Hospital Inpatient Quality Reporting (IQR) Program

Inpatient Value, Incentives, and Quality Reporting (VIQR) Outreach and Education Support Contractor

Hospital-Based Sepsis Care: The Evolving Definition of Sepsis and the Role of the ED Medical Director and Quality Team in Sepsis Care

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Subject-matter experts researched and answered the following questions after the live webinar. The questions may have been edited for grammar.

Question 1: **Are blood products considered colloids?**

Yes. For purposes of the Sepsis (SEP)-1 measure, blood products are considered colloids.

Question 2: **We keep hearing about the SEP-3 definition; does CMS have any thoughts of going with this definition in the future?**

No, not at this time. As was discussed during the presentation, SEP-1 uses criteria based on systemic inflammatory response syndrome (SIRS). These criteria are better at early identification of severe sepsis and septic shock than the criteria used in the SEP-3 definition. The SEP-3 definition is better at identifying high risk patients later in the course of the disease. Early identification is the purpose of the screening criteria in SEP-1. Screening criteria, such as SIRS-based criteria, are better at early identification because early identification promotes early treatment.

Question 3: **Regarding the COVID-19 exclusion, the specifications manual includes abstraction guidance that says to select Value 2 if there is physician/Advanced Practice Nurse (APN)/Physician Assistant (PA) documentation that COVID-19 is suspected or present. Does this mean that the patient does not need to be coded as a confirmed COVID-19 case to be excluded from the population? For instance, if a patient is suspected of having COVID-19 on admission (versus just an admissions screening), is this patient excluded from the population? Otherwise, they would meet the sepsis criteria.**

This abstraction guidance was put into the manual in 2020 to remove these patients from the measure denominator since COVID-19 is a viral infection. Frequently these patients appear septic, may not initially be septic, but they may develop a bacterial sepsis later. However, the initial COVID-19 treatment may not be consistent with the SEP-1 requirements. The COVID-19 ICD-10-CM code was added later to remove these patients from the SEP-1 initial patient population. There may be cases that are not coded as COVID-19 for unclear reasons, but there is clear clinician documentation in the medical record that they suspect or have confirmed that COVID-19 is present. The abstraction guidance was retained to make sure there is another option for the abstractor to exclude those cases.

Question 4: **Is the guideline still 3-hour bundle and 6-hour bundle, or is there a shift to a 1-hour bundle from the 3-hour bundle? If so, please provide evidence that the 1-hour bundle has better outcomes.**

At this time, CMS is not changing from the 3-hour and 6-hour bundles for the SEP-1 measure. The literature is not clear that a 1-hour bundle results in better outcomes. For purposes of the measure, we want to be careful that the window for treatment does not get so narrow that it is virtually impossible for providers to meet the measure because a lot of processes need to occur to get an antibiotic started.