Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.7 Measure Updates and FAQs

Questions and Answers

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Webinar attendees submitted the following questions and subject-matter experts provided the responses. The questions and answers have been edited for grammar.

Unable to Determine (UTD) Allowable Value Option

Question 1: **If you select UTD in version 5.7, does that cause the case to fail the measure?**

It depends for which data element "UTD" is selected. Selecting "UTD" for some data elements will cause the case to proceed to category "D" and fail the measure. However, for other data elements, selecting "UTD" will not cause the case to fail.

Broad Spectrum or Other Antibiotic Administration Selection

Question 2: **Slide 13. If you go to the lab results and can see the date and time and sensitivity of the culture, can you use it? Or, does it have to be physician documentation?**

The lab results alone would not be acceptable. Only physician/Advanced Practice Nurse (APN)/Physician Assistant (PA) documentation referencing the results of a culture from within five days prior to the antibiotic start time is acceptable. Here is the relevant guidance for convenience:

- There is Physician/APN/PA documentation referencing the results of a culture from within 5 days prior to the antibiotic start time. The documentation must:
    - Identify the date of the culture results (must be within 5 days prior to the antibiotic start time).
    - Identify the suspected causative organism from the culture result and its antibiotic susceptibility.

Question 3: **Slide 13. For facilities that have electronic health records (EHRs), if the positive culture was done within five days at the same EHR-using facility, the culture would be in the**

EHR. Is it acceptable to use this documentation or would you need to have additional documentation?

Additional physician/APN/PA documentation that references the results of a culture from within five days prior to the antibiotic start time identifies the causative organism and antibiotic susceptibility is required.

Question 4: **Slide 13. Please re-examine the criteria as physicians will not document the date of the culture.**

Thank you for the input. The guidance in the specification manual is reviewed regularly for opportunities to improve the measure guidance and to reduce abstraction burden.

Question 5: **Slide 14. Why would you abstract "No" when the antibiotic was administered within three hours?**

You would select value "2" (No) because the PA documentation does not identify the date of the culture, which needs to occur within five days prior to the antibiotic start time, or the causative agent and its antibiotic susceptibility.

Question 6: **Slide 14. Can you provide an example of allowable documentation referencing the results of the culture?**

One example of acceptable physician/APN/PA documentation from the *Broad Spectrum or Other Antibiotic Administration Selection* data element is:

- Acceptable physician/APN/PA documentation: "Urine culture results from 9/10/17 show enterococcus, sensitive to vancomycin." The patient has severe sepsis with criteria met on 9/15/17 at 1500 and the only antibiotic started is IV vancomycin at 1530.

Question 7: **Is it acceptable for a physician to document three days ago, rather than month, date, and time?**

Yes, documentation such as "3 days ago" is acceptable for determining whether the culture was obtained within five days prior to the antibiotic start time.

Question 8: **To be considered an exclusion, does it have to be the same antibiotic that was administered prior to 24 hours?**

Yes, the same intravenous (IV) antibiotic must be administered within the 24 hours prior and more than 24 hours prior to *Severe Sepsis Presentation Time* to exclude the case based on the antibiotic administration time in the *Broad Spectrum or Other Antibiotic Administration Time* data element.

Question 9: **The patient is admitted, and a culture was obtained prior to the antibiotic being administered. If the antibiotic used on admit was susceptible, is there a time frame of when this should be documented?**

The *Broad Spectrum or Other Antibiotic Administration Selection* data element does not provide a time frame within which the physician/APN/PA documentation indicating the organism from the culture results is susceptible to the antibiotic ordered. If the culture results are within five days prior to the antibiotic start time and the physician/APN/PA documented at some point in the medical record that the organism from the culture results is susceptible to the antibiotic ordered, this is acceptable.

Question 10: **If severe sepsis is met with an infectious source of clostridium difficile (C. difficile), is vancomycin the only acceptable oral antibiotic?**

Yes. Only oral or rectal vancomycin and IV metronidazole monotherapy administered within three hours after the *Severe Sepsis Presentation Time* is acceptable if physician/APN/PA documentation within 24 hours before the antibiotic start time indicates the presence of C. difficile.

Crystalloid Fluid Administration

Question 11: **Slide 15. IV Merrem in 100 milliliters (mL) normal saline (NS) is given over 30 minutes, which is 200cmL/hour (hr). Can this NS be applied toward the target ordered volume?**

Yes. Crystalloid fluids or balanced crystalloid fluids used to dilute medications and administered at a rate greater than 125 mL/hr may be used toward the target ordered volume. If the volume infused without dilution fluids is equal to or greater than the target ordered volume, do not count fluids used for diluting medications towards the target ordered volume.

Question 12: **Slide 16. What if the antibiotic diluted with crystalloid fluids (100 mLs) was administered first and the targeted amount of IV fluids (30 mL/kilogram) was administered second as the times ordered are 1200 and 1225 respectively? As the antibiotic was administered first, shouldn't the 100mLs be counted?**

No. Based on the guidance, if the volume infused without the dilution fluids is greater than or equal to the target ordered volume, do not count the fluids used to dilute the medication towards the target ordered volume. The guidance in the *Crystalloid Fluid Administration* data element does not require the dilution fluids to be used based on the sequence of administration.

Question 13: **Slide 16. Is it correct that just because the target ordered volume is enough, if there is not a stop time, we cannot count that amount?**

If start time and rate, duration, or end time was not documented for the target ordered volume, then do not count the fluids.

In the example in Slide 16, do not count the crystalloid fluids used to dilute the medication because the volume administered is greater than or equal to the target ordered volume without using the dilution fluids.

Question 14: **Slide 16. Would we count the diluted medication if the ordered amount is not completely infused but it would be met with the 100 mL of Zosyn?**

Yes. If the volume infused does not meet the target ordered volume without the dilution fluids, then use the dilution fluids to reach the target ordered volume.

Question 15: **Slide 16. The physician orders three separate 1000 ml boluses and the patient target ordered volume is 2500, but**

there are diluted antibiotics in between the first and second liter. Would you count the diluted antibiotics as the fluids are not mentioned as a 30 ml/kilogram (kg) dose?

No, do not use the dilution fluids because the volume infused from the three boluses (without the dilution fluids) is greater than or equal to the target ordered volume.

Question 16: **Slide 16 and 17. What is the rationale for being able to include diluted medications, but not a crystalloid at 125 mL/hr?**

Fluids used to dilute a medication should be used to reach the target ordered volume when the volume infused without the dilution fluids is not enough to reach the target ordered volume. The *Crystalloid Fluid Administration* data element requires that all crystalloid fluids, including fluids used to dilute a medication, must be administered at a rate greater than 125 mL/hr in order to count toward the target ordered volume. Fluids administered at a rate of 125 mL/hr or less are considered as infusing at a maintenance rate rather than a rate suitable for fluid resuscitation.

Question 17: **Slide 16 and 17. Does it count if the provider does not order one bolus at 30 mL/kg, but rather several individual boluses of lesser amounts that when added up equal the 30 mL/kg? How would you abstract if a crystalloid fluid used in dilution is started prior to one of these crystalloid boluses not used as a dilution?**

Multiple boluses are acceptable if each bolus has an infusion rate greater than 125 mL/hr and the total volume is within 10 percent of the 30 mL/kg volume. The sequence of the dilution fluids does not matter. If the volume infused from the crystalloid boluses is equivalent to the target ordered volume without using the dilution fluids, do not count the dilution fluids toward the target ordered volume.

Question 18: **Slide 17. What is the time frame that we are permitted to use the IV fluid-mixed medications?**

All acceptable crystalloid fluids must be ordered and initiated within six hours prior through three hours after *Initial*

Hypotension Date and *Time* or *Septic Shock Presentation Date* and *Time.*

Question 19: **Slide 17. If the NS had been within 10 percent, would you need to use the 250 ml to reach your target volume?**

No, if the volume ordered and infused equaled the 30 mL/kg volume or a volume within 10 percent of the 30 mL/kg volume, do not count the dilution fluids toward the target ordered volume.

Question 20: **Slide 17. If the Vancomycin contained only 200 mL NS and is combined with the 2000 mL NS, it would only be a total of 2200mL. Would this be acceptable?**

Yes, 2200 mL would be acceptable in that scenario because 2200 mL is within 10 percent of the 30 mL/kg volume of 2250 mL.

Question 21: **Slide 17. If the example would have been Vancomycin in 250 ml of 0.9% NS over two hours, would we use it since the rate would be 125 mL/hr?**

No, do not count fluids administered at 125 mL/hr or less toward the target ordered volume.

Question 22: **Slide 17. Does this patient pass the *Crystalloid Fluid Administration* criteria since they received 2250 mL over two hours despite one fluid order infusing at 125 ml/ hr?**

1. **Non-hypotensive patient meeting systemic inflammatory response syndrome (SIRS) criteria and has an infection is ordered and receives Lactated Ringers (LR) at 125 ml/hr. No end time is documented. This is IV #1.**
2. **The patient later becomes hypotensive and meets severe sepsis criteria and LR 2000 ml is ordered at 1000 mL/hr. This is IV #2; IV #1 continues.**
3. **Weight is 75 kg (30 mL/kg = 2250 mL).**
4. **The patient receives 2250 mL over two hours. (LR, in total, is infusing at 1125 ml/hr.)**

The *Crystalloid Fluid Administration* data element indicates to not use fluids administered at a rate of 125 mL/hour or less toward the target ordered volume. Therefore, the fluids from IV #1 cannot

count toward the target ordered volume. Assuming the order and infusion documentation for IV #2 meets the criteria in the *Crystalloid Fluid Administration* data element, a total volume of 2000 mL would be infused from IV #2. To meet the crystalloid fluid target for a 75 kg patient, the volume infused would need to be 2025 mL (10 percent less than 30 mL/kg) – 2250 mL (30 mL/kg). This patient case would not meet *Crystalloid Fluid Administration* criteria, because the crystalloid fluid volume infused is less than the acceptable target volume for a 75 kg patient.

Question 23: **Slide 17. Does the abstractor have the option of using the diluent for the antibiotic if it affects the outcome of the *Persistent Hypotension* assessment?**

No, guidance for use of dilution fluids in the *Crystalloid Fluid Administration* data element is based on meeting the target ordered volume, not the assessment of *Persistent Hypotension*.

Question 24: **Slide 18. The rate for the Zosyn is 100 ml over 30 minutes, which is faster than 125 ml/hr. Why can't the Zosyn be used towards the target ordered volume?**

You would not count the fluids used to dilute the medication because the volume infused without the dilution fluids equals the target ordered volume.

Question 25: **Slide 21. If multiple orders are written for crystalloid fluids, that are less than but within 10 percent of the target volume, and within one order it includes the statement "Give at least 30 mL/kg," is it acceptable to use the fluids given within 10 percent of the target volume?**

No, if 30 mL/kg volume is ordered, a volume less than the 30 mL/kg volume would not be acceptable.

Question 26: **Slide 21. Do you take the 10 percent off the fluids that the physician ordered, or the 30ml/kg amount required?**

The intent of the measure is infusion of 30 mL/kg of crystalloid fluids. The target ordered volume needed to meet the measure is based on 30 mL/kg or a volume ordered that is up to 10 percent less than 30 mL/kg. A fluid volume that is within 10 percent of the 30 mL/kg volume is acceptable only if it was ordered by a

physician/APN/PA. It is not acceptable for purposes of the measure to infuse less fluid than is ordered.

Question 27: **Can we use fluids used for dilution toward the total volume if the infusion rate is less than 125 ml/hr? How fast does the dilute with antibiotics need to run?**

No. The *Crystalloid Fluid Administration* data element indicates to not use fluids administered at a rate of 125 mL/hr or less toward the target ordered volume. The infusion rate for any fluids to count toward the crystalloid infusion must be greater than 125 mL/hr.

Question 28: **Slide 22. I thought we can subtract 10 percent. So, in the example, 2400 ml minus 240 ml would equal 2160 ml that would be needed to meet this measure. Is that correct?**

No. Determine the target ordered volume needed to meet the measure based on the volume that the physician/APN/PA ordered. A target ordered volume within 10 percent of the 30 mL/kg volume is only acceptable if the physician/APN/PA ordered a volume within 10 percent of 30 mL/kg. In this case, the physician ordered 3,000 mL, which is greater than or equal to the 30 mL/kg volume (2,400 mL), so only 2,400 mL is required for the measure.

Question 29: **The patient weighs 80 kg and needs 2400 mL; NS 2200 mL bolus is ordered (within 10 percent) and Zosyn in NS 100 ml is ordered. Is the target ordered volume 2200 mL since it's within 10 percent, or should we consider the target volume as 2300 mL, which is still within 10 percent?**

Use the 2200 mL of NS that the physician/APN/PA ordered because that volume is within 10 percent of the 30 mL/kg volume (2400 mL). In this example, the 100 mL of NS mixed with Zosyn is not needed to reach the target ordered volume.

Question 30: **Slide 22 and 23. In slide 22 you stated the 2400 mL was the target ordered volume even though the order was for 3000 mL. Why in slide 23 is the answer "B"?**

On slide 22, the physician ordered 3000 mL, but the patient's weight is 80 kg. Therefore, the target ordered volume based on

the patient's weight is 2400 mL (80 kg x 30 mL/kg). On slide 23, based on the patient's weight of 110 kg, the 30 mL/kg volume would be 3300 mL (110 kg x 30 mL/kg). The physician only ordered 3000 mL, which is acceptable because the ordered volume is within 10 percent of the 30 mL/kg volume.

Question 31: **Slide 23. In the example where the patient was 110 kg and the target ordered volume would be 3300 ml, what if the physician ordered 3000 mL NS and there was also an antibiotic in 100 mL NS administered during that time or after, would we include the 100 mL NS in the volume?**

No, you would not need to count further dilution fluids toward the target volume because the volume ordered and infused (3000 mL) is within 10 percent of the 30 mL/kg volume.

Question 32: **Slide 23. The question was a bit deceiving, as it asked which fluid volume should be infused and not what minimum fluid volume should be infused to meet the measure.**

The question asks what fluid volume should be infused for the measure. An ordered volume of either 30 mL/kg or ordered volume within 10 percent of the 30 mL/kg volume would be acceptable.

Question 33: **Slide 24. Why is 2970 mL incorrect since it is 10 percent?**

The target ordered volume is based on the volume of fluids ordered, which is 3000 mL in this example. Because the target ordered volume (3000 mL) is within 10 percent of the 30 mL/kg volume (3300 mL), 3000 mL is acceptable. If the physician/APN/PA ordered 2970 mL of crystalloid fluids, 2970 mL would be acceptable as the target ordered volume.

Question 34: **Is there anything being done to make it easier to calculate fluid bolus completion times when there are multiple boluses given?**

Thank you for the question. The guidance in the specification manual is reviewed regularly for opportunities to improve the measure guidance and to reduce abstraction burden. We will include fluid calculation examples in future national provider calls as a reference for abstractors.

Question 35: **If the physician order states NS (30ml/kg) over one hour, however, there is no weight stated in the order and the volume infused on the Medication Administration Record (MAR) does not match the volume required for the first weight documented in the record, do we still treat the NS ordered at 30 mL/kg as meeting the requirements?**

No, you would need to determine the 30 mL/kg target ordered volume based on the documented weight. Therefore, if the volume administered is not within 10 percent of the 30 mL/kg target ordered volume based on the documented weight, select value "2" (No) for *Crystalloid Fluid Administration*.

Question 36: **Does it have to be documented that the medications were mixed with a crystalloid fluid or can it be assumed?**

The physician/APN/PA fluid order must include the type of fluid and demonstrate that a medication is diluted in a crystalloid fluid listed in the "Inclusion Guidelines for Abstraction" section in order to count the infusion towards the target ordered volume.

Question 37: **If the physician ordered NS two liters (L) IV now and the Registered Nurse (RN) documented the end time, can we count this in our target ordered volume for crystalloid fluids?**

No, the physician/APN/PA fluid order must include a start time and rate, duration, end time, or a term such as bolus, wide-open, or open for the infusion to count toward the target ordered volume. The infusion would not count toward the target ordered volume if the physician/APN/PA fluid order only includes the start time.

Question 38: **If a patient has two separate IVs running at the same time, each at 100 mL/hr, is this allowed?**

No, only count infusions with a rate greater than 125 mL/hr towards the target volume.

Question 39: **If the crystalloid fluid bolus is not ordered as 30 mL/kg but is ordered in separate one-liter bolus increments, do we need to use the fluids mixed with medication if given in between the one-liter boluses? For example:**

- **Target volume 2000 mL**
- **1200 Liter 1 at 1000 mL/hr**
- **1245 Vancomycin in 500 mL NS at 1000 mL/hr**
- **1300 Liter 2 at 1000 mL/hr**

No, do not count the dilution fluids because the total volume ordered without the dilution fluids is greater than or equal to the target ordered volume.

Question 40: **Your examples for the crystalloid fluid administration make it appear that you must have a single order to not use dilution fluids. Can fluids ordered with multiple orders still exclude the dilution fluids if the total without the dilution fluids equals or is more than the target amount?**

Yes, if the total volume of fluids ordered via multiple orders is greater than or equal to the target ordered volume, do not count the dilution fluids.

Question 41: **If the 30 mL/kg will not be completed in three hours, can you use the dilute toward that amount?**

The measure does not require the target ordered volume to be completely infused within a specified time frame. If the volume infused equals the target ordered volume without the dilution fluids, do not count the dilution fluids.

Question 42: **Do we need documentation that the fluids were just ordered or the actual start and stop times?**

Physician/APN/PA fluid orders must include a start time and rate, duration, or end time.

Question 43: **Additional clarification is requested for fluid requirements when septic shock is documented by the physician for an intensive care unit (ICU) patient that already has cardiogenic shock and is on two vasopressors. Currently, the measure can only be met if the targeted fluids are given.**

Thank you for the question. *Crystalloid Fluid Administration* is required for all patients for whom value "1" (Yes) is selected for *Initial Hypotension* or *Septic Shock Present.*

Question 44: **Emergency medical service (EMS) documented 1000 mL NS bolus was started at 1500. After arrival to the emergency department (ED), the RN documented 1000 mL was given by EMS. Can the 1000 mL given by EMS count towards the 30 mL/kg bolus?**

No, the fluids administered by EMS would not count toward the target ordered volume without documentation of a rate, duration, or end time for the infusion.

Question 45: **Does an IV flush, documented as 10 mL, count towards the volume if within the time frame?**

No, crystalloid fluids given to flush IVs are listed in the Exclusion Guidelines for Abstraction in the *Crystalloid Fluid Administration* data element and would not be used toward the target ordered volume.

Question 46: **Is there a plan to include an exception for IV fluids when flooding the patient with 30 mL/kg might be clinically harmful (e.g., a patient with congestive heart failure or on dialysis)?**

The current exclusions from *Crystalloid Fluid Administration* only include (1) documentation that the patient has a ventricular assist device (VAD) and (2) documentation that a patient refused receiving fluids.

Question 47: **Can you explain the use of ideal weight?**

The ideal body weight (IBW) is acceptable for determining the target ordered volume of crystalloid fluids if the patient has obesity or body mass index (BMI) greater than 30. In order to use IBW to determine the target ordered volume, the physician/APN/PA documentation must indicate that the IBW is being used to determine the target ordered volume and the patient has obesity or BMI greater than 30. The IBW must also be documented in the medical record.

Directive for Comfort Care and Palliative Care

Question 48: **Slide 25. If a physician documents a "comfort measures only" recommendation on day one, but on day two the family refuses comfort measures, do I say "Yes" to comfort measures only on day one since this documentation is the documentation that is within six hours of severe sepsis time? Is there a time frame for discussing palliative care for it to count as an exclusion?**

You would select value "1" (Yes). You should only use documentation that is within the time frame specified in the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element, which is "prior to or within 6 hours of the presentation of severe sepsis." You should not use documentation outside of this time frame. If a physician/APN/PA documented a recommendation for comfort measures only and the family refused comfort measures in separate notes but both within the specified time frame, you would still select value "1" (Yes). Based upon the last bullet point in the Notes for Abstraction, inclusion documentation would be used over refusal documentation in another source in the medical record.

Documentation of "discussing palliative care" is not acceptable for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element. Documentation of a "discussion" is not included as an acceptable context to suffice the data element.

If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only (CMO) or Palliative Care, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO or Palliative Care, the source that indicates the patient is CMO or Palliative Care would be used, select value "1" (Yes).

Question 49: **Slide 25. Would the documentation of "Discuss hospice care with patient" qualify to meet the criteria?**

No, documentation of a "discussion" of hospice care is not acceptable because a "discussion" is not included as an

acceptable context to meet the criteria in the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element.

Question 50: **Slide 25. If the patient had a consult for palliative care, can we answer "Yes" even though comfort measures were not implemented?**

Yes. Documentation of a palliative care consult within the specified time frame is an acceptable context to select value "1" (Yes) for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element, regardless of whether palliative care was started at that time or not.

Question 51: **Slide 25. Would the documentation of "Discussed palliative care but patient cannot decide at this time" be acceptable?**

No, documentation of a "discussion" of palliative care is not acceptable because a "discussion" is not included as an acceptable context to select value "1" (Yes) for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element.

Question 52: **Slide 25. When will "End of Life Care" be added as an inclusion term?**

"End of Life Care" is an acceptable inclusion term in the Inclusion Guidelines for Abstraction for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element in version 5.7 of the specifications manual.

Question 53: **Slide 26. Has the guidance changed? This question was submitted approximately nine months ago to *QualityNet* and the response was to select value 1 "Yes."**

The guidance was updated in manual v5.6 to state "only the earliest physician/APN/PA documentation of an inclusion term documented in the following contexts suffice." Value "2" (No) was selected in the example on slide 26 because "reviewed" is not included as an acceptable context within the data element.

Question 54: **Slide 26. Has "terminal care" now been added as an acceptable inclusion term?**

"Terminal care" is an acceptable inclusion term in the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element in version 5.7 of the specifications manual.

Question 55: **Slide 27. Just because the physician "discusses" or "recommends" palliative care with family does not mean that the family is on board even though the provider recommends it. How can we answer "Yes" to this?**

Documentation of a "discussion" is not an acceptable context to select value "1" (Yes) for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element. However, documentation of a "recommendation" for one of the inclusion terms is an acceptable context to select value "1" (Yes) for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element. The intent of this data element is to exclude patient cases where consideration of comfort care or palliative care may have impacted the timing of care that may adversely impact meeting the measure timing requirements. For purposes of the measure, comfort or palliative care does not need to be implemented. As the question reflects, a discussion of comfort or palliative care with the family does not indicate comfort or palliative care is being pursued. Documentation of a clinician recommendation also does not confirm comfort or palliative care are being implemented, but it is a stronger consideration or endorsement of comfort or palliative care and is therefore an acceptable context.

Question 56: **Slide 28. Why is the answer "A," since it is not used within the correct context?**

Thank you for the question. The correct answer to the question on slide 28 is B, Value "2" (No). In the presentation you viewed, the circle was inadvertently placed around the incorrect answer. The correct answer, B, Value "2" (No), is marked on the slide deck available online at QualityReportingCenter.com.

Question 57: **Are patients with severe sepsis or septic shock that are in palliative or hospice care excluded from the sepsis population?**

A case may be excluded if there is physician/APN/PA documentation within the specified time period including one of the acceptable inclusion terms documented within one of the acceptable contexts. Please refer to the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element.

Question 58: **If a patient is already in hospice care, from another company that is not offered at our hospital, prior to the arrival to the ED, is that considered meeting criteria for comfort care or palliative care?**

No, select value "2" (No) if the only documentation of hospice care refers to the pre-arrival time period. Here is the relevant passage from the guidance for your convenience:

- If the ONLY documentation found is an inclusion term in the following situations, select Value "2."
    - Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.

Question 59: **If palliative care is listed in the "Active Patient List," would this be acceptable to select "Yes"?**

No, select value "2" (No) because the "Active Patient List" is not one of the acceptable contexts provided in the data element.

Question 60: **If palliative care is consulted, but the patient would like aggressive measures, is this still considered an exclusion? If the palliative care consult is for pain control, is this still considered an exclusion?**

Yes. Select value "1" (Yes) if a palliative care consult is ordered within the specified time frame. Do this regardless of whether the patient would like aggressive measures or if the palliative care consult is for pain control.

Question 61: **If the physician documents patient is a do not resuscitate comfort care (DNRCC), does this meet the criteria for the comfort care data element?**

Yes, "DNRCC" is included as an acceptable inclusion term for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element.

Question 62: **If there is RN documentation of the patient being on comfort care and treatment orders are discontinued by the physician, will this meet criteria to be excluded for comfort care?**

No, physician/APN/PA documentation of an inclusion term within an acceptable context is required. Nursing documentation is not acceptable.

Question 63: **If there is an order for consultation or evaluation by a hospice care service, do we need to look for the actual order or is the documentation that there is an order acceptable?**

You would only select value "1" (Yes) if an order for a consultation or evaluation by a hospice care service is in the medical record. Documentation that there is an order is not acceptable in place of the actual order.

Initial Hypotension

Question 64: **Slide 30. Do you differentiate between active labor and active delivery? I am used to delivery as pushing, or very near the time of birth. Please provide a definition for active delivery.**

The guidance in the *Initial Hypotension* data element does not define active labor nor active delivery. For abstraction purposes, the medical record documentation must indicate the time period in which the patient is in active labor to determine which criteria may be excluded.

Question 65: **Slide 30. Would hypotension during dialysis be excluded if there is a notation that the hypotension is related to the dialysis?**

No, the hypotensive readings documented as "related to the dialysis" would be used. Further documentation of a non-infectious source causing the acute condition in this scenario is required to disregard hypotensive blood pressure (BP) readings attributed to an acute cause.

Question 66: **Slide 30. Do you use the hypotensive BPs during a code situation?**

Yes, use the hypotensive BP readings unless the BP readings are obtained within the operating room (OR), interventional radiology, during active delivery, or procedural/conscious sedation.

Question 67: **Slide 30. Would this guidance also apply to hypotension following sedation for intubation? If so, how do we know**

the time frame in which hypotensive values should not be used? Additionally, patients who are intubated often remain hypotensive for some time after sedation even though the procedure may only take a few minutes. At what point do we include BPs post-intubation where the patient has received sedation?

Yes, the guidance would apply to hypotension following sedation for intubation. For abstraction purposes, the medical record documentation must indicate the time period during which the patient is under procedural/conscious sedation. Only exclude BP readings during the time period when the patient is under procedural or conscious sedation. An example of this scenario is provided on slide 31.

Question 68: **Slide 30. How long after documentation that conscious sedation was administered would this apply?**

For abstraction purposes, the medical record documentation must indicate the time period during which the patient is under procedural/conscious sedation. Only exclude BP readings during the time period when the patient is under procedural or conscious sedation. An example of this scenario was provided on slide 31.

Question 69: **Slide 30. If the new or persistent hypotension time frame occurs when the patient is in the OR, would you select "No" for *Persistent Hypotension* or not assessed?**

You would select value "2" (No) if the patient was in the OR, interventional radiology, active delivery, or procedural/conscious sedation during the hour-long window to assess for *Persistent Hypotension.*

Question 70: **Slide 30. Why do we have to include BPs in the post anesthesia care unit (PACU) or recovery room, as they are still experiencing the effect of medications causing hypotension?**

The guidance within the *Initial Hypotension* data element does not exclude hypotensive readings taken within the PACU. If hypotension is due to a medication while the patient is in the PACU, further physician/APN/PA documentation attributing the hypotension to the medication is required to exclude the hypotensive reading(s). Hypotensive BPs obtained within the

OR are not used because medications are being administered to the patient that have a high likelihood of causing hypotension. The duration of these effects after the medication is stopped can vary depending on several factors. This makes determining the length of time after the medication is stopped to accept hypotension difficult to identify.

Question 71: **Are hemodialysis treatment areas and the preoperative care units excluded?**

No, they are not excluded; use criteria obtained in either of these areas. Only exclude BP readings obtained within the OR, interventional radiology, during active delivery, or procedural/conscious sedation.

Question 72: **Patients often have two mean arterial pressure (MAP) scores at the same time (e.g., one MAP calculated and one MAP cuffed). Would you use the lower value? Sometimes the MAP is also notated by arterial line versus cuffed and/or calculated. Which of the three would I use?**

Any hypotensive MAP reading documented within the specified time frame would be acceptable for meeting criteria. The guidance does not distinguish between the method the MAP reading is obtained.

Question 73: **Can nursing notes, denoting the times of the procedure, be used to determine presence of procedural sedation?**

Yes, nursing documentation is acceptable.

Persistent Hypotension

Question 74: **Slide 32. How would you abstract if the patient is only in the OR, interventional radiology or in active delivery for most of the hour-long window to assess for *Persistent Hypotension*?**

Assess for *Persistent Hypotension* based on BPs obtained outside of the OR, interventional radiology, or active delivery for the hour-long window after the target ordered volume of crystalloid fluids are completely infused.

Question 75: **Slide 32. Does OR include the recovery room or PACU for determining *Persistent Hypotension*?**

No. Use BP readings obtained in the PACU to determine *Persistent Hypotension*. Only exclude BP values obtained in the OR, interventional radiology, during active delivery, or procedural/conscious sedation.

Question 76: **Slide 32. Is there any consideration being made to not using hypotensive readings for a time frame following general anesthesia regardless of the patient's location?**

Thank you for the question. We are not able to comment on future updates being considered for the measure.

Question 77: **Slide 32. If the patient is receiving a vasopressor within an hour post IV fluid resuscitation, but the patient is in the OR, would you abstract Value "1" or "2"?**

Select value "2" (No) if the patient is in the OR during the hour to assess for *Persistent Hypotension.*

Question 78: **Slide 32. How do you abstract *Persistent Hypotension* when the patient is in interventional radiology and there is no time frame specific for the interventional radiology stay? Same for active labor. How do you establish the time frame to determine when the patient is in that condition, if this is not clearly documented?**

For abstraction purposes, the medical record documentation must indicate the time period in which the patient is in the OR, interventional radiology, active delivery, or procedural/conscious sedation to determine which hypotensive BP readings to exclude. Slide 31 presents an example of acceptable documentation for this time frame.

Question 79: **Slide 33. What is the appropriate answer to the question if the OR time was 1340–1425?**

If the time frame to assess for *Persistent Hypotension* was 1400 to 1500 as in the example on slide 33 and the patient was in the OR from 1340 to 1425, assess for *Persistent Hypotension* based

on the BPs obtained outside of the OR (from 1426 to 1500 in this case).

Question 80: **Slide 35. Does the vasopressor have to be started in the hour *Persistent Hypotension* is to be assessed to select value "1"?**

No. The guidance in the *Persistent Hypotension* data element does not include a time frame for the vasopressor administration. If *Persistent Hypotension* was unable to be determined, and at least one or more blood pressures were obtained, then you would select Value "1" (Yes) for *Persistent Hypotension* if the patient received a vasopressor. If you select Value "1" (Yes) for *Persistent Hypotension* based vasopressor administration, the case will then go to the *Vasopressor Administration* data element for abstraction.

Question 81: **Slide 35. By choosing Value "2," does that mean the case will fallout for *Persistent Hypotension*?**

Selecting value "2" (No) for the *Persistent Hypotension* data element would not cause the case to fail the measure. When you select value "2" (No) in this example, the algorithm takes the case to the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.

Question 82: **Slide 36. How do you define "unable to determine" in the statement "if one or more blood pressures were documented within the time frame and persistent hypotension is unable to be determined but a vasopressor was administered, select Value 1"?**

The *Persistent Hypotension* data element provides two scenarios in which *Persistent Hypotension* may be "unable to be determined":

1. Cases where only one blood pressure is obtained during the hour to assess for *Persistent Hypotension* and that BP is hypotensive.

2. Cases where there is a normal BP documented but the last BP reading in the hour is low.

In both scenarios, *Persistent Hypotension* would be "unable to be determined" and you would select value "3" (No). However, if there were one or more BPs documented and *Persistent Hypotension* was "unable to be determined" but a vasopressor was administered, select value "1" (Yes).

Question 83: **Slide 36. Does the vasopressor have to be administered within the time frame to select Value "1"?**

Same response as question 80.

Question 84: **Slide 39. Why else would a vasopressor be administered if no BPs were documented?**

Vasopressors are administered for hypotension. However, if no BPs were obtained following the completion of the target ordered volume of crystalloid fluids, select value "3" (No) for *Persistent Hypotension*.

Question 85: **Slide 39. Will choosing value "3" for not assessing *Persistent Hypotension* fail the measure?**

Yes, the case would fail if value "3" (No) or UTD is selected for *Persistent Hypotension.*

Question 86: **Four BPs were obtained between 1500 and 1600: The first three BPs were normal; the last BP was low. Would you not be able to determine that *Persistent Hypotension* was not met based on page 1–125 in Version 5.6a of the specifications manual?**

No, *Persistent Hypotension* would be "unable to be determined" because the hour ended with a single hypotensive BP reading. Page 1–125 of manual version 5.6 and page 1–90 of manual version 5.7 state to select value "3" (No) if there is a normal BP reading documented and the hour ends with a single hypotensive BP reading.

Question 87: **If there are two consecutive low BPs, but the last BP in the time frame is normal, would you select value "2"?**

Yes, select value "2" (No) if the hour ends with a normal BP reading. If there are more than two BPs documented, refer to the last two consecutive BPs within the hour. If there is a low BP followed by a normal BP, select value "2" (No).

Question 88: **How would we abstract if the BP was back to normal one minute after the hour was over and never dropped again?**

Would we be required to give vasopressors for a single low BP after the fluid bolus?

Only assess for *Persistent Hypotension* in the one-hour time frame after completion of the target ordered volume of crystalloid fluids. Do not use BPs documented outside of the one-hour time frame. If the last BP in the hour is low, you would select value "3". Clinicians should use their best clinical judgement for determination of interventions that are in the best interest of each individual patient. There is no requirement in SEP-1 for administration of a vasopressor if only a single hypotensive reading was documented.

Question 89: **For *Initial Hypotension* or *Persistent Hypotension*, if we have a MAP greater than 65 and systolic BP less than 90, can we take into consideration the MAP and rule out initial or persistent hypotension?**

No, use the hypotensive systolic blood pressure reading to meet *Initial Hypotension* or *Persistent Hypotension* criteria.

Question 90: **If *Persistent Hypotension* is UTD, there was a normal BP followed by a low BP within the hour after conclusion of fluids, but within the time frame the physician documented that the patient didn't want vasopressors. Will this case fail?**

The outcome depends on whether the patient had *Initial Hypotension* or *Septic Shock Present.*

If the patient had initial hypotension, you select value "1" (Yes) for *Initial Hypotension*. The algorithm will take the case through the *Crystalloid Fluid Administration* data elements. Then you would select value "3" (No) for *Persistent Hypotension* due to hour ending with a single hypotensive BP reading, and the case would fail.

If the patient did not have initial hypotension, you select value "2" (No) for *Initial Hypotension*. The algorithm then directs the case to *Septic Shock Present*. If the patient had septic shock, select value "1" (Yes) for *Septic Shock Present*, then you would select value "1" (Yes) for the *Administrative Contraindication to Care, Septic Shock* data element based on the documentation of the patient's refusal of a vasopressor. The case would be excluded rather than fail the measure.

Question 91: **Is it possible for a case to pass *Persistent Hypotension* and vasopressor administration if a vasopressor is started before the crystalloid fluids are completed? For example, septic shock and *Initial Hypotension* are present at 1200. Crystalloid fluids are started at 1215 and completed at 1414; vasopressor was started at 1400. *Persistent Hypotension* is noted between 1415 and 1515. Can this scenario pass due to vasopressor being started before crystalloids are completed?**

The case would pass if the *Vasopressor Administration Date* and *Time* was within six hours after the *Septic Shock Presentation Date* and *Time*. Vasopressor administration prior to the completion of crystalloid fluids would not affect whether the case passes or fails the measure.

Question 92: **If *Persistent Hypotension* is selected as Value "1," due to the patient receiving a vasopressor and the vasopressor was administered greater than six hours from presentation, will the case potentially fail?**

Yes, the case would fail if *Vasopressor Administration* occurs more than six hours after septic shock presentation.

Question 93: **IV fluids that infused more than 125 mL/hr are acceptable toward the 30mL/kg bolus. Is there any time period to complete the fluid bolus to assess the *Persistent Hypotension*?**

No, the guidance does not specify a time frame for the completion of the target ordered volume of crystalloid fluids. The target ordered volume of crystalloid fluids must be ordered and initiated within six hours prior through three hours after the *Initial Hypotension Time* or *Septic Shock Presentation Time.*

Question 94: **The patient's target ordered volume is 2000 mLs. NS 2000 mLs is ordered and initiated at 0800 to infuse over one hour. NS 500 mLs with IV Vancomycin was initiated at 0815 to infuse at 250 mLs/hr. I understand with the recent guidance the NS with the Vancomycin is not counted towards the target ordered volume as it is not needed. When evaluating for *Persistent Hypotension* and the one hour following target volume administration, is the NS with the Vancomycin considered?**

No, do not use the fluids used to dilute the medication. Use the target ordered volume determined by the *Crystalloid Fluid*

Administration data element to determine the hour to assess for *Persistent Hypotension.*

Question 95: **Is one low BP needed for end organ dysfunction and two needed for *Persistent Hypotension*? If so, do I use the first hypotensive reading time or the second time?**

Organ dysfunction can be met with a single hypotensive BP reading. *Persistent Hypotension* requires two consecutive hypotensive BP readings documented in the hour following the completion of the target ordered volume of crystalloid fluids. For the second question, without further information, we are unable to provide an accurate response to this question. Please submit your question via the *QualityNet.org* online Q&A tool for further assistance.

Question 96: **How do I abstract if the time frame during the hour to assess for *Persistent Hypotension* overlaps? For example, the hour to assess for *Persistent Hypotension* is 1200–1300. The patient is on the floor from 1200–1230 and no vital signs are recorded, the patient is then in the OR from 1230–1300. How would this be abstracted?**

If no BPs were documented outside of the OR within the one-hour time frame, select value "3" (No) or UTD. Do not use BPs obtained in the OR (from 1230–1300 in this example) to assess for *Persistent Hypotension.* Only use BPs documented outside of the OR and within the one-hour time frame.

Question 97: **Is Value "1' (Yes) abstracted if you are unable to determine *Persistent Hypotension* in the hour, but a vasopressor was started after the hour and within the six-hour time frame?**

Yes, select Value "1" (Yes) if one or more BPs are documented within the hour after the target ordered volume of crystalloid fluids is completely infused and *Persistent Hypotension* was unable to be determined but a vasopressor was administered. The guidance in the *Persistent Hypotension* data element does not provide a specified time frame for vasopressor administration.

Question 98: **If a hypotensive patient has only one BP taken during the hour after IV fluids, is a vasopressor indicated?**

For measure abstraction purposes, the case will only proceed to the *Vasopressor Administration* data element if value "1" (Yes) was selected for *Persistent Hypotension.*

Question 99: **We continue to abstract cases that multiple BPs are checked in the hour after the 30 mL/kg fluids have been infused. When only the last BP in the hour is hypotensive and BPs following the hour are not hypotensive, the case will fail if a vasopressor is not started. However, the last BP in the hour is the only hypotensive BP, so vasopressors are not started. Could you please consider another option for this question that we can answer that the BPs have been assessed but we are unable to determine if *Persistent Hypotensio*n is present without the case failing?**

Thank you for the question. The guidance in version 5.8 has been updated to address the scenario you described above. The updated guidance in version 5.8 states that "if there is a normal blood pressure followed by a low blood pressure, select Value "2" (No or UTD)." This will result in bypassing *Vasopressor Administration* and will not result in patient case failure. Specification manual version 5.8 is available for download on *QualityNet.org.*

Question 100 **How do you abstract *Persistent Hypotension* if all the BPs are normal, but a vasopressor was administered?**

Select value "2" (No) for *Persistent Hypotension* if all readings during the hour to assess for *Persistent Hypotension* were normal.

Repeat Volume Status and Tissue Perfusion Assessment Performed

Question 101 **Slide 40. Why was the fluid reassessment abstraction rule changed to earliest documentation from latest?**

The guidance was updated to use the earliest assessment documented within the specified time frame to reduce abstraction burden.

Question 102 **Slide 41. It was my understanding that at least five of the parameters needed to be documented as assessed to meet the**

requirement for repeat assessment. Is the example used in the slide "severe sepsis exam completed" enough?

Yes, physician/APN/PA documentation of "severe sepsis exam completed" documented within the specified time frame would suffice selecting value "1" (Yes). The *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element can be met by any one of the three options provided in the data element. The physician/APN/PA documentation "severe sepsis exam completed" suffices the first option within the data element regarding physician/APN/PA documentation attesting to performing or completing an exam. The second option to meet the repeat assessment criteria as defined by the data element requires physician/APN/PA documentation indicating or attesting to reviewing five of the eight parameters.

Question 103 **If you see documentation of a History and Physical within the time frame for fluid reassessment, is that enough to answer "Yes" or do you need to look for at least five of the data elements in fluid reassessment to answer "Yes"?**

No, documentation of a History and Physical (H&P) in the medical record is not on its own acceptable for selecting value "1" (Yes). Select value "1" (Yes) if documentation within the H&P sufficed five of the eight parameters and was documented within the specified time frame.

Question 104 **If the physician documentation includes elevated brain natriuretic peptide, chest x-ray showing pulmonary edema, or unresponsive to fluids based on EV1000 clinical platform, would that documentation exclude the case from the data element for full 30 mL/kg administered? Also, does the physician need to attest to reviewing the EV1000 for it to be used towards criteria for repeat volume status? Would RN documentation alone suffice for repeat volume status assessment?**

A case would not be excluded from *Crystalloid Fluid Administration* based on documentation of "elevated brain natriuretic peptide, chest x-ray showing pulmonary edema, or unresponsive to fluids based on EV1000 clinical platform." Only select value "4" (No) for *Crystalloid Fluid Administration* and exclude the case if there was physician/APN/PA documentation that the patient had a VAD or documentation that the patient or authorized patient advocate refused IV fluids.

Physician/APN/PA documentation attesting to reviewing the "EV1000" is not acceptable for meeting criteria of the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.

Select value "1" (Yes) if nursing documentation demonstrates that a central venous pressure, central venous oxygen saturation, echocardiogram, or fluid challenge or passive leg raise was measured or performed.

Question 105 **Can the exams be taken from different physician assessments? If two providers document the repeat volume status exam, but only the second documentation is in the appropriate time window, would you still choose the first?**

Use the earliest documentation of an assessment within the specified time frame to determine which allowable value to select for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. In this case, use the second provider's documentation if it is the earliest documentation within the time frame.

Question 106 **Does the physician documentation of "rechecked, patient resting comfortably" qualify for the perfusion assessment?**

No, this documentation is not consistent with the guidance requiring physician/APN/PA documentation attesting to performing or completing a physical examination, perfusion (re-perfusion) assessment, sepsis (severe sepsis or septic shock) focused exam, or systems review.

Question 107 **Documentation of the results of a comprehensive physical exam clearly indicates that a physical exam has been completed. Why is this documentation not acceptable? Logic dictates that documentation of the findings cannot occur without completing a physical exam.**

Select value "1" (Yes) if the physician/APN/PA documentation of a comprehensive physical exam indicates review of five of the eight parameters listed in the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. The presence of a physical exam on the medical record alone is not acceptable for physician/APN/PA documentation attesting to performing or completing a physical exam. Acceptable physician/APN/PA

attestation documentation must be similar to the examples provided within the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.

Question 108 **Why do findings of a comprehensive physical exam documented under an admit H&P not meet criteria? These findings could not occur if a physical exam did not occur. The specifications state that "documentation indicating or attesting to performance or completion of a physical exam." The findings of a comprehensive physical exam should be accepted.**

Same response as 107.

Question 109 **What is the "appropriate time window" for the repeat volume and tissue perfusion assessment?**

The specified time frame for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element is from the *Crystalloid Fluid Administration Date* and *Time* through six hours after the *Septic Shock Presentation Date* and *Time*.

Severe Sepsis Present

Question 110 **Slide 42. If severe sepsis/septic shock is met by SIRS criteria would this new guidance apply?**

No, the updated guidance on slide 42 does not apply if *Severe Sepsis Present* is met by clinical criteria.

Question 111 **Slide 42. Is documentation stating sepsis is related to a viral, fungal, or parasitic infection now required within a six-hour time frame of documentation? It did not have a time frame in previous versions of the specification manual.**

Physician/APN/PA documentation indicating severe sepsis or septic shock is due to a viral, fungal, or parasitic infection must occur within six hours after documentation of clinical criteria or physician/APN/PA documentation of Severe Sepsis in order to select value "2" (No) for *Severe Sepsis Present*. This guidance has not changed in manual version 5.7.

Question 112 **Slide 43. Why wouldn't you continue to look for clinical criteria or documentation during the entire length of stay?**

For purposes of the measure, only abstract the earliest presentation of severe sepsis. The case will be excluded if value "2" (No) is selected for *Severe Sepsis Present.*

Question 113 **Slide 43. Would you still select "No" for *Severe Sepsis Present* if septic shock was documented after the six-hour time frame but still within the 24 hours?**

No, select value "1" (Yes) for *Severe Sepsis Present*. Then, select value "2" (No) for *Septic Shock Present* if septic shock presented more than six hours after the *Severe Sepsis Presentation Time.*

Question 114 **Slide 43. Wouldn't "no further concern for septic shock" indicate it was once present and is now resolving?**

Take the documentation at face value as indicating septic shock is not present. Select value "2" (No) if *Severe Sepsis Present* was met by physician documentation of septic shock and there is documentation indicating septic shock was not present within six hours after documentation of severe sepsis presentation.

Question 115 **Slide 44. If the patient has a history of end stage renal disease (ESRD) and is on hemodialysis, do you dismiss the elevated creatinine?**

Do not use the elevated creatinine value(s) for patients with ESRD who are on hemodialysis.

Question 116 **Slide 44. The physician documented organ dysfunction, not related to infection, in the ED. Do you use any organ dysfunction during the hospital stay or only abnormal values during the time of documentation?**

Use the evidence of organ dysfunction. To not use evidence of organ dysfunction, physician/APN/PA documentation prior to or within 24 hours after the *Severe Sepsis Presentation Time* must attribute the evidence of organ dysfunction to be normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition with a non-infectious source.

Question 117

Slide 44. The slide states, "The abnormal value or reference to the abnormal value must be in the same documentation." The example on slide 45 leads one to believe the documentation of chronic atrial fibrillation (A-fib) and documentation of A-fib with rapid ventricular response (RVR) are separate notes. Can you please clarify? Does the abnormal value have to be in the same sentence as the condition or is it acceptable for it to be on same page?

The example on slide 45 only includes the "chronic A-fib." The example does not attribute an abnormal value or reference to the abnormal value to the chronic condition. Therefore, use the elevated heart rate per the example on slide 45. If a chronic condition and abnormal value are documented in separate notes, do not disregard the abnormal value.

The example on slide 48 provides APN documentation attributing the elevated heart rate (RVR) to A-fib. The ED physician documentation in the example demonstrates A-fib is a chronic condition for this patient. Therefore, the elevated heart rate is in the same documentation as the chronic condition and you would not use elevated heart rate.

Question 118

Slide 45. If the ED physician documents history of A-fib and the ED vital signs flowsheet documents heart rate of 120 beats/minute, do you abstract the elevated heart rate as SIRS criteria?

Yes, use the elevated heart rate. To not use the elevated heart rate, physician/APN/PA documentation prior to or within 24 hours after the *Severe Sepsis Presentation Time* must state within the same documentation that the elevated heart rate is normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition with a non-infectious source.

Question 119

Slide 45. The patient has an elevated bilirubin of 2.5 and the lab result is included in the physician note and, within the same progress note, the physician documents "elevated liver function tests due to chronic hepatitis." Is the bilirubin result excluded as organ dysfunction?

No, use the elevated bilirubin as evidence of organ dysfunction. To not use the elevated bilirubin, physician/APN/PA documentation prior to or within 24 hours after the *Severe Sepsis Presentation Time* must state within the same documentation that the elevated bilirubin is

normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition with a non-infectious source.

Question 120 **Slide 48. Is it now acceptable for those two items to be documented in different places? I thought they needed to be documented together.**

No, the abnormal value or reference to the abnormal value must be in the physician/APN/PA documentation that it is normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition with a non-infectious source. The example on slide 48 provides APN documentation attributing the elevated heart rate (RVR) to A-fib. The ED physician documentation in the example demonstrates A-fib is a chronic condition for this patient. Therefore, the elevated heart rate is in the same documentation as the chronic condition and you would not use elevated heart rate.

Question 121 **Slide 48. If the only documentation was the APN note of A-fib with RVR, would you still not use the elevated heart rate? In the example, the APN note does not say if the A-fib with RVR is part of the patient's history or if the RVR is new for this patient. If the A-fib is chronic but the RVR is new for this admission, should the heart rate be used as criteria for severe sepsis?**

Use the elevated heart rate if the only documentation states "A-fib with RVR" because A-fib may be an acute condition for the patient. To not use the elevated heart rate, physician/APN/PA documentation prior to or within 24 hours after the *Severe Sepsis Presentation Time* must state within the same documentation that the elevated heart rate is normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition with a non-infectious source.

Do not use the elevated heart rate if the elevated heart rate (RVR) is documented as due to chronic A-fib.

Question 122 **Slide 48. Why is the answer "No" if the chronic condition is not in the same documentation as the abnormal value? In the example, the APN note does not document chronic A-fib.**

The example on slide 48 provides APN documentation attributing the elevated heart rate (RVR) to A-fib. The ED physician documentation in the example demonstrates A-fib is a chronic condition for this patient. Therefore, the elevated heart rate is in the same documentation

as a chronic condition based on the APN documentation "A-fib with RVR," and you would not use elevated heart rate.

Question 123 **Slide 48. If the A-fib is not identified as being chronic but there is documentation of A-fib with RVR, would we still abstract the elevated heart rate?**

Yes, abstract the elevated heart rate if the only documentation states "A-fib with RVR" because A-fib may be an acute condition for the patient. To not use the elevated heart rate, physician/APN/PA documentation prior to or within 24 hours after the *Severe Sepsis Presentation Time* must state within the same documentation that the elevated heart rate is normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition with a non-infectious source.

Question 124 **Slide 48. A-fib with RVR is a rhythm interpretation that can be an acute or new condition. To accept documentation of "A-fib with RVR" without further documentation in the same note that the patient has a history of A-fib does not make sense. "A-fib with RVR" does not mean the patient has a history of A-fib. It means their current rhythm on the electrocardiogram is A-fib with an RVR and by no means indicates chronicity, that it is due to medication, that it is normal for the patient, or that it is due to a condition that is not infectious. I do not think we should be automatically excluding any heart rates when the rhythm interpretation of "A-fib with RVR" is documented without further documentation in the same note indicating the patient has a history of A-fib.**

Abstract the elevated heart rate if the only documentation states "A-fib with RVR" was documented since A-fib may be an acute condition for the patient. To not use the elevated heart rate, physician/APN/PA documentation prior to or within 24 hours after the *Severe Sepsis Presentation Time* must indicate that the elevated heart rate is normal for the patient, due to a chronic condition, due to a medication, or due to an acute condition with a non-infectious source within the same documentation.

Question 125 **What is the difference between A-fib with RVR and A-fib with tachycardia? How is it possible to say that A-fib with tachycardia is acceptable but with an RVR it is not acceptable? A-fib with tachycardia is A-fib with RVR.**

There is no distinction within the measure between the documentation of "A-fib with RVR" or "A-fib with tachycardia." Both consider the

elevated heart rate to be due to A-fib. A-fib must be indicated as a chronic condition for the patient in order to not use the elevated heart rate based on either documentation of "A-fib with RVR" or "A-fib with tachycardia."

Question 126 **Where in the SEP-1 algorithm does it show excluding a patient that is receiving IV antibiotics for more than 24 hours prior to presentation of severe sepsis?**

The Broad Spectrum Antibiotic Timing calculation on page SEP-1-10 of the Measure Information Form determines whether the *Broad Spectrum or Other Antibiotic Administration Date* and *Time* happened more than 24 hours before *Severe Sepsis Presentation Date* and *Time*. If the Broad Spectrum Antibiotic Timing indicates that the *Broad Spectrum or Other Antibiotic Administration Date and Time* happened more than 24 hours before *Severe Sepsis Presentation Time*, then the case would be excluded.

Question 127 **If a provider documents sepsis with organ dysfunction but the criteria is not met, can this documentation be used for severe sepsis?**

The documentation of "sepsis" is acceptable for criteria A (infection). Do not use the documentation of "sepsis with organ dysfunction" as documentation of severe sepsis.

Question 128 **If the physician documents sepsis without organ dysfunction, can this documentation exclude the organ dysfunction if one of the organ dysfunction criteria was met?**

No. The physician/APN/PA documentation must state that the SIRS criteria or evidence of organ dysfunction is normal for the patient, due to a chronic condition, or due to a medication, or due to an acute condition that has a non-infectious source or process in order to not use the organ dysfunction criterion.

Question 129 **If the patient is admitted to ICU from PACU still intubated, does this count as organ dysfunction?**

No, documentation of intubation alone is not used as evidence of organ dysfunction. Only initiation of mechanical ventilation is used as evidence of organ dysfunction.

Question 130 **If a patient has a history of chronic kidney disease and a creatinine of 2.5, can this be used as criteria for organ dysfunction if there is no physician documentation linking the two?**

Yes, use the elevated creatinine as evidence of organ dysfunction.

Question 131 **We have received guidance in the past that if the patient has A-fib and is on Eliquis we would discount both the elevated heart rate and the elevated international normalized ratio. Why has this guidance changed?**

The guidance regarding when to not use the elevated heart rate has not been updated in manual version 5.7. If you have further questions about a specific scenario, please follow-up by submitting a question through the *QualityNet.org* online Q&A tool.

Question 132 **When looking at SIRS criteria, should an abnormal temperature be used for patients that are under a treatment plan for targeted temperature management? If so, is this directive located in the specification manual?**

Do not use the abnormal temperature that is due to an artificial intervention. The below guidance is in the *Severe Sepsis Present* data element (pages 1–124 of the data dictionary):

- SIRS criteria or a sign of organ dysfunction due to artificial interventions should not be used.

  Example: Mechanical ventilator rate set at 24 and respiratory rate is 24, the respiratory rate would not be used for SIRS criteria.

- If an artificial intervention is unable to control a patient's physiological function, the SIRS criteria or a sign of organ dysfunction should be used.

  Example: Mechanical ventilator rate set at 24 and respiratory rate at 28, the respiratory rate should be used for SIRS criteria.

Question 133 **If severe sepsis is met but within six hours the physician documents "pneumonia not suspected as patient does not appear toxic," do we stop abstracting there, answering "no" to severe sepsis? Or, do we move on to the next day when pneumonia is confirmed and say "Yes" to severe sepsis if all elements are met within six hours of each other again?**

Only select value "2" (No) for *Severe Sepsis Present* if there is physician/APN/PA documentation within six hours after severe sepsis presented indicated the patient does not have sepsis or severe sepsis.

Do not use pneumonia to meet criteria A (infection) if within six hours after the documentation of pneumonia there is physician/APN/PA documentation indicating pneumonia is not present. Continue to review for documentation of an infection that is within six hours of criteria B and C to establish severe sepsis criteria.

Question 134 **If there is physician documentation of severe sepsis/septic shock being present on admission, but the patient never met criteria, do we choose Value "1" or "2"?**

Select value "1" (Yes) for *Severe Sepsis Present* based upon the physician/APN/PA documentation of severe sepsis or septic shock.

Question 135 **If a patient meets severe sepsis criteria but not shock, but the physician says septic shock, would it be "Yes" to both? If the patient was "Yes" to severe sepsis due to physician documentation of septic shock and within six hours, and had the physician saying no septic shock, then would we say no to both severe sepsis and septic shock? In the first case scenario, would it be "Yes" to severe sepsis and the "No" to septic shock?**

If severe sepsis is met by clinical criteria, and septic shock is met by physician documentation of septic shock, select value "1 (Yes)" to both *Severe Sepsis Present* and *Septic Shock Present*.

If severe sepsis is met by clinical criteria, and septic shock is met by physician documentation of septic shock, and there is additional physician documentation indicting septic shock is not present, select value "1 (Yes)" for *Severe Sepsis Present* and select value "2 (No)" for *Septic Shock Present*.

Based on updated guidance for version 5.7, if the presence of severe sepsis is based on physician documentation of septic shock, and within six hours there is additional physician documentation indicting septic shock is not present, select value "2 (No)" for both *Severe Sepsis Present*. The patient case will be excluded from the measure and you will not need to abstract the *Septic Shock Present* data element.

Question 136 **Clinical criteria was met for severe sepsis at 1513; then, IV antibiotic was started at 1526 for community acquired**

pneumonia without severe sepsis. Would I abstract 1513 as the presentation time?

Based upon only the information in the question, select value "2" (No) if severe sepsis was present at 1513 and the physician/APN/PA documentation at 1526 indicates severe sepsis is not present. If you have further questions pertaining to this scenario, please follow-up by submitting a question through the *QualityNet.org* online Q&A tool.

Question 137

Our ED physicians list many possible diagnoses in their initial differential diagnosis when the patient presents to the ED. They often change their admitting diagnosis following assessments, labs and diagnostic exams to be more focused, and that may or may not include an infective process. Should that initial differential diagnosis be used as documentation of infection when that is not included in the admitting diagnosis as the physician has effectively ruled that out?

Yes, use physician/APN/PA documentation of an infection on a differential diagnosis list. To not use a documented infection, further physician/APN/PA documentation is required within six hours following the initial documentation of the infection indicating the infection is not present.

Question 138

How would you abstract the following scenario when there are multiple inclusions, times, negations, negative qualifiers in a single provider note and finalize it with a final impression that includes an inclusion term?

The ED note start time is 1030. Within the ED note there is a timed screen for severe sepsis with a box checked for severe sepsis now at 1040. Additionally, within the note, there is documentation that the physician has screened the patient for severe sepsis and found it unlikely. Towards the end of the note, the physician decides to finalize it with a final diagnosis of septic shock at 1030. Since there is a positive and negative qualifier for severe sepsis, do we disregard this documentation? Would severe sepsis be at 1040?

Select value "1" (Yes) for *Severe Sepsis Present* and *Septic Shock Present* with a presentation time of 1030 for both based upon the physician documentation of septic shock. Disregard the documentation of severe sepsis containing both a positive and negative qualifier at 1030. If there was further documentation within six hours after severe

sepsis presentation indicating the patient did not have sepsis or severe sepsis, then select value "2" (No) for *Severe Sepsis Present.*

Question 139 **If the patient meets criteria, or there is documentation for severe sepsis, and the provider adds documentation stating no septic shock, would we still abstract "Yes" for *Severe Sepsis Present*? What if severe sepsis presentation is at 1500, then there is documentation at 1600 that indicates no severe sepsis, and then at 1800 there's another presentation that meets severe sepsis? Are you going to take 1800 as severe sepsis presentation?**

Select value "1" (Yes) for *Severe Sepsis Present* if severe sepsis was met by clinical criteria or physician/APN/PA documentation of severe sepsis, even if there is documentation stating no septic shock.

Select value "2" (No) for *Severe Sepsis Present* if severe sepsis presented at 1500 and there was physician/APN/PA documentation at 1600 indicating severe sepsis was not present. The case would be excluded upon selecting value "2" (No) for *Severe Sepsis Present.* You would not abstract the 1800 presentation. Based on guidance in the *Severe Sepsis Presentation Time* data element, if there are multiple severe sepsis presentation times, only abstract the earliest presentation time.

Severe Sepsis Presentation Date and Time

Question 140 **Slide 49. The discharge summary states that the patient had severe sepsis present on arrival. Do I count that as the first site of diagnosis, or do I not count it at all?**

Do not use documentation of severe sepsis in a discharge summary. Suggested data sources for this data element are any physician/APN/PA documentation, any ED record, hourly output record, intake/output record, laboratory results, nurses' notes, and vital signs record or flow sheet.

Question 141 **Slide 49. Can we take documentation of sepsis on admission after 24 hours of admit? Is there a specific time frame as to when this must be documented?**

Yes, documentation of sepsis on admission is acceptable for criteria a (documentation of an infection). To establish severe sepsis, all three clinical criteria (a, b, and c) must be met within six hours of each other.

Question 142 **Slide 49. Is it acceptable to use queries to the physicians to meet present on admission?**

Yes, any physician/APN/PA documentation of severe sepsis that is not from a discharge note, discharge summary, or documented after the time of discharge is acceptable for establishing severe sepsis.

Question 143 **Slide 49. Does the physician/APN/PA note need to be the note open time? If there is no note open time, do I continue and look at the admit order, disposition to inpatient, or arrival to floor or unit documentation? What does disposition to inpatient mean?**

Slide 49 provides guidance on how to determine the *Severe Sepsis Presentation Time* when severe sepsis is only documented as "present on admission." If severe sepsis is documented as "present on admission," use the earliest time of the following:

- Physician/APN/PA note
- Admit order
- Disposition to inpatient
- Arrival to floor or unit

If the physician/APN/PA note does not have a time, use the earliest time among the remaining options. The disposition to inpatient represents when the patient status is changed to inpatient status indicating the patient is being admitted to the hospital.

Question 144 **Slide 49. Severe sepsis criteria are met on hospital day two. On hospital day three the physician documents "admitted with severe sepsis." Would you use the criteria time or go back to arrival to unit time for severe sepsis?**

Use the time severe sepsis clinical criteria were met on day two to establish the *Severe Sepsis Presentation Time*. The updated guidance on slide 49 applies to cases where the only documentation of severe sepsis being present is in a physician/APN/PA note that severe sepsis was present on admission. In this question, the presence of severe sepsis is not limited to only a physician/APN/PA note.

Question 145 **Slide 49. Does the documentation have to specifically state "Severe sepsis present on admission" or can documentation such as "Admit diagnosis: severe sepsis" in a note be acceptable?**

The guidance on slide 49 only pertains to severe sepsis documented as "present on admission."

Question 146 **Slide 49. If the admit order is "planned" prior to initiation, do you use the planned time or the initiation time?**

Use the earliest admit order time to establish *Severe Sepsis Presentation Time.* Planned admission does not necessarily represent the time of the admit order.

Question 147 **Slide 49. If the only documentation states, the "patient was admitted for severe sepsis" would I follow the guidance on this slide?**

No, use the time of the physician/APN/PA documentation of severe sepsis in this case. The guidance on slide 49 only applies when severe sepsis is documented as "present on admission."

Question 148 **Slide 49. Can you clarify the guidelines regarding the use of admission date and time if there is documentation that severe sepsis was present on admission? It was stated that this date and time can be used if "severe sepsis was present on admission" is the only documentation of severe sepsis. If there is other documentation of severe sepsis in the chart and there is documentation of severe sepsis present on admission, can you still use the choices for admission date and time?**

No, the guidance on slide 49 applies when severe sepsis is documented only as "present on admission." In this case, use the earliest time of physician/APN/PA documentation of severe sepsis.

Question 149 **If a patient presents to the ED and meets all criteria for severe sepsis in the ED and then is admitted to the hospital, which presentation time do I use as *the Severe Sepsis Presentation Time*, the time the patient met criteria in ED or the admission time?**

Use the earliest *Severe Sepsis Presentation Time* available. If the patient met criteria in the ED, and then was admitted to the hospital, use the time severe sepsis clinical criteria was met in the ED.

Question 150 **If it is noted that severe sepsis is present on admission, and severe sepsis is also found by organ dysfunction and SIRS, do you select the clinical findings finding over the physician documentation of present on arrival?**

If there are multiple sources of documentation indicating severe sepsis was present, use the earliest time severe sepsis clinical criteria were met. The updated guidance on slide 49 applies to cases where the only documentation of severe sepsis being present is in a physician/APN/PA note that severe sepsis was present on admission. Based on the question it appears this is asking about a situation where the presence of severe sepsis is not limited to only a physician/APN/PA note.

Question 151 **If the patient meets all criteria for severe sepsis in the ED, but the ED physician documents that the patient does not have sepsis, but the inpatient physician documents sepsis as a diagnosis/problem, what time would you document as the onset time?**

If the patient met severe sepsis clinical criteria and within six hours after meeting clinical criteria there is physician/APN/PA documentation stating, "the patient does not have sepsis," you would select value "2" (No) for *Severe Sepsis Present.* Based on guidance in the *Severe Sepsis Presentation Time* data element, if there are multiple severe sepsis presentation times, only abstract the earliest presentation time. Since the first presentation time was negated, you do not need to continue abstraction.

Question 152 **If "severe sepsis" is documented both at a specified time and a non-specified time in the same provider note, you would use the specified time. If an infection is documented both at a specified and a non-specified time in the same note, would the specified time take precedence?**

No, the guidance is different for each of the scenarios described. For criteria A (documentation of infection), use the earliest time documented (may be documentation for an infection with a specified time or the note opened time for documentation of an infection without a specified time) that is also within six hours of criteria B and C to establish the earliest *Severe Sepsis Presentation Time.*

Question 153 **If the lactic value is the organ dysfunction used to abstract the *Severe Sepsis Presentation Time*, can we use the same value as the *Initial Lactic Acid* if that's the only value and use the *Repeat Lactic Acid* value present after the severe sepsis time?**

Yes, an elevated lactate can be used as evidence of organ dysfunction and as the *Initial Lactate Level Result.* The *Repeat Lactate Level Collection* must occur after the *Initial Lactate Level Collection* and within six hours after the *Severe Sepsis Presentation Time.*

Question 154 **If severe sepsis presentation is met on 11/20/2019 at 1610, and there is physician documentation at 1600 that severe sepsis criteria is not met at time of admission, admission time is 1840. Is it the timing of the physician documentation that needs to occur within six hours after severe sepsis presentation or is it the six-hour time window starting with the admission time?**

The six-hour time frame within which physician/APN/PA documentation indicating severe sepsis was not present starts with *Severe Sepsis Presentation Time.*

Septic Shock Presentation Date and Time

Question 155 **Slide 50. Is it correct for the initial lactate we use the resulted time and not the draw time? If so, is this guidance the same for the repeat lactate?**

Use the time of the *Initial Lactate Level Result* to establish presence of septic shock. Use the lactate collection date and time for the *Initial Lactate Level Collection* and *Repeat Lactate Level Collection* data elements.

Question 156 **Slide 50. I thought the instructions say that if it is initial lactate time, we use the collection time and if the lab result is used to meet for severe sepsis then we use the resulted time.**

Slide 50 pertains to establishing the *Septic Shock Presentation Time* when septic shock is met by severe sepsis and an *Initial Lactate Level Result* ≥4. Use the time of the *Initial Lactate Level Result* when available to establish the *Septic Shock Presentation Time.* Use the lactate collection date and time for the *Initial Lactate Level Collection* and *Repeat Lactate Level Collection* data elements.

Question 157 **Slide 50. Is it acceptable to use labs drawn at a clinic when a patient is admitted as a direct admit?**

Yes, it is acceptable to use documentation in pre-hospital records for determining presence of Septic Shock.

Question 158 **Slide 50. If there is nursing documentation that the lactate values were reported to the physician with a time and the lab results are documented by laboratory with a later time, can we take the nursing documentation which is earlier and correct?**

No, use the time the lactate result is documented by the laboratory. The lactate result time from the lab is the priority source.

Question 159 **Slide 50. Is the CMS Data Abstraction Center aware of the guidance for the lab results time? They used the lab times in the ED physician note instead of the actual lab result times and our facility was dinged for this.**

The guidance on slide 50 was updated in manual version 5.7 and applies to discharges January 1–June 30, 2020. The CMS Data Abstraction Center will use manual version 5.7 upon validation of first and second quarter 2020 discharges.

Question 160 **Slide 51. If there is other documentation of septic shock, other than Physician/PA/APN documentation of septic shock on arrival, do I use the earliest time of either admission or clinical criteria?**

Use the earliest documented arrival time to the ED if the patient entered through the ED and septic shock was documented as "present on arrival."

Question 161 **Slide 51. If septic shock is documented as present on admission, do we use the earliest time out of the four options even though it's not stated septic shock on that document/location?**

Yes, you would use the earliest time of either the physician/APN/PA note, admit order, disposition to inpatient, or arrival to floor or unit.

Question 162 **Slide 53. If, within the lab result, the lab tech has documented that the physician was notified at 1820 of the result of 4.5, would**

you then abstract the time as 1820? If the lab documents the time that the results of the initial lactate were called to the ED or inpatient units, can that time be used?

If a time is not available for the lactate result from the lab, the earliest time within a narrative note directly associated with the lactate result (e.g., lactate sent to the lab, lactate received, lactate result) may be used.

Question 163 **Slide 53. Why isn't the initial lactate draw time used? The data element *Initial Lactate Level Collection* data element asks, "Was an initial lactate level drawn within the specified time frame?" It does not ask if the lactate level was resulted within the specified time frame. If the collection time is earlier than the lab result time, would we abstract the collection time?**

Slide 53 is identifying the presence of septic shock, which in this slide is determined by a lactate level greater than 4 millimoles (mmol)/L. Because the presence of septic shock is based upon the lactate level, the time of the *Initial Lactate Level Result* is used. The *Initial Lactate Level Collection* data element is looking for the time the initial lactate level was drawn because the initial lactate needs be drawn within the specified time frame to meet the numerator criteria of a lactate being drawn within three hours of severe sepsis presentation.

Question 164 **What is the crystalloid fluid timing when septic shock is met by the lactate level? Is it six hours prior to the lactate result time to three hours after the septic shock time?**

Acceptable crystalloid fluids must be ordered and initiated within the six hours prior through three hours after *Initial Hypotension* or the *Septic Shock Presentation Time.* If a case meets septic shock criteria based on a lactate level greater than or equal to four, use whichever time comes later between *Severe Sepsis Presentation Time* or the *Initial Lactate Level Result* to determine *Septic Shock Presentation Time*. If the *Septic Shock Presentation Time* is based on the time of the *Initial Lactate Level Result*, then acceptable crystalloid fluid must be ordered and initiated within the six hours prior through three hours after the time of the *Initial Lactate Level Result/Septic Shock Presentation Time.*

Question 165 **Can you explain why the note open time, if earlier, would be taken for the time of infection if infection is documented within the note without a time, instead of an actual time documented for the infection within the note? This is a huge issue with the ED**

physicians as they do not know the patient has an infection when they open the note when they walk into the room.

The note opened time is used when an infection is documented within a note without a specified time. Using the note opened time provides a consistent time to use in abstraction when a specified time is not available within the narrative documentation.

Question 166 **Shouldn't the guidance for lactate result time also be used for imaging results that are pulled into the physician notes?**

No, the guidance regarding the time of the *Initial Lactate Level Result* pertains to establishing the *Septic Shock Presentation Time.* Imaging results are not included as a criterion for meeting septic shock.

Question 167 **Would the following documentation be appropriate as inclusion terms?**

- **"Shock, probably r/t sepsis"**
- **"sepsis, severe"**
- **"shock, sepsis"**
- **"shock, cardiogenic vs. septic"**

The following terms are acceptable for identifying the presence of an infection for the *Severe Sepsis Present* data element, because sepsis is acceptable as an infection. These cannot be used for *Septic Shock Present* because the word "shock" is not referenced as related to Severe Sepsis or Septic Shock.

- Shock, probably r/t sepsis
- shock, sepsis

The following is acceptable for the *Severe Sepsis Present* data element, because is references sepsis as severe.

- sepsis, severe

The following is acceptable for the *Septic Shock Present* data element, because shock is being considered as either cardiogenic or septic. Shock described as septic is acceptable.

- shock, cardiogenic vs. septic

Question 168 **To be considered septic shock, is the word "shock" acceptable or does it have to specifically state "septic shock"?**

No, documentation of "shock" alone is not acceptable documentation of septic shock. Acceptable physician/APN/PA documentation must reflect septic shock or severe sepsis with shock.

Transfer From Another Hospital or Ambulatory Surgery Center (ASC)

Question 169 **Slide 54. Is a transfer from a psychiatric floor or a psychiatric building on campus to the ICU in the same hospital considered a *Transfer From Another Hospital or ASC*?**

If the psychiatric facility is a unit within your hospital, select value "2" (No). If the psychiatric facility is a separate hospital within your hospital, then select value "1" (Yes).

Question 170 **Slide 54. If the patient is received from a psychiatric building on our campus, is this considered a transfer?**

If the psychiatric facility is a unit within your hospital, select value "2" (No). If the psychiatric facility is not within your hospital or if it is a separate hospital within your hospital, then select value "1" (Yes).

Question 171 **Slide 54. Would you select "Yes" if the patient was received as a transfer from an urgent care facility?**

No, select value "2" (No) for the *Transfer From Another Hospital or ASC* data element if a patient transferred from an urgent care center.

Question 172 **Slide 54. If a patient comes from the OR and is admitted to the floor or ICU and severe sepsis is present, would you select "No" for *Transfer From Another Hospital or ASC*?**

Yes, select value "2" (No) for the *Transfer From Another Hospital or ASC* data element because the patient is transferred between two units in the same hospital.

Question 173 **Slide 54. Are transfers from one unique unit in the hospital (e.g., rehab unit, detox unit) considered transfers?**

No, select value "2" (No) for the *Transfer From Another Hospital or ASC* data element if patients are transferred from psych or rehab units inside the hospital.

Question 174 **Slide 54. If a patient transfers from another ED, which shares the same hospital CMS Certification Number (CCN) but has a different encounter number, do you answer "Yes" or "No" to *Transfer From Another Hospital or ASC*? The ED visit from the first ED is usually bundled with the second ED visit which then results in an admission.**

Select value "1" (Yes) for the *Transfer From Another Hospital or ASC* data element if the patient transferred from an ED outside of your hospital.

Question 175 **Slide 54. If a patient was seen in the ED and was transferred from a sister hospital is this considered an outside hospital transfer?**

Yes, select value "1" (Yes) for the *Transfer From Another Hospital or ASC* data element if the patient transferred from an outside hospital to your hospital.

Question 176 **Slide 54. Is a free-standing emergency clinic, that is not attached to a hospital but has 24-hour access and has ED emergency physicians, considered a *Transfer From Another Hospital or ASC*?**

Select value "1" (Yes) for the *Transfer From Another Hospital or ASC* data element if the patient is received as a transfer from a free-standing ED. Select value "2" (No) if the patient is received as a transfer from a clinic.

Question 177 **Slide 54. For *Transfer From Another Hospital or ASC*, what is the difference between a 24-hour, seven-day-a-week free standing ER and an urgent care center?**

The *Transfer From Another Hospital or ASC* data element does not provide definitions for each facility. For abstraction purposes, use the documentation within the medical record identifying the type of

facility the patient was transferred from to determine if value "1" (Yes) or value "2" (No) is appropriate.

Question 178 **Slide 54. If you have a distinct part rehabilitation or psychiatric unit, with a different CCN, would this be considered a transfer?**

No, you would select value "2" (No) if the patient transferred from another unit of your hospital.

Other Data Elements

Question 179 **If a patient does not meet severe sepsis criteria and refuses treatment, is that justification for answering "Yes" for the *Administrative Contraindication to Care, Severe Sepsis* data element?**

If *Severe Sepsis Present* is not met by clinical criteria or physician/APN/PA documentation, select value "2" (No) for *Severe Sepsis Present.* The case would be excluded before reaching the *Administrative Contraindication to Care, Severe Sepsis* data element in the algorithm.

Question 180 **If a patient receives an antibiotic within 24 hours prior to *Severe Sepsis Presentation*, but there is no documentation to indicate that it was administered for infection, as a prophylactic for surgery, or for an obstetrics (OB) patient with ruptured membranes, group B strep, or prior C-section, would this antibiotic be used to abstract that there is an acceptable blood culture delay?**

In this situation, you would select value "2 (No)" for the *Blood Culture Collection Acceptable Delay* data element. A blood culture delay is only acceptable if there is documentation indicating the antibiotic was for surgical prophylaxis, was started for an infection, was started prior to arrival, was for OB ruptured members, group B strep or c-section prophylaxis, or there was clinician documentation that delaying the antibiotic to draw the culture could be detrimental to the patient. This question indicates there is not documentation of any of these situations that supports an acceptable delay for obtaining a blood culture.

Sepsis Bundles

Question 181 **Slide 57. Will the bundle-level results be publicly displayed on *Hospital Compare* in January 2020 or only on the preview report?**

The bundle-level results are available with the January 2020 *Hospital Compare* release. They were included in the hospital-specific preview reports and are available in the following *Hospital Compare* downloadable datasets:

- Timely and Effective Care - Hospital
- Timely and Effective Care - National
- Timely and Effective Care - State

Question 182 **Slide 58. Where do the IV fluids given for severe sepsis with *Initial Hypotension* fall in these bundles?**

The IV fluids are in the Septic Shock 3-hour bundle. This is illustrated in the annotated algorithm downloadable from the Hospital Inpatient Specifications Manuals Version 5.5a - Discharges 01/01/2019 - 06/30/2019 page on *QualityNet* at https://qualitynet.org/inpatient/specifications-manuals#tab4.

Being included in the Septic Shock 3-hour bundle is supported by the following section of the SEP-1 numerator statement:

AND within three hours of initial hypotension:

- Resuscitation with 30 mL/kg crystalloid fluids

OR within three hours of septic shock:

- Resuscitation with 30 mL/kg crystalloid fluids

Question 183 **In the Quarter 1 2019 bundle-level report we received, cases where septic shock was not present were included in both the numerator and denominator for the Septic Shock 3-hour bundle, even if they did not have *Initial Hypotension* present. Can you explain why these cases are included in the Septic Shock 3-hour bundle?**

Since we do not have access to the individual cases, the medical records, or the allowable values you abstracted for the data elements, we are not able to provide an explanation. We recommend you review the annotated algorithm downloadable from the Hospital Inpatient Specifications Manuals Version 5.5a - Discharges 01/01/2019 -

06/30/2019 page on *QualityNet* at https://qualitynet.org/inpatient/specifications-manuals#tab4.

Question 184 **When will the Sepsis (SEP)-1 bundles be available within *QualityNet* reporting for end users to run?**

The bundle-level results became available with the January 2020 *Hospital Compare* release. The results are accessible in the following *Hospital Compare* downloadable datasets:

- Timely and Effective Care – Hospital
- Timely and Effective Care – National
- Timely and Effective Care – State

Question 185 **Will these bundle-level results be included in the SEP-1 benchmarks of care on *QualityNet*?**

CMS is no longer publishing the benchmarks of care reports on *QualityNet*. The bundle-level results are accessible in the following *Hospital Compare* downloadable datasets:

- Timely and Effective Care – Hospital
- Timely and Effective Care – National
- Timely and Effective Care – State

The national data set includes national average results and a 90th percentile result.

Other Questions and Comments

Question 186 **Where can I find the definitions for Value "1," Value "2," "Value 3," etc.?**

The data elements provide the definitions for all the allowable values. Each data element in the specifications manual provides the allowable value definitions and guidance on selecting that allowable value.

Question 187 **Will CMS be moving to the 1-hour bundle anytime soon? Additionally, does CMS plan on changing current definitions of sepsis and septic shock to meet SEP-3 definitions?**

CMS does not currently have plans for incorporating a 1-hour bundle or changing to the SEP-3 definitions for the SEP-1 measure.

Question 188 **What is the progress on mortality being considered for the SEP-1 measure? Are there any data available regarding sepsis mortality rates and how they correspond with the SEP-1 measure performance?**

CMS does not currently have sepsis mortality data that can be compared to SEP-1 performance.

Question 189 **What are the financial implications of a hospital failing the SEP-1 measure?**

SEP-1 performance does not currently impact CMS payment, rather payment is based on reporting data for SEP-1.

Question 190 **Looking at the responses to your polls, there is such a variation that I suggest you create a certified online course for abstractors to enhance their skills and improve their guideline interpretation. I would suggest exploring other types of educational delivery methods to achieve this goal and prevent more confusion. I am sure that the inter-rater reliability in this measure will never be above 65 percent.**

Thank you for the comments. The Q&As, examples, and Poll the Audience questions in the National Provider Calls are intended to educate abstractors about updates and frequently asked questions (FAQ) about the guidance. We are consistently considering feasible methods to provide education for abstractors.

Question 191 **From the responses, it's clear that data abstraction is not consistent across the country on SEP-1. Is there going to be an initiative to simplify the measure or increase education efforts to improve consistency of abstraction? This is the most complicated abstraction for any measure in CMS history.**

Thank you for the question. CMS and the measure stewards are consistently working toward reducing abstractor burden and simplifying the measure where possible.

Question 192 **Where can further questions regarding the continued complexity of this measure and accompanying rules be forwarded to?**

You may submit questions via the online tool found on *QualityNet.org*.