



Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.8 Measure Updates

Presentation Transcript

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Candace Jackson: Hello and thank you for tuning into the *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.8 Measure Updates On Demand* webinar. My name is Candace Jackson, and I am the [Hospital] Inpatient Quality Reporting Program Lead at CMS's Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be your virtual host for the webinar. I would like to welcome our speakers for this webinar. Noel Albritton is the Lead Solutions Specialist, and Jennifer Witt is the Senior Health Informatics Solutions Coordinator for CMS's Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor.

The purpose of the event is to provide clarification and rationale for the changes and updates to the SEP-1 measure and abstraction guidance in version 5.8 of the specifications manual, to discuss updates to the SEP-1 measure abstraction guidance related to patients with COVID-19, and to provide responses to some of the frequently asked questions.

At the end of the presentation, participants will be able to understand and interpret the updated guidance in version 5.8 of the specifications manual to ensure successful reporting for the SEP-1 measure.

This slide just lists the acronyms that are used throughout the presentation.

That concludes our introduction. I will now turn this 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 this presentation we will be reviewing the updated guidance in specification manual v5.8. I would also like to point out before we begin, we will review the updated guidance in manual v5.8 and review some questions containing scenarios relevant to the updated guidance. Yellow highlight was used to reflect guidance that was updated in specifications manual v5.8.

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We'll begin with discussing the *Broad Spectrum or Other Antibiotic Administration Selection* data element. Oral fidaxomicin has been added to the acceptable antibiotics for patients with C. diff. The guidance for patients with C. diff whom did not receive an antibiotic from Table 5.0 or Table 5.1 remains the same as in previous manual versions. In this scenario, there must be physician/APN/PA documentation within 24 hours prior to the antibiotic start time identifying the presence of C. diff, and one of the antibiotics identified in the guidance on this slide must be administered within 3 hours after severe sepsis presentation. Let's take a look at a scenario involving this guidance.

Q. Would you select Value "1" (Yes) for the *Broad Spectrum or Other Antibiotic Administration Selection* data element based on the physician documentation below for administration of oral Difucid within three hours after severe sepsis presentation?

Severe Sepsis Presentation Date/Time: 7/4/2020 1100

Physician Note 7/4/2020 0600: "suspect C. diff"

Difucid (PO): start date/time: 7/4/2020 1230

The answer is A. Yes. select Value "1" (Yes). There is physician documentation within 24 hours prior to the antibiotic start time identifying the presence of C. diff, and oral Difucid was administered within 3 hours after the *Severe Sepsis Presentation Time*.

For the *Crystalloid Fluid Administration* data element, the guidance continues to allow the ideal body weight to be used to determine the target ordered volume when the required physician/APN/PA documentation and ideal body weight value is present. For manual v5.8, the guidance states, "Other acceptable weight terms include predicted weight, dosing weight, and adjusted body weight." This was moved to clarify the documentation requirements for using one of these weights to determine the target ordered volume. The updated guidance clarifies that, to use the predicted weight, dosing weight, or adjusted body weight to determine the target ordered volume of crystalloid fluids, there must be

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physician/APN/Pa documentation that the patient has obesity and the predicted weight, dosing weight, or adjusted body weight is being used to determine the target ordered volume. As similar to using the ideal body weight, the actual predicted weight, dosing weight, or adjusted body weight value must also be included in the medical record documentation as well. However, the actual predicted weight, dosing weight, or adjusted body weight value is not required to be included in the physician/APN/PA documentation. Next, we would like your participation in responding to the following question:

If all the following weights are documented in the medical record, which would you use to determine the target ordered volume if the physician fluid order states, “NS IV 30 mL/kg over 2 hours, BMI >30, use adjusted body weight”?

- A. IBW 69 kg
- B. Adjusted Body Weight 75 kg
- C. Weight 190 lbs
- D. Predicted Weight 68 kg

You would use the adjusted body weight of 75 kg because there is physician documentation of obesity and direction to use the adjusted body weight to determine the target ordered volume.

Next, we'll review updates for the *Initial Hypotension* data element. The guidance states, “If hypotension is normal for the patient, due to a chronic condition, or due to a medication, it should not be used.” This remains in manual v5.8. However, to clarify, the guidance states, “The abnormal value or reference to the abnormal value must be in the same documentation, same sentence, or paragraph.” This was added. This updated is intended to reflect the guidance stating “same documentation” is referring to documentation being within the same sentence or paragraph. This means an abnormal criterion in once section of a note and a chronic condition in another section would not be within the same documentation. Let's review a scenario pertaining to this guidance. The question is:

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Q. Would you use the hypotensive value based on the below physician documentation to establish *Initial Hypotension*?

“Administering 30 mL/kg based on hypotension. This is not abnormal for her due to diabetes.”

The answer is A. No, do not use the hypotensive blood pressure readings to establish initial hypotension because the reference to the abnormal value is included in the same documentation (same paragraph) as the chronic condition. Here is another question:

Q. Would you use the hypotensive value based on the below physician documentation to establish *Initial Hypotension*?

ED Diagnosis: Hypotension

MD Orders: Nitro Sublingual 0.4 mg

Yes, use the hypotensive blood pressure readings to establish *Initial Hypotension* because the reference to the abnormal value (hypotension) is NOT included in the same documentation (same sentence or paragraph) as the medication.

Also updated for the *Initial Hypotension* data element in manual v5.8, a new example was added to the guidance referring to hypotension documented as due to an acute condition with a non-infectious source. In this guidance, if hypotension documented by the physician/APN/PA was due to an acute condition that has a non-infectious source/process, the hypotensive readings would not be used. The new example states, “Hypotension related to dehydration, not sepsis.” In this scenario, dehydration is the acute condition, and the inclusion of “not sepsis” is the non-infectious source. Based on this example, the hypotensive readings would not be used to establish initial hypotension because the documentation is attributing the hypotension to an acute condition that does not have an infectious source. This example was added to v5.8 due to receiving questions from abstractors and facilities referring to scenarios similar to this example.

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Also updated for the *Initial Hypotension* data element, this guidance states, “Use of documentation in pre-hospital records (ambulance records, nursing home records) that is considered part of the medical record is acceptable for determining *Initial Hypotension*. If the criteria for determining *Initial Hypotension* were met prior to arrival and the patient is not hypotensive on arrival to the ED or hospital, select Value “2” (No). This guidance was updated based on feedback from hospitals and abstractors related to cases where initial hypotension presented prior to arrival to the hospital and required the patient to receive the target ordered volume of crystalloid fluids. Based on the updated guidance in manual v5.8, if hypotension was present prior to arrival and not present on arrival to the ED or hospital, you would select Value “2” (No) for initial hypotension. Next, we would like your participation in answering the following question:

Which value would you select for *Initial Hypotension* if EMS documentation includes blood pressures of 85/51 at 1530 and 84/53 at 1545 and a blood pressure of 92/60 was documented in the ED on arrival?

- A. Value “1” (Yes)
- B. Value “2” (No)

Select Value “2” (No) because the patient was hypotensive prior to arrival but not hypotensive on arrival to the ED.

For the *Initial Hypotension Date* and *Initial Hypotension Time* data elements, guidance was updated to address *Initial Hypotension* met prior to arrival. The updated guidance includes two exceptions for prior to arrival. For patients who met criteria for *Initial Hypotension* prior to arrival and remain hypotensive when they arrive at the Emergency Department (ED), use the earliest documented ED arrival time. For patients who met criteria for *Initial Hypotension* prior to arrival and remain hypotensive when they arrive to the hospital, use the earliest documented time when the patient arrives to floor or unit.

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In both scenarios, the patient met *Initial Hypotension* prior to arrival, and they remained hypotensive after arrival to the hospital. Therefore, you would use the arrival time to the ED or the arrival time to the hospital for patients that did not come in through the ED. Let's look at another scenario.

Q. What date and time would you use from the below documentation to establish the *Initial Hypotension Date* and *Initial Hypotension Time*?

Urgent Care: 1415: BP = 83/51

Ambulance: 1430: BP = 85/54

ED Arrival: 1442

ED Flow Sheet: 1443: BP = 86/53

This answer is you would use 1442 for the *Initial Hypotension Time* because the patient met *Initial Hypotension* prior to arrival to the ED and remains hypotensive upon arrival.

The *Initial Lactate Level Result* data element was also updated in manual v5.8 with guidance regarding when to use and not use the *Initial Lactate Level Result*. This guidance was updated to maintain consistency throughout the measure in terms of when to use or not use a criterion. For that reason, the updated guidance in the *Initial Lactate Level Result* data element will look similar to guidance within other data elements. The updated guidance on this slide states, "For the following, physician/APN/PA documentation prior to or within 24 hours after *Severe Sepsis Presentation Time* is required. If the elevated lactate is due to the following, select Value "1." Inferences should not be made. The abnormal value or reference to the abnormal value must be in the same documentation (same sentence or paragraph).

Normal for that patient

Is due to a chronic condition

Is due to a medication

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This guidance allows for Value “1” to be selected for the *Initial Lactate Level Result* data element if there is physician/APN/PA documentation considering the abnormal lactate value or reference to the abnormal lactate value to be normal for the patient, due to a chronic condition, or due to a medication.

The updated guidance for the *Initial Lactate Level Result* data element also includes the guidance, “If the elevated lactate is due to an acute condition that has a non-infectious source/process, select Value ‘1.’” An example is also included in the guidance which demonstrates acceptable physician/APN/PA documentation for selecting Value “1.” The example states: “Lactate 4.3 r/t seizure” “Seizure post brain injury.” (Seizure is the acute condition and brain injury is the non-infectious source). It’s important to note, to suffice this guidance and select Value “1” in this case, the elevated lactate or reference to the elevated lactate must be documented as due to an acute condition and the acute condition is documented as having a non-infectious source. Let’s look at an example where this guidance applies.

Q. Would you select Value “1” (≤ 2) for the *Initial Lactate Level Result* data element based only on the below APN documentation?

APN Note: “Lactic acidosis r/t alcohol consumption, infection not suspected.”

A. The answer is Yes. You would select Value “1” because the reference to the elevated lactate (lactic acidosis) is documented as due to alcohol consumption and not due to an infection.

The guidance on this slide was also included in the updates for the *Initial Lactate Level Result* data element. This guidance was again updated to maintain consistency throughout the measure in terms of when to use or not use a criterion. The first bullet point states, “If the elevated lactate should not be used based on the above guidance, all instances of less severe values should not be used.” This bullet point applies when an elevated lactate result is documented as normal for the patient, due to a chronic condition,

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due to a medication, or due to an acute condition with a non-infectious source. For example, if there was physician documentation stating a lactate of 5.0 is due to a medication and based on the initial lactate level collection time, you identify the initial lactate level result is 4.5, you would select Value “1” for the *Initial Lactate Level Result* data element. The lactate of 5.0 was attributed to a medication and the lactate result of 4.5 is a less severe value than 5.0. The second bullet point states, “If the elevated lactate is due to the following, the elevated lactate value should be used.”

Acute condition

Acute on chronic condition

Infection

The updated guidance on this slide for the *Initial Lactate Level Result* data element allows for a term that represents or is defined by an elevated lactate to suffice when documented as normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source. For example, terms such as “hyperlactemia” and “lactic acidosis” both define an elevated lactate value. If a term that represents or defines the elevated lactate was documented as normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source, you would select Value “1” for the *Initial Lactate Level Result* data element. Next, we would like your participation responding to the following question:

Which value would you select for the *Initial Lactate Level Result* if the result of the initial lactate was 3.3 and the PA documented “lactic acidosis secondary to metformin use”?

Value “1” (≤ 2)

Value “2” (> 2 and < 4.0)

Value “3” (≥ 4)

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Select Value “1” because the PA documentation attributes the elevated lactate (lactic acidosis) to be due to a medication.

Lastly, for the *Initial Lactate Level Result* data element, guidance for determining if the initial lactate level result should be used when there is conflicting documentation was added. The first bullet point on this slide refers to conflicting documentation within the same documentation, and the second bullet point refers to conflicting documentation in separate sources. If there is conflicting documentation within the same physician/APN/PA documentation, you would use the lactate result to select the appropriate value for the *Initial Lactate Level Result* data element. If there is conflicting physician/APN/PA documentation within separate pieces of documentation, you would use the latest physician/APN/PA documentation that is within 24 hours after the *Severe Sepsis Presentation Time* to determine if the lactate result should be used or if Value “1” would be selected for the *Initial Lactate Level Result* data element.

Noel Albritton:

Thank you, Jennifer. For the *Persistent Hypotension* data element, the allowable value associated with “unable to be determined” or “UTD” was updated. In previous versions of the manual, you would select Value “3” (No) if persistent hypotension was unable to be determined. However, upon selecting Value “3” (No), the case would fail the measure. For manual v5.8, if persistent hypotension is unable to be determined, you would select Value “2” (No) which would allow the case to proceed in the algorithm to the next data element for abstraction rather than fail the measure.

The guidance on this slide also received a slight update for the *Persistent Hypotension* data element. The third sub-bullet point on this slide was updated to state, “If there is a normal blood pressure followed by a low blood pressure, select Value ‘2.’” In previous versions of the manual, if there was a normal blood pressure followed by a low blood pressure, you would have selected Value “3.” By selecting Value “3” in that scenario, the case would have failed the measure. However, the update in manual v5.8 allows Value “2” to be selected, and the case will continue in the algorithm to the next data element for abstraction rather than fail the measure. Next, let’s take a look at a scenario.

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This question asks:

Q. Which allowable value would you select for *Persistent Hypotension*?

Hour to assess for Persistent Hypotension is from 0950 to 1050

BP readings at 1020 is SBP of 92 and at 1045 a SBP of 84

A. In this scenario you would select Value “2” (No) for *Persistent Hypotension*. There are multiple blood pressures documented, but they are a normal blood pressure followed by a low blood pressure. Therefore, you would select Value “2” (No) for *Persistent Hypotension* because persistent hypotension is unable to be determined.

The *Repeat Lactate Level Collection* data element was also updated in manual v5.8. The definition, suggested data collection question, and allowable value descriptions were updated to state “within the specified time window” rather than reiterating the actual specified time window in each section of the data element. The specified time window for the *Repeat Lactate Level Collection* data element is provided in the notes for abstraction within the data element. We’ll review that next.

The guidance on this slide provides the specified time window for the *Repeat Lactate Level Collection* data element. The specified time window for the repeat lactate level collection was also updated in manual v5.8. The first bullet point states, “A repeat lactate level is the next lactate level drawn after the initial lactate level if the initial lactate is elevated.” The specified time window for the repeat lactate collection begins after the *Initial Lactate Level Collection Time* and ends 6 hours after the *Severe Sepsis Presentation Time*.

The *Repeat Lactate Level Collection Time* window in previous versions of the manual began at the *Severe Sepsis Presentation Time* and went through 6 hours after the *Severe Sepsis Presentation Time*. In manual v5.8, the time window begins after the *Initial Lactate Level Collection Time* and continues through 6 hours after the *Severe Sepsis Presentation Time*. This was updated based on questions and examples received from hospitals and

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abstractors regarding lactate collection times. Often, the repeat lactate level was collected shortly after the initial lactate level result was known. Even though a repeat lactate may have been collected, if the collection time was prior to the *Severe Sepsis Presentation Time*, the case would fail the measure. The updated time frame for the repeat lactate level collection now allows for these cases to proceed in the algorithm as long as the repeat lactate level collection occurs after the *Initial Lactate Level Collection Time* through 6 hours after *Severe Sepsis Presentation*. The second bullet point on this slide states, “If a repeat lactate level was drawn but not in the time window beginning after *the Initial Lactate Level Collection Time* and ending 6 hours after the *Severe Sepsis Presentation Time*, choose Value “2.” Therefore, if a repeat lactate level collection did not occur in the specified time period, you would select Value “2” (No) for the repeat lactate level collection. Next, we would like your participation in a question.

Which allowable value would you select for the *Repeat Lactate Level Collection* data element if the *Initial Lactate Level Result* was 4.4 and collected at 1300, the *Severe Sepsis Presentation Time* was 1530, and the only other lactate collection occurred at 1500 with a result of 3.2?

Value “1” (Yes)

Value “2” (No)

For this Knowledge Check question, you would select Value “1” (Yes) because the lactate collection at 1500 occurred within the specified time window for the *Repeat Lactate Level Collection* data element beginning after the *Initial Lactate Level Collection Time* and ending 6 hours after the *Severe Sepsis Presentation Time*.

The urine output parameter in the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element was also updated in manual v5.8. The updated guidance states, “Physician/APN/PA documentation must reference urine output (e.g., increased or decreased urine output, oliguria, anuria, urine concentration, urine color).” This guidance was updated due to

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questions we have received regarding acceptable documentation for the urine output parameter. The examples provided in the updated guidance refer to urine output. Other terminology, such as difficulty urinating or dysuria that do not refer to the urine output, would not be acceptable to meet this parameter. Also, documentation that simply refers to output alone without indicating urine output would not be acceptable to meet this parameter. Let's review a scenario. This question asks:

Q. Does the documentation below meet the urine output parameter for one of the five parameters to suffice the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element?

PA Note: "I&Os reviewed"

A. The answer is No, the PA documentation "I&O's reviewed" is not acceptable documentation to meet the urine output parameter. Acceptable documentation should reference the urine output rather than "I&O's" or "output" alone.

The *Septic Shock Present* data element was also updated in manual v5.8 to clarify the clinical criteria for meeting septic shock. The guidance concerning how septic shock is met by *Severe Sepsis Present* and *Persistent Hypotension* was updated to align with how Value "1" (Yes) is selected for the *Persistent Hypotension* data element. The updated guidance states, "*Persistent Hypotension* evidenced by persistent hypotension or new onset of hypotension was present within one hour after the target ordered volume of crystalloid fluids was completely infused." In previous versions of the manual, this guidance included *Persistent Hypotension* evidenced by two consecutive hypotensive blood pressure readings. With the recent updates to the *Persistent Hypotension* data element, specifically the ability to select Value "1" (Yes) for persistent hypotension based on persistent hypotension being unable to be determined but a vasopressor was administered, the updated guidance in v5.8 allows for Value "1" (Yes) to be selected for *Septic Shock Present* regardless of how Value "1" (Yes) was selected for *Persistent Hypotension* data element. Let's review an example to further clarify this scenario.

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This question asks:

Q. Which allowable value would you select for *Septic Shock Present* based only on the documentation below?

Severe Sepsis Presentation Time: 1700

Target ordered volume completed: 1800

Blood pressures documented: 1810 = 93/59 and 1825 = 82/50

Levophed via PICC start time: 1905

You would select Value “1” (Yes) for *Septic Shock Present* data element. Based on the two blood pressure readings and the administration of a vasopressor, you would select Value “1” (Yes) for *Persistent Hypotension*. Therefore, *Septic Shock Present* clinical criteria including *Severe Sepsis Present* and *Persistent Hypotension* were met at 1825.

Also updated for the *Septic Shock Present* data element, guidance was added for documentation of septic shock that is due to a viral, fungal, or parasitic infection. The new guidance states, “If clinical criteria for Septic Shock are NOT met, and the only physician/APN/PA documentation of Septic Shock indicates that Septic Shock is due to a viral, fungal, or parasitic infection, choose Value ‘2.’” You may recognize this guidance because the *Severe Sepsis Present* data element already included a similar bullet point. This bullet point was added to the *Septic Shock Present* data element to be consistent within the data elements and allow cases with only physician/APN/PA documentation of septic shock that is due to a viral, fungal, or parasitic infection to select Value “2” (No). Let’s review another scenario pertaining to this guidance.

This question asks:

Q. Which allowable value would you select for the *Septic Shock Present* data element based only on the documentation below when septic shock clinical criteria were not met?

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APN Note: “Pt with septic shock r/t influenza.”

A. Select Value “2” (No) because septic shock clinical criteria were not met, and the only documentation of septic shock indicates that it is related to a viral infection.

For the *Septic Shock Presentation Date* and *Time* data elements, the guidance was updated to determine which time to use when a “note opened” time stamp is not available. The updated guidance states, “If a timestamp reflecting the “note opened” or started time is unavailable, use the following sources in priority order:

1. Provider Patient Care Initiated time (e.g. Seen date, Contact date, etc.)
2. Scribe time
3. Earliest time at the beginning of the note reflecting when the note was opened or started.”

In this scenario, a specified time is not available for the physician/APN/PA documentation of septic shock. Therefore, you would review for the “note opened” time to determine the septic shock presentation time. However, if a “note opened” time stamp is not available, the updated guidance provides a priority order for other time stamps that would be acceptable for establishing the *Septic Shock Presentation Time*. The first priority if a “note opened” time stamp is not available would be the time stamp reflecting the provider patient care initiated date and time, the seen date and time, the contact date and time, or a time stamp similar to these which reflects when care was initiated. If a time stamp reflecting when care was initiated is not available in your medical record, the second priority is a scribe date and time. If a scribe date and time is not available for the note containing the physician/APN/PA documentation of septic shock, the earliest date and time at the beginning of the note reflecting when the note was opened or started would be acceptable.

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This guidance was added in manual v5.8 due to questions received from abstractors and facilities regarding which time to use when a specified time and “note opened” time stamp is not available. The timestamps included in the priority order are intended to provide guidance specifically for the scenarios when a specified time or “note opened” timestamp is not available. Next, let’s review a scenario.

This question asks:

Q. Which date and time would you use for the *Septic Shock Presentation Date* and *Time* based only on the documentation below if a specified time and “note opened” timestamp was not available?

PA Note: “septic shock secondary to pneumonia.”

Contact date/time: 8/1/2020 1600

Scribe date/time: 8/1/2020 1620

Unspecified date/time at top of note: 8/1/2020 1545

A. In this scenario, you would use the contact date/time of 8/1/2020 at 1600 because this timestamp has the highest priority based on the guidance when a specified time or “note opened” timestamp is not available.

For the *Severe Sepsis Present* data element, additional guidance was added to manual version 5.8 to address cases with COVID-19. The additional guidance is noted in blue highlight in the *Severe Sepsis Present* data element. The additional guidance states, “Select Value ‘2’ if there is physician/APN/PA documentation that coronavirus or COVID- 19 is suspected or present.” Upon selecting Value “2” for the *Severe Sepsis Present* data element, the case will be excluded from the measure. To select Value “2” (No) for *Severe Sepsis Present* and exclude the case, there needs to be physician/APN/PA documentation of confirmed COVID-19 or suspected COVID-19. We’ve received questions regarding orders for COVID-19 tests. To clarify, an order for a COVID-19 test alone should not be used to select Value “2” (No) unless there is further physician/APN/PA

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documentation that COVID-19 is suspected. This additional guidance only applies to specifications manual version 5.8 at this time which includes discharges beginning July 1, 2020–December 31, 2020.

Also updated in the *Severe Sepsis Present* data element is the guidance for determining the time of infection documentation for establishing *Severe Sepsis Present* clinical criteria A. Similar to the guidance we discussed for the *Septic Shock Presentation Date* and *Time* data elements, this updated guidance also states, “If a timestamp reflecting the “note opened” or start time is unavailable, use the following sources in priority order:

1. Provider Patient Care Initiated Time (e.g. Seen Time, Contact Time, etc.)
2. Scribe Time
3. Earliest time at the beginning of the note reflecting when the note was opened or started.”

Again, if a specified time and “note opened” time was not available for the documentation of an infection, you would use the priority order provided in the guidance on this slide to determine the time of the infection.

Further clarification was added in v5.8 for the guidance pertaining to disregarding documentation of an infection. The updated guidance states, “If physician/APN/PA documentation within 6 hours following the initial documentation of the infection indicates that the infection is not present, disregard the initial documentation of the infection.” Two examples are also provided in the guidance. The first example states, “The ED APN documents ‘sepsis’ at 0800. PA notes ‘does not meet sepsis criteria at 0930. Disregard APN documentation of ‘sepsis.’” The documentation of sepsis is disregarded in this case because the PA documentation within 6 hours after indicates sepsis is not present. The second example states, “The MD notes ‘pneumonia’ at 1200. At 1500 MD notes ‘no clear source of infection.’ Disregard the documentation of pneumonia.”

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In this example, there is a specific infection documented, which was pneumonia. The MD documentation within 6 hours after indicates no infection is present, which allows the earlier documentation of pneumonia to be disregarded. In both of these scenarios, you would disregard the earlier infection documentation, but continue reviewing the medical record for later documentation of an infection that is also within 6 hours of *Severe Sepsis Present* criteria B and C.

This new guidance was added to the *Severe Sepsis Present* data element for manual v5.8. It states, “If physician/APN/PA documentation within 6 hours following the initial documentation of an infection indicates that the infection is due to a viral, fungal, or parasitic source, disregard the initial documentation of the infection.” This guidance was added to address scenarios where an acceptable infection is documented, but, also within 6 hours, the infection is attributed to a viral, fungal, or parasitic infection. Let’s review an example to clarify.

This question asks:

Q. Would you use the infection documentation below at 1300 to establish *Severe Sepsis Present* criteria A?

ED MD Note at 1300: “Obtaining CXR, likely pneumonia.”

Hospitalist Note at 1430: “CXR with PNA r/t influenza.”

A. You would not use the documentation of pneumonia at 1300 in this case. You would disregard the infection documentation of pneumonia at 1300 because the physician documentation within 6 hours after 1300 attributes pneumonia to a viral infection. Similar to the update we discussed earlier for the *Initial Hypotension* data element, the *Severe Sepsis Present* data element has also been updated to clarify the guidance regarding “in the same documentation.” The guidance stating, “If SIRS criteria or a sign of organ dysfunction is normal for the patient, due to chronic condition, or due to a medication, it should not be used,” remains in manual v5.8. However, to clarify the guidance stating, “The abnormal value or reference to the abnormal value must be in the same

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documentation,” “same sentence or paragraph” was added. Therefore, the guidance stating “same documentation” is referring to documentation being within the same sentence or paragraph. This means an abnormal criterion in once section of a note and a chronic condition in another section would not be within the same documentation. Let’s review a scenario pertaining to this guidance.

Q. Would you use the elevated INR value based on the below physician documentation to establish *Severe Sepsis Present* organ dysfunction?

“INR this AM 2.3, sending to CT now, will recheck INR in AM. Continue Coumadin 2.5 QD for now.”

A. You would not use the INR of 2.3 to establish organ dysfunction in this scenario because the abnormal value and medication are included in the same documentation. Also, the example on this slide was updated in the *Severe Sepsis Present* data element. This example was updated to include “not due to infection” after receiving questions from hospitals and abstractors concerning this type of documentation. In this updated example, the elevated creatinine is attributed to an acute condition and the documentation includes the acute condition is not due to an infection. Therefore, you would disregard the elevated creatinine value. Next, let’s review another example.

This question asks:

Q. Would you use the low platelet count to establish *Severe Sepsis Present* criteria C (organ dysfunction) based only on the documentation below that is within the specified timeframe?

PA Note: “anemia with thrombocytopenia, infection not suspected.”

A. You would not use the low platelets in this case because thrombocytopenia is attributed to anemia (acute condition) and an infection is not suspected (which is the non-infectious source).

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The guidance for selecting Value “2” (No) for *Severe Sepsis Present* was also updated. The guidance now states, “Choose Value ‘2’ if at the same time or within 6 hours after documentation meeting clinical criteria or physician/APN/PA documentation of severe sepsis there is additional physician/APN/PA documentation indicating:

- Patient is not septic.
- Patient does not have Septic Shock, and Severe Sepsis was met by physician/APN/PA documentation that Septic Shock was present.
- Severe Sepsis or Septic Shock is due to a viral, fungal, or parasitic infection.”

In previous versions of the manual, the timeframe for this guidance only included within 6 hours after the *Severe Sepsis Presentation Time*. Due to feedback received from hospitals and abstractors, the timeframe for this documentation was updated to include documentation at the same time as *Severe Sepsis Presentation* or within 6 hours after. Next, we would like you to participate and respond to the following question:

Which allowable value would you select for the *Severe Sepsis Present* data element if the PA documented “no sepsis” at 0730 and all three severe sepsis clinical criteria were met at 0730?

Value “1” (Yes)

Value “2” (No)

You would select Value “2” (No) in this scenario. The severe sepsis clinical criteria were met at the same time as the PA documentation indicating the patient did not have sepsis.

The *Severe Sepsis Presentation Date* and *Time* data elements were also updated with the guidance to determine the *Severe Sepsis Presentation Date* and *Time* when a specified time and “note opened” time stamp is not available. Similar to our earlier review of similar guidance, the *Severe Sepsis Presentation Date* and *Time* data element states, “If a timestamp

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reflecting the “note opened” or started time is unavailable, use the following sources in priority order:

1. Provider Patient Care Initiated time (e.g. Seen date, Contact date, etc.)
2. Scribe time
3. Earliest time at the beginning of the note reflecting when the note was opened or started.

As we discussed earlier, a specified time or “note opened” time stamp is not available for the physician/APN/PA documentation of severe sepsis. Therefore, the updated guidance provides a priority order for other time stamps that would be acceptable for establishing the *Severe Sepsis Presentation Date and Time*.

That concludes our review of v5.8 measure updates, we hope this has been helpful. Thanks again to everyone for joining us today. Candace, I will turn it back over to you.

Candace Jackson: Thank you, Noel and Jennifer. If you have questions that are pertinent to the webinar topic please submit them to the *QualityNet* Inpatient Questions and Answers tool at the link provided on this slide. If your question pertains to a specific slide, please include the slide number. If you have a question unrelated to the current webinar topic, we recommend searching for the topic in the *QualityNet* Inpatient Questions and Answers tool. If you do not find an answer, feel free to use the tool to submit a new question. Thank you for watching our On Demand webinar. We hope you have a great day.