Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

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

Presentation Transcript

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Candace Jackson: Hello and welcome to the Hospital IQR Program's Severe Sepsis and Septic Shock Management Bundle (Composite Measure) Version 5.7 Measure Updates and FAQs webinar. My name is Candace Jackson and I am the Hospital Inpatient Quality Reporting Program Support Contractor Lead from the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation and the questions and answers will be posted to the inpatient website *www.QualityReportingCenter.com* in the future. You can also download the webinar slide at the inpatient website. Again, that is *www.QualityReportingCenter.com*. If you have a question as we move through the webinar, please type your question into the Ask a Question section located on the left-hand side of your screen with the slide number associated to your question at the beginning. As time allows, we will have a short question-and-answer session at the conclusion of the webinar. Applicable questions that are not answered during that question-and-answer session will be posted to the *QualityReportingCenter.com* website in the upcoming weeks. I would now like to welcome and introduce our guest speakers for today: Noel Albritton, Lead Solution Specialist; Jennifer Witt, Senior Health Informatics Solutions Coordinator; Bob Dickerson, Program Analyst, all from the Inpatient and Outpatient Measure Maintenance Support Contractor.

The purpose of today's webinar is to clarify the changes and rationale behind the updated changes to the SEP-1 measure and guidance in version 5.7 of the specifications manual and to review frequently asked questions.

At the end of the presentation, participants will be able to understand and interpret the updated guidance in version 5.7 of the specs manual.

This slide just lists the acronyms that will be used throughout the presentation.

Today's presentation of frequently asked questions will follow the same format as our previous sepsis webinars. We will review frequently asked

questions, then review the relevant guidance from the manual, followed by questions we would like you to respond to. I would now like to turn the presentation over to Noel and Jennifer. Noel and Jennifer, the floor is yours.

Jennifer Witt: Thank you. Hello everyone and thank you for joining us. For today's presentation, we will be reviewing the updated guidance and specifications manual, version 5.7. We will also review frequently asked questions and ask a few questions we would like you to respond to. I would also like to point out before we begin, yellow highlight is used throughout the presentation to denote guidance that was updated in specification manual 5.7.

There was a slight algorithm update for manual version 5.7. This slide shows the algorithm flow from the last version of the specifications manual, manual version 5.6. To reach "O" in the algorithm, you must select Value 1 "Yes" for Septic Shock Present. Then, if you selected Value 2 "No" for Persistent Hypotension in manual version 5.6, the Initial Lactate Level result was rechecked prior to reaching the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. Due to this algorithm flow, only cases in which Value 1 "Yes" was selected for Persistent Hypotension or cases with Value 3 selected for the Initial Lactate Level result would proceed to connector P on this slide. Therefore, if Value 2 was selected for Persistent Hypotension, or if Value 1 or 2 was selected for the Initial Lactate Level result, and septic shock was present only by Physician/APN/PA documentation of septic shock, the case would not reach connector P and the case would not go to the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.

On page SEP-1-17 of the measure form, the algorithm was updated so that all cases in which Value 1 "Yes" is selected for *Septic Shock Present* would proceed to *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. With the version 5.7 algorithm update, the Initial Lactate Level result is no longer rechecked in this part of the algorithm. If Value 1 "Yes" was selected for *Septic Shock Present* and Value 2 "No" was selected for *Persistent Hypotension*, the case will proceed to

connector P regardless of how septic shock was met. Therefore, if *Septic Shock Present* was only met by Physician/APN/PA documentation of septic shock and persistent hypotension was Value 2 "No," the case would go to connector P which would lead to the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.

To provide consistent and clear direction for the selection of appropriate allowable values in cases where Unable to Determine needs to be selected, Unable to Determine was added to the appropriate level values for the data elements listed on this slide. This update does not impact the guidance within the data element notes for abstraction or the algorithm. The update was only to clarify the appropriate allowable value to select and to be consistent throughout the other data elements for the measure.

This guidance in the *Broad Spectrum or Other Antibiotic Administration Selection* data element was not further updated in manual version 5.7. However, we continue to see questions related to this guidance and would like to review it. Cases only reach the *Broad Spectrum or Other Antibiotic Administration Selection* data element when the broad spectrum or other antibiotic administration time is within three hours after the *Severe Sepsis Presentation* time. If the Broad-spectrum Antibiotic Administration Time is within three hours after *Severe Sepsis Presentation* time, then you would determine if the IV antibiotic administered was a monotherapy or two combination therapy antibiotics. The rationale for reviewing whether the antibiotic administered within three hours after Severe Sepsis Presentation is a monotherapy antibiotic or two combination therapy antibiotics is because the antibiotic selection in this case occurs after severe sepsis has presented. The guidance on this slide provides an exception for scenarios where a monotherapy antibiotic or two combination therapy antibiotics were not administered but rather a product was administered based on culture and susceptibility testing. The guidance specifies the requirements which include physician/APN/PA documentation referencing the results of a culture from within five days prior to the antibiotic start time, the physician/APN/PA documentation must identify the date of the culture results to determine the results were

within five days of antibiotic start time, and the physician/APN/PA documentation must identify the causative organism and antibiotic and susceptibility. Let's review a question pertaining to this scenario.

Here's a question that contains this scenario. The question is, "Is the PA documentation acceptable for selecting Value 1 "Yes" for the *Broad-Spectrum or Other Antibiotic Administration Selection* data element based on administration of IV Vanco within three hours after severe sepsis presentation? Severe sepsis presentation date and time is 1/5/2020 at 1300. Vancomycin was started on 1/5/2020 at 1330. The ED PA note states, "Lower left leg wound culture positive MRSA, starting IV Vanco now." The answer is no, the administration of IV Vanco alone is not acceptable in this scenario because the PA documentation does not identify the date of the culture or the causative agent and its antibiotic susceptibility. As the guidance reviewed on the previous slide states, the Physician/APN/PA documentation must identify the date of the culture results to determine the results were within five days of the antibiotic start time and must identify the causative organism and antibiotic susceptibility. If the Physician/APN/PA documentation contain these requirements, then the administration of IV Vanco in this scenario would be acceptable for selecting Value 1 "Yes" for the *Broad Spectrum or Other Antibiotic Administration Selection* data element.

Guidance within the *Crystalloid Fluid Administration* data element has also been updated. The updates states, "Crystalloid fluids or balanced crystalloid fluids that are given to dilute medications may be used toward the target ordered volume. If the volume infused without dilution fluids is the same as the target ordered volume, fluids used for diluting medications do not need to be counted. In previous versions of the specifications manual, crystalloid fluids given to dilute medications were acceptable to use toward the target ordered volume of crystalloid fluids. The updated guidelines in manual version 5.7 does not require the use of crystalloid fluids given to dilute medications in cases where the target ordered volume of crystalloid fluids is met without the use of crystalloid fluids given to dilute medications. For example, if the physician ordered normal

saline IV 30 mL/kg over two hours and there was another order for crystalloid fluids mixed with IV antibiotics started during the timeframe, only that 30 mL/kg volume of crystalloid fluids ordered and administered would be used to determine when the target ordered volume was completely infused. This guidance was updated based on facility and abstractor feedback intended to decrease abstraction burden related to the use of crystalloid fluids to dilute medication. Let's review some examples.

Here is a question about the use of crystalloid fluids used to dilute a medication. The question is, "Is the 100 milliliters of crystalloid fluids used to dilute the medication required to be used?" Orders are 0.9 percent normal saline, 30 mL/kg. The weight is 75 kilograms at 1000 mL/hr. The second order is Zosyn 3.37 milligrams and 100 milliliters of 0.9 percent normal saline over 30 minutes. The answer is no. Order 1 equals a target ordered volume of 30 milliliters per kilogram. In this scenario, the physician ordered a volume of 30 milliliters per kilogram for the patient. The updated guidance in manual version 5.7 allows us to only use 30 milliliters per kilogram to meet the target ordered volume and determine when the target ordered volume completely infused. In this scenario, the crystalloid fluids used to dilute the medication can be disregarded, as that infusion is not required to be used towards the target ordered volume.

Here's another question similar to the last scenario: "Should the 250 milliliters of crystalloid fluids used to dilute the medication count towards the target ordered volume?" The orders are 0.9 percent normal saline, 2000 milliliters at 1000 milliliters per hour. The second order is Vancomycin in 250 milliliters of 0.9 percent normal saline over 90 minutes. The patient wasted 75 kilograms and 30 milliliters per kilogram would equal 2250 milliliters. The answer is yes, use the fluids given to dilute the Vancomycin. The 2000 milliliters on Order 1 is not within 10 percent of the target ordered volume. The 2000 milliliters in Order 1 plus the 250 milliliters in Order 2 equals 2250 milliliters target volume. In this scenario, the patient weighs 75 kilograms which would require 2250 milliliters to equal 30 milliliters per kilogram. The physician/APN/PA ordered 2000 milliliters of normal saline and 250 of normal saline mixed

with the medication. Therefore, the target ordered volume is 2250 milliliters, since the complete 30 milliliters per kilogram volume was ordered. You would use crystalloid fluids mixed with the medication because the 2000 milliliters of normal saline ordered is not within 10 percent of the 30 milliliters per kilogram volume based on the patient's weight. In this scenario, using the crystalloid fluid to dilute the medication is beneficial as it allows the target ordered volume to be reached in the case to proceed in the measure. Let's take a look at one more question we would like you to respond to.

MD orders Zosyn in 100 milliliters normal saline over 30 minutes and normal saline 30 milliliters per program in 1 hour. Do the fluids mixed in the Zosyn need to be used towards the target ordered volume? A, Yes. B, No.

Noel Albritton: I will repeat the question for everyone. MD orders Zosyn in 100 milliliters normal saline over 30 minutes and normal saline 30 milliliters per kilogram in one hour. Do the fluids mixed in Zosyn need to be used toward the target ordered volume? A, Yes. B, No. If you could go ahead and close the polling for us, please.

The correct answer is B, no. The crystalloid fluids used to dilute Zosyn, in this case, would not need to be used toward the target ordered volume. In this scenario, the physician ordered 30 milliliters per kilogram of normal saline so you would not count the fluid used to dilute the medication for the target ordered volume.

Jennifer Witt: Thanks, Noel. This guidance was not updated in manual version 5.7; however, we continue to receive questions related to this guidance and crystalloid fluids used to dilute medications. The guidance states. "Only those crystalloid fluids even at a rate greater than 125 mL per hour should be used toward the target ordered volume. Do not use crystalloid fluids given at 125 mL per hour or less towards the target ordered volume." This guidance applies to all crystalloid fluids used to meet the target ordered volume including crystalloid fluids used to dilute medications. Therefore, if you were to use crystalloid fluids to dilute medications to meet the

target ordered volume, the crystalloid fluids used to dilute medications are also required to be administered at greater than 125 mL per hour. If, for example, there was an antibiotic diluted in crystalloid fluids infusing at 100 mL per hour, those fluids would not be used towards the target ordered volume due to the rate of the infusion.

Also, for the *Crystalloid Fluid Administration* data element, this guidance was not further updated in manual version 5.7, but we continue to receive questions about it. The guidance states, "Crystalloid fluid volumes ordered that are equivalent to 30 mL/kg or within 10 percent less than 30 mL/kg are considered the target ordered volume." This guidance is referring to the volume of fluids ordered that become the target ordered volume. If the physician/APN/PA ordered a volume equaling 30 mL per kilogram or a volume greater than 30 mL per kilogram, the target ordered volume would be the 30 mL per kilogram. If the physician/APN/PA ordered a volume that is within 10 percent of the 30 mL per kilogram volume, the volume ordered that is within 10 percent of the 30 mL per kilogram volume would be the target ordered volume. Let's review a couple questions related to this guidance.

The first question states, "Is the target ordered volume 2160 mL, 2400 mL, or 3000 mL?" The patient weighs 80 kilograms and the MD orders normal saline IV 3000 mL at 1000 mL and hour. The answer is, based on the patient's weight of 80 kg, the target ordered volume is 2400 mL. In this scenario, the physician ordered more than the 30 mL per kg of fluids so the crystalloid fluid volume that is equivalent to the 30 mL per kilogram volume is 2400 mL in this case.

Let's take a look at another scenario. Physician order: normal saline IV 3000 mL at 1000 mL per hour for a 110-kilogram patient. So, 30 mL per kilogram times 110 kilograms equals 3300 mL. What fluid volume should be used? A, 2970 mL. B, 3000 mL. C, 3250 mL. D, 3300 mL.

Noel Albritton: I will repeat the question for everyone. The physician ordered normal saline IV 3000 mL at 1000 mL per hour for a 110-kilogram patient. That's 30 mL/kg multiplied by 110 kgs equals 3300 mL. Which fluid volume

should be infused for the measure? A, 2970 mL. B, 3000 mL. C, 3250 mL. D, 3300 mL.

If you will close our polling, please. The correct answer in this case is B, 3000 mL. Based on the patient's weight of 110 kilograms, the 30 milliliters per kilogram volume is 3300 mL. However, the physician only ordered 3000 mL because 3000 mL is within 10 percent of the 30 mL per kilogram volume. 3000 mL is a target ordered volume. Notice that we did not automatically take 2970 mL as a target ordered volume even though this volume is also within 10 percent of the 30 mL per kilogram volume. The physician did not order 2970 mL. Based on the ordered volume of 3000 mL, that is the target ordered volume

Jennifer Witt: Thanks, Noel. The *Directive for Comfort Care or Palliative Care, Severe Sepsis Continuing Guidance* data element was not further updated in manual version 5.7. However, there continues to be questions related to the guidance on this slide related to the context in which an inclusion term is documented. So, let's review the guidance for further clarification. The guidance states. "Only the earliest physician/APN/PA documentation of an inclusion term documented in the following contexts suffices. Then, the acceptable contexts are provided, which include a recommendation, order for consult or evaluation, request from a patient, a plan, or a referral. To be clear, this guidance is not referring to or stating that the only explicit documentation of one of these contexts is acceptable. So, acceptable documentation of an inclusion term is required to reflect one of these contexts but does not require to explicitly use the language of the context provided in the guidance. For example, the first context states, "Comfort measures only recommendation." Other acceptable documentation would also include "Palliative care recommendation" or "Hospice recommended." Acceptable documentation would also include a physician stating, "I recommend comfort measures." Let's review some of these questions about guidance.

The first question for the *Directive for Comfort Care or Palliative Care Severe Sepsis* data element is, "APN documentation within the timeframe: Reviewed terminal care with patient's family." Question: Would you

choose Value 1 “Yes” or Value 2 “No” for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element? The answer is you would select Value 2 “No” in this case because the inclusion term “terminal care” is not used within one of the acceptable contexts noted in the data elements. If you recall from the previous slide, the acceptable contexts include a recommendation, order for consultation, a request, a plan, or a referral. Therefore, the documentation of only a review of an acceptable inclusion term would not suffice one of the contexts and therefore would not suffice selecting Value 1 “Yes.”

Let’s review another question. This question and scenario are frequently received. “The MD notes within the timeframe: Discussed plan of care with patient, recommend palliative care at this time.” Should Value 1 “Yes” or Value 2 “No” be selected? You would select Value 1 “Yes” in this scenario because palliative care is an acceptable inclusion term and it is used within an acceptable context. In this scenario, explicit language of the context provided in the data element is not used. However, the documentation continues to reflect the physician’s recommendation for the patient to receive palliative care based on the documentation “recommend palliative care.”

Next, we would like you to participate in a question. Which value would be selected if the PA notes within the timeframe “Discussed palliative care with family?” A, Value 1 “Yes.” B, Value 2 “No.”

Noel Albritton: I will repeat the question for everyone. Which value would you select if the PA notes within the timeframe “Discussed palliative care with family?” A, Value 1 “Yes.” B, Value 2 “No.” All right. If you could go ahead and close our polling, please. The correct answer for this one is actually B, Value 2 “No.” Palliative care is an acceptable inclusion term, but it is not used within one of the acceptable contexts in the data element. The slide should have circled Value 2 “No” for this question.

Jennifer Witt: Thanks, Noel. This guidance and the initial hypotension data element was not updated in version 5.7, but we continue to receive questions. So, let’s review the guidance. The bullet point states, “Hypotensive blood pressures

obtained within the operating room, interventional radiology, during active delivery, or procedural/conscious sedation should not be used." This guidance allows for hypotensive blood pressures to not be used when documented in one of the areas listed because the procedure the patient is undergoing in those areas has a higher potential to cause a hypotensive blood pressure reading. Therefore, hypotensive blood pressure readings documented while the patient is in one of these areas would simply not be used. However, continue to review the medical record for hypotensive readings documented outside of these areas to determine if initial hypotension is present. I would also like to note that only hypotensive blood pressures documented while the patient is in one of these particular areas in the hospital would not be used. Hypotensive blood pressures documented in areas of the hospital not included in this list would still be acceptable to use for establishing the presence of initial hypotension. Also, to not use hypotensive readings obtained in these areas of the hospital or during active delivery or procedural/conscious sedation, the documentation within the medical record would need to clearly indicate when the patient is in these areas or procedures. If the medical record does not provide clear documentation indicating when the patient is in these areas of the hospital or an active delivery or procedural/conscious sedation, you must use a hypotensive blood pressure reading.

This question provides an example of documentation within the medical record indicating the patient is receiving sedation during the time of the procedure. The question is, "Would you use the hypotensive blood pressure readings below to establish initial hypotension?" ED MD notes at 0800: "Lumbar puncture at bedside, versed for comfort/sedation." ED MD notes at 08 25: "LP complete without complication." Vital signs at 0815, it was 87/56, and at 0820, it was 84/53. The answer is no; you do not use hypotensive readings at 0815 and 0820 to establish initial hypotension because the medical record indicates that patient is in a procedural sedation from 0800 to 0825. Notice the guidance within a data element does not provide a list of sedative medications. Therefore, the documentation in the example indicates the patient was in a procedure with sedation between 0800 and 0825 in the medical record identifying the

time period in which you would not use the hypotensive readings. For the next part of the presentation, I will turn it over to Noel.

Noel Albritton: Update for manual version 5.7: Hypotensive BPs obtained within the operating room, interventional radiology, during active delivery, or procedural/conscious sedation should not be used. If the patient is in one of these settings during the hour-long window to assess for *Persistent Hypotension*, select Value 2. This guidance was updated to provide clear abstraction guidance for which value to select for *Persistent Hypotension* when the one-hour window occurs when the patient is in the operating room, interventional radiology, during active delivery, or in procedural/conscious sedation. Upon selecting the Value 2 for *Persistent Hypotension*, the case will proceed to *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. Let's take a look at a question pertaining to this scenario.

This question asks, "Which allowable value would be selected for *Persistent Hypotension*?" The hour to assess for *Persistent Hypotension* is from 1400 to 1500. There are hypotensive readings at 1430 of 88 and at 1500 of 84. The patient is in the OR from 1340 to 1530. The answer, in this case, is you would select Value 2 "No" for *Persistent Hypotension* due to the hour-long window to assess for *Persistent Hypotension* occurring while the patient was in the OR. With the hour to assess for *Persistent Hypotension* occurring from 1400 to 1500 and the patient documented as in the operating room during that hour, the hypotensive readings documented during that hour would not be used for *Persistent Hypotension*.

Another update for the *Persistent Hypotension* data element in version 5.7 states, "If persistent hypotension presentation is more than six hours after the Septic Shock Presentation Time, choose Value '2.'" In this scenario, persistent hypotension may be found based on the blood pressure readings documented in the hour after completion of the target ordered volume of crystalloid fluids. However, if persistent hypotension was identified more than six hours after septic shock presentation, when you select Value 2 "No" for *Persistent Hypotension* in this scenario, the case would not

proceed to the *Vasopressor Administration* data element. In the past, there have been cases where persistent hypotension was found greater than six hours after septic shock presentation and a vasopressor was administered for that persistent hypotension. However, that vasopressor administration occurred outside the timeframe and those cases would fail at the *Vasopressor Administration* data element.

Let's look at a question or scenario based on this guidance. This question asks, "Which allowable value would you select for *Persistent Hypotension.* The *Septic Shock Presentation Time* is 1500. *Persistent Hypotension* is present at 2300, and the vasopressor was administered at 2305. In this scenario, you would select Value 2 "No" because *Persistent Hypotension* occurs more than six hours after the *Septic Shock Presentation Time*. In this scenario, the patient has septic shock and persistent hypotension and a vasopressor was administered. If the case continues to the *Vasopressor Administration* data element, the case would fail due to the timing of the vasopressor being greater than six hours after septic shock presentation. However, with the updated guidance in manual version 5.7, you would select Value 2 "No" for *Persistent Hypotension* and the case would not proceed to the *Vasopressor Administration* data element. The case would proceed to the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element.

This guidance for the *Persistent Hypotension* data element was not further updated in manual version 5.7. However, we continue to receive questions related to this guidance; so, let's review. The guidance states. "If one or more blood pressures were documented within the timeframe and persistent hypotension is unable to be determined but a vasopressor was administered, select Value '1.'" Based on this guidance, if there was only one reading documented during the hour to assess for persistent hypotension and that reading was hypotensive, or if there was a normal reading followed be a hypotensive reading at the end of the hour, persistent hypotension would be unable to be determined. However, if a vasopressor was administered per the guidance on this slide, Value 1 "Yes" would be selected for *Persistent Hypotension*. I would like to point

out if there are no blood pressures documented during the hour to assess for persistent hypotension, the guidance on this slide would not apply. This guidance only applies when there is one or more blood pressures documented within the hour to assess for persistent hypotension. Also, we frequently receive questions regarding whether there is a timeframe for the administration of a vasopressor that suffices this guidance and select Value 1 “Yes” for persistent hypotension. The guidance in the *Persistent Hypotension* data element does not provide a specified timeframe for administration of a vasopressor. Therefore, we are only looking for whether one or more blood pressures were documented in the hour to assess whether persistent hypotension is unable to be determined and whether the patient received a vasopressor. It’s also worth noting that if Value 1 “Yes” was selected *Persistent Hypotension* based on this guidance, the case would proceed to the *Vasopressor Administration* data element where it would be determined if the patient received a vasopressor within six hours after septic shock presentation.

Next, let’s review a scenario. With the guidance from the previous slide in mind, let’s review this frequently asked question. “Which value would you select for persistent hypotension in this scenario?” The hour to assess for persistent hypotension is 1330 to 1430. The blood pressures documented during this time are 99/67 at 1340; 93/58 at 1400; and 84/50 at 1425. On the MAR we can see that Vasopressin was started at 1430. In this scenario, the hour to assess for persistent hypotension ended with a single hypotensive blood pressure reading. Therefore, you could not determine persistent hypotension. However, a vasopressor was also administered. Based on the guidance from the previous slide, Value 1 “Yes” would be selected for *Persistent Hypotension*.

Next we would like your participation with answering the following question. “Which value would you select for *Persistent Hypotension* if no BPs were documented during the hour, but a vasopressor was administered?” A, Value 1 “Yes” Hypotension Present. B, Value 2 “No” Hypotension Not Present. C, Value 3 “No” Not Assessed.

Jennifer Witt: I will go ahead and repeat the question. "Which value would you select for *Persistent Hypotension* if no blood pressures were documented during the hour, but a vasopressor was administered?" A, Value 1 "Yes" Hypotension Present. B, Value 2 "No" Hypotension Not Present. C, Value 3 "No" Not Assessed. Let's go ahead and close the poll.

Select Value 3 "No" for *Persistent Hypotension* in this scenario because there are no blood pressures documented during the hour to assess for persistent hypotension. In order to select Value 1 based on the guidance we previously discussed, one or more blood pressures would need to be documented within the hour to assess for persistent hypotension along with the administration of a vasopressor.

Noel Albritton: Thanks, Jennifer. The *Repeat Volume Status and Tissue Perfusion Assessment Performed Date* and *Time* data element has also been updated in manual version 5.7. The updated guidance states, "If there are multiple repeat volume status and tissue perfusion assessments performed, abstract the date and time of the earliest assessment documented within the appropriate time window." In previous versions of the manual, you would use the latest assessment documented within the appropriate time window. To reduce abstraction burden for this data element, the guidance was updated so, that in version 5.7, you would use the earliest assessment documented within the appropriate time window. Now, let's review a question regarding this updated guidance.

The question states, "What time you would use for the *Repeat Volume Status and Tissue Perfusion Assessment Performed Time*?" The time window for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* is 1300 to 1900. The MD note at 1400 states, "Severe sepsis exam completed." Then, an APN note at 1600 includes documentation requirements for performing five of the eight parameters including cap refill is normal, increased urine output, temperature and heart rate are normal, pulses present bilaterally, and skin appears normal. The correct time for the *Repeat Volume Status and Tissue Perfusion Assessment Performed Time* is 1400 because this is the earliest assessment within the appropriate time window.

The *Severe Sepsis Present* data element has also been updated in manual version 5.7. This update includes, "Choose Value '2' if within six hours after documentation meeting clinical criteria or physician/APN/PA documentation of Severe Sepsis there is additional physician/APN/PA documentation indicating the patient does not have septic shock and severe sepsis was met by physician/APN/PA documentation that septic shock was present. This update is to clarify the scenario in which Value 2 "No" would be selected for *Severe Sepsis Present* when Severe Sepsis is met but there is also physician/APN/PA documentation indicating septic shock is not present. In this scenario, if severe sepsis was met by physician/APN/PA documentation of septic shock but within six hours after documentation of septic shock there is additional physician/APN/PA documentation that the patient does not have sepsis shock, you would select Value 2 "No" for *Severe Sepsis Present.*

Let's review a question to further clarify this scenario. This question asks, "What value would you select for *Severe Sepsis Present* in the following scenario if there is no further documentation of severe sepsis or clinical criteria being met?" The MD documents at 0918: "Likely septic shock causing evaluated lactate." Then, the MD notes at 1130: "Patient with seizures x2, lactate decreasing, no further concern for septic shock." Based on this scenario, you would select Value 2 "No" for *Severe Sepsis Present* because *Severe Sepsis Present* was initially met by physician documentation of septic shock and further documentation within six hours after indicates that septic shock was not present. In this scenario, the patient did not meet severe sepsis clinical criteria nor was there documentation of severe sepsis. However, the physician was concerned by the elevated lactate and considered septic shock to be the likely source. This would allow Value 1 "Yes" to be selected for *Severe Sepsis Present*. However, within six hours of the documentation meeting severe sepsis, there's further documentation attributing the elevated lactate to another cause and indicating septic shock was not present. Therefore Value 2 "No" would be selected for *Severe Sepsis Present* based on updated guidance in manual version 5.7.

Guidance related to when to not use SIRS criteria or signs of organ dysfunction was not updated in version 5.7. However, we continue to receive questions related to this guidance; so, let's review. The guidance in *Severe Sepsis Present* data element continues to allow for SIRS criteria or evidence of organ dysfunction to be disregarded when documentation by the physician/APN/PA prior to or within 24 hours after *Severe Sepsis Presentation Time* considers SIRS criteria or evidence of organ dysfunction to be normal for the patient due to a chronic condition or due to a medication. More recently, we have received questions regarding acceptable documentation for this guidance. Questions are specifically referencing whether the documentation of a chronic condition alone would suffice to disregard an abnormal value. As the guidance states, the physician/APN/PA documentation must include the abnormal SIRS criteria or evidence of organ dysfunction or a term referencing or defining the abnormal criteria, and the documentation must include the abnormal criteria is normal for the patient due to a chronic condition or due to a medication. Therefore, if there is only documentation of a chronic condition or only documentation of an abnormal value, this would not be acceptable documentation to disregard the abnormal value.

Next let's take a look at some questions and examples. We often receive questions presenting this scenario. The question is, "Would you use the elevated heart rate to meet SIRS criteria based only on the documentation below?" The MD documented "Chronic A-fib." Based on this documentation, yes, use the elevated heart rate to meet SIRS criteria because the physician documentation does not attribute the elevated heart rate to the chronic condition. The guidance on the previous slide and within the data element states inferences should not be made. Therefore, documentation of a condition alone, such as chronic A-fib, would not disregard the elevated heart rate. You would not infer that the elevated heart rates documented elsewhere in the medical record are due to this condition. To not use the SIRS criteria or sign of organ dysfunction, further physician/APN/PA documentation including the abnormal SIRS criteria or sign of organ dysfunction or a term referencing or defining the abnormal criteria and documentation considering abnormal criteria is

normal for the patient due to a chronic condition or due to a medication is necessary Let's review one more question related to this. This question states, "Would you use the elevated heart rate to meet SIRS criteria based only on the documentation below?" The MD documented "A-fib with tachycardia, history of A-fib." Based on this documentation, no, the elevated heart rate would not be used because the physician documentation attributes the elevated heart rate to the chronic condition. This scenario presents physician documentation which attributes the elevated heart rate or tachycardia to the chronic condition, A-fib. The term referencing or defining the abnormal criteria is present; the chronic condition is present; and, therefore you would not use the elevated heart rate in this scenario.

Next, we would like your participation in responding to the following question. "ED MD notes 'chronic A-fib.' APN notes 'A-fib with RVR." Would you use the elevated heart rate to meet SIRS criteria?" A, Yes or B, No.

Jennifer Witt: I will go ahead and reread the question. "ED MD notes 'chronic A-fib.' APN notes 'A-fib with RVR. Would you use the elevated heart rate to meet SIRS criteria?" A, Yes or B, No. Let's go ahead and close the poll. The answer is no. The elevated heart rate would not be used in this scenario because the APN attributes the elevated heart rate, or RVR in this case, to be due to A-fib, and further documentation indicates A-fib is a chronic condition for this patient. Therefore, the elevated heart rate is documented as due to a chronic condition and the elevated heart rate would not be used.

Noel Albritton: Thanks, Jennifer. Further updates were also made to the *Severe Sepsis Presentation Date* and *Time* data elements related to documentation of *Severe Sepsis Present on Admission*. The updated guidance states if the only documentation of severe sepsis being present is in a physician/APN/PA note that severe sepsis was present on admission, use the earliest time of the following: Physician/APN/PA note, admit order, disposition to inpatient, or arrival to the floor or unit. This guidance only pertains to cases in which the only documentation of severe sepsis states

severe sepsis was present on admission. Therefore, if the only documentation of severe sepsis states severe sepsis was present on admission, then you would use the earliest time of either the physician/APN/PA note, admit order, disposition to admit, or arrival to the floor unit.

The *Septic Shock Presentation Date* and *Time* data elements also received updates for manual version 5.7. This update pertains to determining the septic shock presentation date and time when septic shock is met by severe sepsis and an initial lactate level result greater than or equal to 4. When septic shock is met by severe sepsis and an initial lactate level result greater than equal to 4, the later time of either severe sepsis presentation or the initial lactate level result will be used as a septic shock presentation time. If the initial lactate level result is later than the severe sepsis presentation time, the updated guidance on this slide defines how to determine the time of the initial lactate level result that will then be the septic shock presentation time. Like guidance in other data elements, the updated guidance in the septic shock presentation date and time uses a priority order to determine the time that should be used for the initial lactate level result. The priority source for the time of the initial lactate level result is the time of the result from the lab. If the primary source is not available time, then you'd use a supporting source in order to determine the septic shock presentation time based on initial lactate level result.

Similar to the update previously discussed for Severe *Sepsis Presentation Date* and *Time* data elements, this guidance was also added to the *Septic Shock Presentation Date* and *Time* data elements. This guidance only pertains to cases in which the only documentation of septic shock states that septic shock was present on admission. If the only documentation of septic shock in the medical record states septic shock was present on admission, you would use the earliest time of either of the physician/APN/PA note, admit order, disposition to admit, or arrival to the floor unit.

Next, we would like you to answer the following question. “If the following lactate result times are documented, which time would you choose for the initial lactate level result?” A, Flow sheet – lactate 4.5 at 1915. B, PA notes – lactate 4.5 at 1820. C, Lab results – lactate 4.5 at 1830. D, Initial lactate collection time – 1730.

Jennifer Witt: I will go ahead and reread the question. “If the following lactate result times are documented, which time would you choose for the initial lactate level result?” A, Flow sheet – lactate 4.5 at 1915. B, PA notes – lactate 4.5 at 1820. C, Lab results – lactate 4.5 at 1830. D, Initial lactate collection time – 1730.

Let’s go ahead and close the poll. The answer is C, lab results – lactate 4.5 at 1830. The correct answer is the lab result at 1830 because this is the primary source. There are multiple times available for the initial lactate level result of 4.5. Therefore, in this scenario, we follow the priority order and use the primary source to determine the time of the initial lactate level result. I also want to comment on another scenario we are frequently asked about. Often there is a result time available from the lab and the physician’s note has the lab results pulled into their note. We would continue to follow the guidance in this scenario and use the time of the lab result documented by the lab.

Noel Albritton: Thanks, Jennifer. The last topic I will discuss today is the *Transfer from Another Hospital or ASC* data element. No further updates were made to this data element in manual version 5.7, but we continue to receive questions and would like to review. This data element allows for cases to be excluded from the measure if the patient was transferred from another hospital or ASC. Acceptable documentation in the medical record must indicate the patient was received at your hospital as a transfer from another acceptable location such as an outside ED, another hospital, or ambulatory surgery center. The question we are regularly seeing pertains to drug and alcohol centers. Let’s take a look at this question. The question states, “The patient was transferred from a freestanding inpatient drug and alcohol rehab facility. Is this considered a transfer from another hospital?” The answer is no, this is not an acceptable transfer from another

hospital. The data element provides specific locations in which a patient transferring from would suffice selecting Yes for the *Transfer from Another Hospital or ASC* data element. Receiving a patient from a freestanding inpatient drug and alcohol treatment facility would not suffice any of the acceptable locations specified in the data element. If, however the patient transfer from an inpatient drug and alcohol treatment center that was in another hospital, then yes would be selected for the *Transfer from Another Hospital or ASC* data element.

That concludes our review of version 5.7 measure updates and frequently asked questions. We hope this has been helpful. Thanks again to everyone for joining us today. I would I will turn it over to Bob to review some *Hospital Compare* information.

Robert Dickerson: Thank you, Noel. Before we turn to the question-and-answer portion of the call, we want to take a minute to let you know about SEP-1 bundle-level results that will be available in the downloadable datasets from *Hospital Compare* starting with the January 2020 release. Initial bundle-level reporting will only include bundle-level results for the first quarter of 2019. This information will be available in the Timely and Effective Care data sets for hospitals, national, and state performance. With each quarter release of *Hospital Compare* data, a new quarter of data will be added to the bundle-level results until four quarters of data are available. At that point, updates to the bundle-level results will correspond with the same four quarter roll up as the SEP-1 composite score in the same downloadable datasets.

With this upcoming release, Timely and Effective Care downloadable datasets will include the SEP-1 composite score as has been reported in the previous *Hospital Compare* quality updates, and, in addition, you will see a severe sepsis 3-hour bundle score, which includes a composite of the broad spectrum and other antibiotic administration, blood culture collection, and initial lactate collection. You will also see a severe sepsis 6-hour bundle which looks at the repeat lactate for patients with an elevated initial lactate, the septic shock 3-hour bundle which looks at the administration of crystalloid fluid for eligible patients, and the septic

shock 6-hour bundle which includes the composite for the vasopressor administration and repeat volume status and tissue perfusion assessment for those patients who are eligible.

As noted earlier, these bundle results will include data for the first quarter of 2019 only, which corresponds with version 5.5a of the CMS Specifications Manual. Two documents are available on *QualityNet* that provide information on how the bundle-level results were derived. This slide contains a link to the location on *QualityNet* where these documents are posted along with the version 5.5a Specifications Manual under Sepsis Resources. With that, I would like to turn the presentation back over to Candace for the question-and-answer session.

Candace Jackson: Thank you, Bob. At this time, we have time to address some of the questions that have come into our question box. Before we begin, I would like to thank Noel, Jennifer, and Bob for providing information for today's webinar.

Our first question is… I am hearing some background noise, so make sure you are on mute. Our first question: "If a patient presents in the ED, meets all criteria for Severe Sepsis in the ED, and then is admitted to the hospital, which presentation time do I use? A, the time the patient met criteria in the ED or B, the admission time for Severe Sepsis presentation time?

Noel Albritton: Thanks, Candace, This is Noel. I will answer that one. For the *Severe Sepsis Presentation Time,* you are going to use the earliest severe sepsis presentation time. So, if the patient met criteria in the ED, and then was admitted to the hospital, you would continue to use the time severe sepsis criteria was met in the emergency room.

Candace Jackson: Thank you, Noel. Our next question is in regard to slide 38. "If a patient meets severe sepsis criteria but not shock, but the physician says septic shock, then would it be 'yes' to both? If the patient only 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, but in the first case scenario it would be 'yes' to severe sepsis and then 'no' to septic shock?"

Noel Albritton: This is Noel again. I'm going to try to break down this question a little bit. I don't think it is associated with slide 38, but for the updated guidance in the *Severe Sepsis Present* data element regarding documentation of septic shock and negation of the documentation of septic shock. In this case, if severe sepsis is met by criteria and then septic shock is documented as not present, then you would continue to select Value 1 "Yes" for *Severe Sepsis Present* because the criteria for severe sepsis were met. If *Severe Sepsis Present* was met only by documentation of septic shock, so there was no severe sepsis criteria met or severe sepsis was not documented, only septic shock was documented, and then within six hours of the documentation of septic shock, there was physician documentation of no septic shock, then you would select Value 2 "No" for *Severe Sepsis Present* based on an updated guidance in manual version 5.7

Candace Jackson: Thank you, Noel. Our next question, "I notice a physician stating sepsis without organ dysfunction. Can this documentation exclude the organ dysfunction if one of the organ dysfunction criteria was met?"

Noel Albritton: The answer for this is no. In the *Severe Sepsis Present* data element, it provides the guidance for disregarding organ dysfunction or SIRS criteria based on physician documentation. In order to exclude or disregard the SIRS criteria/organ dysfunction, the physician documentation would need to attribute the SIRS criteria/organ dysfunction to a chronic condition, medication, or that they are normal for the patient rather than simply saying they are not there or without organ dysfunction. So, you would still need to follow the guidance in the *Severe Sepsis Present* data element to exclude the criteria.

Candace Jackson: Thank you, Noel. Our next question: "Where can I find the definition for Value 2, Value 1, Value 3, etc.?"

Noel Albritton: Thanks, this is a good question. The data elements provide the definitions for all of the allowable values. Depending on what data element you are

looking at, it will give you the allowable value and then the definition for how to select or when to select that allowable value.

Candace Jackson: Our next question, "How fast does the dilute with antibiotics need to run?"

Noel Albritton: So, this question is referring to crystalloid fluid administration and fluids used to dilute medication. All fluids used for the target ordered volume, whether they are just a simple order for normal saline or fluids ordered to dilute medication need to be ran at greater than 125 mL per hour to be used for the target ordered volume. So, you would not use fluids infusing less than or equal to 125 mL per hour toward the target ordered volume.

Candace Jackson: Thank you, Noel. Our next question, "Are you able to show in the algorithm where a patient that is receiving IV antibiotics for more than 24 hours prior to presentation of severe sepsis is excluded?"

Noel Albritton: So, for this one, I am not able to show during the presentation the algorithm, but I will let you know on page SEP-1-10 of the Measure Information Form is where the *Broad Spectrum or Other Antibiotics Administration Date* and *Time* data elements are found in the algorithm. So, once the *Broad Spectrum or Other Antibiotics Administration Date* and *Time* data elements are abstracted, you will reach the broad spectrum antibiotic timing calculation on page SEP-1-10 of the Measure Information Form and that calculation will determine if a broad spectrum or other antibiotic administration time is greater than 24 hours before severe sepsis. That is where the case could possibly be excluded based on the antibiotic timing.

Candace Jackson: Thank you. Our next question, "Would the documentation of 'Discussed hospice care with patient' qualify to meet the criteria?"

Noel Albritton: So, for this question, we touched on this during the presentation. Basically, the discussion of hospice care or discussion of one of the acceptable inclusion terms for the *Directive for Comfort Care* data element is not acceptable because it does not meet one of the contexts that are provided in the data element. So, discussion of palliative care, discussion of comfort measures, does not meet the context as far as a plan

and order recommendation or referral. So, this would not be used to select Value 1 "Yes."

Candace Jackson: On that same topic for palliative care, "If a patient had a consult for palliative care, can we answer 'yes' even though comfort measures were not implemented?"

Noel Albritton: Yes, you can. So, for the *Directive for Comfort Care Severe Sepsis and Septic Shock* data element, it is only looking for the documentation of the inclusion term within an acceptable context regardless of whether it was completely implemented or not. So, if you have a palliative care consult, that would suffice selecting Value 1 "Yes" For the *Directive for Comfort Care Severe Sepsis and Septic Shock* data elements regardless of whether palliative care was started at that time or not.

Candace Jackson: Thank you, Noel. Our next question is in regard to slide 27. If we could go to slide 27, please? "Does within the operating room include the PACU unit?"

Noel Albritton: So, for this question we received quite a few of these, the guidance in the data elements *Severe Sepsis Present* and a couple other ones specifies operating room and those other locations, it does not specify the PACU. So, criteria that are obtained during the patient stay in the PACU would continue to be used. It would not be treated the same as criteria obtained in the operating room, interventional radiology, etc. So, you would continue to use that criteria found in the PACU.

Candace Jackson: Ok and our next question is in regard to the *Persistent Hypotension* data element. "By choosing Value 2 does that mean the case will fall out for persistent hypotension?"

Noel Albritton: For persistent hypotension, selecting Value 2 "No" would not cause the case to fall out. When you select Value 2 "No" for persistent hypotension, it takes the case to the *Repeat Volume Status Tissue Perfusion Assessment* data element. It basically avoids the case for vasopressor administration.

Candace Jackson: Our next question, "If the patient weighs 80 kilograms and needs 2400 mL of fluid, and a 2200 mL bolus is ordered, which is within 10 percent, and Zosyn with normal saline at 100 mL is ordered, is the target volume 2200 mL, since it's still within 10 percent? Should we consider the target volume as 2300 mL, which is still within 10 percent?"

Noel Albritton: For this question, we would use the 2200 mL of normal saline because that's within 10 percent of the 30 mL per kilogram volume 2400 mL. In this example, you can see the 100 mL of saline and Zosyn is not necessary to be used to reach the target ordered volume within 10 percent of 30 mL per kilogram volume. You can just disregard that Zosyn and normal saline 100 mL and use the 2200 mL bolus that is within 10 percent of the 30 mL per kilogram volume.

Candace Jackson: Thank you, Noel. Our next question is, "Does the vasopressor have to be started in the hour persistent hypotension is to be assessed to select Value 1 for *Persistent Hypotension*?"

Noel Albritton: The answer for this is no. The guidance in the *Persistent Hypotension* data element regarding selecting Value 1 based on administration of a vasopressor does not include a timeframe for that administration. So, if persistent hypotension was unable to be determined and at least one or more blood pressure was obtained, then you could select Value 1 "Yes" for *Persistent Hypotension* if the patient received a vasopressor. Again the vasopressor does not have to be administered within that hour or within a specific timeframe. However, kind of like we noted in the presentation, I will also tell you if you do select Value 1 for *Persistent Hypotension* based on that bullet point regarding the vasopressor administration, the case will then go to the *Vasopressor Administration* data element for abstraction. Once the case is there, if the vasopressor was not administered within the specified timeframe for the *Vasopressor Administration* data element, the case could potentially fail at that point if the vasopressor was not administered within that timeframe.

Candace Jackson: Thank you. Our next question, "What is the appropriate time window for RVTP?" I'm assuming that is referencing repeat volume status and tissue perfusion.

Noel Albritton: So, the specified timeframe 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. So, for this one, the *Crystalloid Fluid Administration Date* and *Time* is the date and time that you abstracted earlier in the algorithm for the *Crystalloid Fluid Administration Date* and *Time* data element. So, once you have those that will give you the timeframe to start the *Repeat Volume Status and Tissue Perfusion Assessment Performed* timeframe.

Candace Jackson: Thank you, Noel. Our next question is, "We have a psych building on our campus. If they are transferred from there, is this considered a transfer?"

Noel Albritton: So, if the psych unit is a unit within your hospital, then no, it would not be a transfer. If the psych facility is not within your hospital and it is another location, a separate hospital, then it would be a transfer. To simply explain, if you have a psych unit that is within your hospital, like I said that is not a transfer. But also, if you have a psych hospital within your larger hospital, then it can be a transfer and you can select "Yes" for the transfer data element. I know it's confusing, so if that does not answer that question completely, please feel free to submit one through the online tool about your psych building specifically.

Candace Jackson: We have time for one last question. This says it is in reference to slide 54 and 55. Our numbers might be of a little bit here, so if maybe we could go to 54 or 55. This question says, "What about urgent cares?"

Noel Albritton: For the *Transfer from Another Hospital or ASC* data element, someone transferring or coming to your facility from an urgent care would not suffice that transfer data element so you would select "No." That is included in the guidance within the data element regarding unacceptable transfers as well.

Candace Jackson: Thank you, Noel. That concludes our question-and-answer session. Again, I would like to thank Noel, Jennifer, and Bob for presenting today. Could I have the next slide please? Slide 61? This presentation has been approved for 1.5 CEUs. You can find information on how to obtain your CEUs and additional guidance on the link that was provided on this slide. Next slide, please.

Again, I would like to thank our speakers for today's presentation. As a reminder, all questions submitted during the webinar will be responded to and posted to the *Quality Reporting Center* website at a later date. Next slide, please.

On this slide, you will find the links you need to click on to complete the presentation survey and to retrieve your CEUs. We thank you for joining us today and we hope you have a great rest of your day.