure that wherever you take that information from, one, it meets the criteria for the information you're abstracting for. So, if the information asks for the earliest time of something, you will want to make sure that, out of the multiple times if you have multiple times, you are using the earliest. The other thing that is very important that I recall Noel mentioned is that you want to make sure that time stamp, whether it be a hover over, superscript, subscript, at the beginning of the note, at the end of the note, specifically tagged to the comment or the note, that it is available in any type of an export that you would do of your EHR in the event you have a record that is flagged for validation. So, a third party who would be reviewing and who maybe doesn't have access to the same level of technology that you do when you do abstraction that they will be able to find that. With that, Noel, please supplement with additional thoughts you have.

Noel Albritton: I mean that's exactly accurate, Bob. The difficulty, I guess, if I can add anything, when these questions are submitted to the QualityNet team, is there are different EHRs, and each function and export in different ways. It comes down to determining if that time stamp is specific to the documentation and meets the guidance, and whether that time stamp is going to be available if the case were reviewed or validated later on.

Bob Dickerson: Noel, I think the other thing you just hit on there that is very important, is that there are a lot of EHRs out there. There are ones that are used predominantly. Not every EHR may have the superscript or subscript feature. Not every EHR may have the hover over feature. Keep that in mind as you are doing abstraction. Some of the updated guidance tries to account for these things. Your EHR may not have a feature, and that's fine. Donna, back over to you.

Donna Bullock: Thank you. We have time for one more question: Can you accept pneumonia listed on a chest x-ray as an infection source without the order of an antibiotic?

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Noel Albritton: This is Noel. I can take that one. Yes, the documentation of pneumonia on a chest X-ray would be acceptable as long as it is physician/APN/PA or nursing documentation of pneumonia. If it's not a physician/APN/PA or nursing documentation of an infection on a chest X-ray, then you would not use it to meet criteria A. Documentation of infections such as pneumonia does not require an antibiotic ordered for that condition to meet criteria A. Just the documentation of the infection alone is acceptable for meeting criteria A.

Donna Bullock: Thank you, Bob and Noel. That is all the time we have questions for during this presentation.

This presentation has been approved for one and a half continuing education credits. The link to the survey is posted in the chat section. Also, if you registered for the webinar, you will get an email within 24 hours containing information about the survey and also information about how to get your continuing education credit. Thank you for attending today's presentation.