Hospital Inpatient Quality Reporting (IQR) Program

Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.10 Measure Updates

Presentation Transcript

Speakers

Noel Albritton, MSN, RN
Lead Solutions Specialist
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor
Jennifer Witt, RN
Senior Health Informatics Solutions Coordinator
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor

June 30, 2021
12:30 p.m. Eastern Time

Candace Jackson: Hello and thank you for tuning in to the *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.10 Measure Updates* 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 host for today's webinar. Before we begin, I would like to make a few announcements. This program is being recorded and a transcript of the presentation will be posted to the inpatient website, www.QualityReportingCenter.com in the upcoming weeks. If you are registered for this event, the links to the slides were sent out a few hours ago. If you did not receive that email, you can download the slides at www.QualityReportingCenter.com. This webinar has been approved for 1.5 continuing education credits. If you would like to complete the survey for today's events, please stand by after the event. We will display a link for the survey that you would need to complete for continuing credit. The survey will no longer be available if you leave the event early. If you do need to leave prior to the conclusion to the event, a link of the survey will be available in the summary email one to two business days after the event. 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 this event is to clarify the changes and rationale behind the update to the SEP-1 measure and guidance in version 5.10 of the specifications manual and to respond to frequently asked questions.

At the end of the presentation, participants will be able to understand and interpret the updated guidance in version 5.10 of the specifications manual to ensure successful reporting for the SEP-1 measure.

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

At the end of the presentation, we will have a live Q&A session as time allows. If you have questions as we move through the webinar, please type the questions into the Ask a Question window with the slide number.

We will answer as many questions as time allows after the event. If we are unable to address your question during the live Q&A session, you can submit those questions to the QualityNet Inpatient Question and Answer Tool, which will be discussed later in this presentation.

That concludes our introductions. I will now turn this over to Noel Jennifer. Noel and Jennifer, if 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 specifications manual version 5.10.

To begin, updated guidance in manual version 5.10 is noted in yellow highlight throughout the manual. We also made changes throughout the manual to align with CMS's plain language standards. Plain language updates in the specifications manual are in yellow highlight to indicate the change; however, the plain language updates do not change the intent of the abstraction guidance.

The SEP-1 algorithm was updated in manual version 5.10 to remove the *Broad Spectrum or Other Antibiotic Administration Selection* data element. The *Broad Spectrum or Other Antibiotic Administration Selection* data element was removed to simplify the measure where possible when maintaining the measure's intent. This element of the measure has also maintained a high pass rate which demonstrates minimal room for further improvement. Removing the data element also aids in decreasing the abstraction burden and continues to focus on timing of the antibiotic administration within the measure, rather than focusing on the specific antibiotic administered. The algorithm update on this slide removes the *Broad Spectrum or Other Antibiotic Administration Selection* data element completely, shows cases with a broad spectrum or other antibiotic administration time within 24 hours before to three hours after the severe sepsis presentation time, and proceeds directly to the *Blood Culture Collection* data element.

In the algorithm, the broad spectrum antibiotic timing calculation on this slide uses the *Broad Spectrum or Other Antibiotic Administration Selection* Date and Time and the *Severe Sepsis Presentation Date and Time* to determine the category assignments provided on this slide. Cases with a broad spectrum antibiotic timing greater than 24 hours before the *Severe Sepsis Presentation Time* continue to be excluded from the measure at the broad spectrum antibiotic timing calculation and proceed to a measure category of B. Cases with a broad spectrum antibiotic timing greater than three hours after the *Severe Sepsis Presentation Time* will fail to measure at this timing calculation and proceed to measure category of D. The *Broad Spectrum or Other Antibiotic Administration Selection* data element was also removed from the alphabetical data dictionary. So, the abstraction guidance for this data element is no longer included in the manual.

With the removal of the *Broad Spectrum or Other Antibiotic Administration Selection* data element, the corresponding medication tables in Appendix C were removed. Table 5.0 and 5.1 previously included the monotherapy and combination therapy antibiotics. The antibiotics were removed from these two tables, but the tables continue to be maintained in Appendix C as reserved for future use. You will continue to find the vasopressors for septic shock in Table 5.2 and anticoagulants for sepsis in Table 5.3 of Appendix C.

Guidance was updated for determining if there was documentation of an infection under Criteria A of the *Severe Sepsis Present* data element. The guidance states, “If physician/APN/PA documentation within six hours following the initial documentation of the infection indicates the infection is not present, do not use documentation of that infection made prior to the documentation indicating the infection is not present.” You may recall the previous guidance referred to if there was physician/APN/PA documentation within six hours following the initial documentation of the infection indicates the infection is not present, do not use the initial documentation of the infection. The updated guidance clarifies that the physician/APN/PA documentation should refer to the initial infection documented as not being present.

This guidance was updated to clarify scenarios when you would not use a documented infection if there was physician/APN/PA documentation within six hours after the documented infection that states the infection is not present. Let's review a couple of scenarios related to this guidance.

This question asks, "Would you use the documented infection at 1300 to establish criteria A for the *Severe Sepsis Present* data element based only on the physician documentation below?" The MD note at 1300 states, "Based on symptoms suspect pneumonia." The MD note at 1330 states, "No obvious source of infection." The answer is No. You would not use the infection documentation at 1300 to establish severe sepsis due to the note at 1330 indicating the infection is not present.

This question is also related to establishing the severe sepsis infection criteria. It asks, "Would you use the documented infection at 0900 to establish criteria A for the *Severe Sepsis Present* data element based only on the physician documentation below?" The MD note at 0900 states, "Sepsis likely due to UTI." The MD note at 1200 states, "I do not suspect UTI at this time." The answer is Yes. Use the documentation at 0900 to establish *Severe Sepsis Present* criteria A due to the documentation of sepsis because the documentation at 1200 does not indicate sepsis is not present. The UTI at 0900 could be disregarded because of the documentation at 1200 indicating it's not present. Without documentation that sepsis is not present within six hours after it was present, the documentation of sepsis at 0900 could still be used as infection criteria.

New guidance was added to the *Severe Sepsis Present* data element for the abstraction of clinical criteria when there's conflicting documentation in separate sources before severe sepsis is met. This new guidance states, "Abstract based on the documentation closest to the Severe Sepsis Presentation Time if there's conflicting information before the Severe Sepsis Presentation Time within two or more separate pieces of physician/ APN/PA documentation indicating SIRS criteria or sign of organ dysfunction is normal for the patient due to a chronic condition or medication or due to an acute condition with a non-infectious source and due to or possibly due to an infection, severe sepsis, or septic shock."

In this scenario, you would use the documentation closest to the *Severe Sepsis Presentation Time* to determine if SIRS criteria or a sign of organ dysfunction should be used to establish the presence of severe sepsis when there is documentation of multiple sources before severe sepsis is met indicating the SIRS criteria or sign of organ dysfunction is normal for the patient, or due to a chronic condition or medication or an acute condition with a non-infectious source and due to an infection. Let's review a scenario related to this guidance.

This question asks, "Would you use the elevated heart rate as a SIRS criterion to establish *Severe Sepsis Present* if all three severe sepsis clinical criteria were met at 0800?" The PA note at 0 700 states, "Tachycardic possibly related to infection." The MD notes at 0745, "Tachycardia due to anxiety prior to chest tube placement." The answer is No. There is conflicting documentation before severe sepsis is met and the closest documentation to the severe sepsis presentation time indicates the elevated heart rate is due to an acute condition with a non-infectious source.

As part of the plain language updates to the specifications manual, the definition and suggested data collection question were updated for the *Administrative Contraindication to Care, Septic Shock* data element. The definition now states, "Documentation of refusal of blood draw, IV fluid administration, or vasopressor administration within the specified time frame." The suggested data collection question now states, "Is there documentation that the patient or authorized patient advocate refuse either a blood draw, IV fluid administration, or vasopressor administration within the specified time frame?" You may recall in previous manual versions, the definition and suggested data collection question both included the specified time frame of prior to or within six hours following presentation of septic shock. To reduce redundancy within the data element, the definition and suggested data collection question were updated to only include "within the specified time frame."

Similar to the previous slide, the allowable values for the *Administrative Contraindication to Care, Septic Shock* data element were also updated to only include "within the specified time frame."

Again, these updates were intended to reduce the redundancy, but they continue to meet the intent of the guidance.

The specified time frame for the *Administrative Contraindication to Care, Septic Shock* data element is provided in the new goal point within the notes for abstraction. This guidance states, "The specified time frame for physician/APN/PA or nursing documentation is before or within six hours after the Septic Shock Presentation Time." The specified time frame for this data element did not change, rather the guidance was updated to reduce the redundancy and specifically provide the specified time frame within the notes for abstraction. Next, we would like your participation in the following question.

Which value would you select if the physician documentation within the specified time frame stated this? "Patient spouse says the patient would not want phase vasopressors." A. Value 1 (Yes) B. Value 2 (No) We will give you a few more seconds to enter your answer.

Select A. Value 1 (Yes) because the physician documentation within the specified time frame includes the authorized patient advocate's refusal of vasopressors.

Similar to the updates in the previous slide, the definition and suggested data collection question were updated for the *Administrative Contraindication to Care, Severe Sepsis* data element. The definition now states, "Documentation of refusal of blood draw, IV fluid administration, or IV antibiotic administration within the specified time frame." The suggested data collection question now states, "Is there documentation that the patient or authorized patient advocate refused either a blood draw, IV fluid administration, or IV antibiotic administration within the specified time frame?" The definition and suggested data collection question for this data element also previously included the time frame. This update was also to reduce redundancy within the data element.

Also similar to the previous slides, the allowable values for the *Administrative Contraindication to Care, Severe Sepsis* data element were updated to only include "within the specified time frame." Again, these updates were intended to reduce the redundancy, but they continue to meet the intent of the guidance.

The specified time frame for the *Administrative Contraindication to Care, Severe Sepsis* data element is provided in this new bullet point within the notes for abstraction. This guidance states, 'The specified time frame for physician/APN/PA or nursing documentation is before or within six hours after the severe sepsis presentation time. The specified time frame for this data element did not change rather the guidance was updated to reduce the redundancy and specifically provide the specified time frame within the notes for abstraction.

The new guidance provided on this slide applies to both the *Administrative Contraindication to Care, Septic Shock* and *Administrative Contraindication to Care, Severe Sepsis* data elements. This guidance states, "For purposes of abstraction only, an authorized patient advocate is someone who is authorized to make decisions on behalf of the patient when the patient is not able to. This includes someone who is legally designated and empowered to make medical decisions on the patient's behalf when the patient is unable to themselves." Examples are family members, medical power of attorney, healthcare power of attorney, durable power of attorney for health care, someone documented as an agent for the patient, and attorney in fact. This guidance was added to clarify the role of the authorized patient advocate as far as abstracting the SEP-1 measure. The updated guidance clarifies that an authorized patient advocate is someone who is legally designated to make medical decisions for the patient. Let's review a question related to this new guidance.

This question asks, "Should you select Value 1 (Yes) or Value 2 (No) for the *Administrative Contraindication to Care, Severe Sepsis* data element based only on the documentation below within the specified time frame?" The physician notes, "I, as the authorized patient advocate, will not administer 30 milliliters per kilogram of IV fluids."

The answer is Value 2 (No). Further documentation within the medical record identifying who is legally designated and empowered to make decisions on behalf of the patient must be documented. If there is further documentation within the medical record indicating the physician is legally designated and empowered to make decisions on behalf of the patient, the physician would be considered the authorized patient advocate.

The definition for the *Directive for Comfort Care and Palliative Care, Septic Shock* data element was updated to align with plain language standards and reduce redundance. The updated definition now begins with "Physician/ APN/PA documentation of comfort measures only, palliative care, or another acceptable inclusion term within the specified time frame."

The allowable values for the *Directive for Comfort Care and Palliative Care, Septic Shock and Directive for Comfort Care and Palliative Care, Severe Sepsis* data elements were also updated and now state, "1 (Yes) There is physician/APN/PA documentation of an inclusion term within an acceptable context within the specified time frame. 2 (No) There is not physician/APN/PA documentation of an inclusion term within an acceptable context within the specified time frame or unable to determine from the medical record documentation." Again, these updates were intended to reduce the redundancy, but they continue to maintain the intent of the guidance.

A new bullet point was added to the notes for abstraction that specifies the time frame for the *Directive for Comfort Care and Palliative Care, Septic Shock* data element.

The new goal point states, "The specified time frame for the physician/APN/PA documentation of comfort measures only, palliative care, or another inclusion term is before or within six hours after the presentation of septic shock." The specified time frame for the data element did not change.

Similar to the previous slide, a bullet point was added to the notes for abstraction that specify the time frame for the *Directive for Comfort Care and Palliative Care, Severe Sepsis* data element.

The new goal point states, "The specified time frame for physician/APN/PA documentation of comfort measures only, palliative care, or another inclusion term is before or within six hours after the presentation of severe sepsis." The specified time frame for this date element also did not change. Let's review a scenario related to this guidance.

This question asks, "Which value would you select for the *Directive for Comfort Care and Palliative Care, Severe Sepsis* data element based on the physician documentation below?" The MD note at 1520 states, "Discuss moving patient to hospice care with family. They request palliative care at this time." The MD note at 1700 states, "Patient has severe sepsis with shock." The answer is to select Value 1 (Yes) for the *Directive for Comfort Care and Palliative Care, Severe Sepsis* data element because the documentation before the *Severe Sepsis Presentation Time* indicates the family requested palliative care.

Guidance in the *Blood Culture Collection* data element was updated to clarify the specified time frame. The updated guidance states, "If the Broad Spectrum or Other Antibiotic Administration Time is not within the 24 hours before the Severe Sepsis Presentation Time, the specified time frame is 24 hours before the *Severe Sepsis Presentation Date and Time* through three hours following the *Severe Sepsis Presentation Date and Time.* If the Broad Spectrum or Other Antibiotic Administration Time is within the 24 hours before the Severe Sepsis Presentation Time, the specified time frame is 24 hours before the *Broad Spectrum or Other Antibiotic Administration Time* through three hours following the *Severe Sepsis Presentation Time.* The specified time frame for the *Blood Culture Collection* data element did not change in manual version 5.10. The guidance on the slide was updated to incorporate plain language standards and clarification. For the next part of the presentation, I'll turn it over to Noel.

Noel Albritton: Thanks, Jennifer. Further guidance was added to the *Initial Lactate Level Result* data element for abstraction of the *Initial Lactate Level Result* when there is conflicting documentation in separate sources before severe sepsis is met.

This new guidance states, "Abstract based on the documentation closest to the *Severe Sepsis Presentation Time* if there is conflicting information before the *Severe Sepsis Presentation Time* within two or more separate pieces of physician/APN/PA documentation indicating the elevated lactate is normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source and due to or possibly due to an infection, severe sepsis, or septic shock. In this scenario, you would use the documentation closest to the *Severe Sepsis Presentation Time* to determine if the initial lactate level results should be used to establish the presence of septic shock when there is conflicting documentation and multiple sources before severe sepsis is met indicating the initial lactate level result is normal for the patient, or due to a chronic condition, or medication for an acute condition with the non-infectious source and due to an infection. Let's review a scenario related to this guidance.

This question asks, "Would you select Value 1 or Value 3 for the Initial Lactate Level Result based on the documentation below if the lactate result was 4.5 and severe sepsis was met at 1300?" The APN note at 1130 states, "Lactic acidosis possibly r/t seizures, initiated tramadol." An APN note at 1230 states, "UTI with SIRS criteria and lactic acidosis, suspects sepsis." The answer is to select Value 3 for the *Initial Lactate Level Result* data element because the documentation closest to the *Severe Sepsis Presentation Time* indicates the elevated lactate is due to an infection. As we reviewed on the previous slides, the new guidance states to extract based on the documentation closest to the *Severe Sepsis Presentation Time* if there is conflicting information before the *Severe Sepsis Presentation Time* within two or more separate pieces of physician/APN/PA documentation indicating the elevated lactate is normal for the patient due to a chronic condition or medication or due to an acute condition with a non-infectious source and due to or possibly due to an infection, severe

sepsis, or septic shock. In the scenario, on this slide the documentation at 1230 attributes the elevated lactate to an infection, and this documentation is closest to the *Severe Sepsis Presentation Time;* therefore, you would select Value 3 for the Initial Lactate Level Result data element.

Similarly, further guidance was added to the *Initial Hypotension* data element for the abstraction of hypotensive readings when there is conflicting documentation and separate sources before severe sepsis is met. This new guidance states, "Abstract based on the documentation closest to the *Severe Sepsis Presentation Time* if there is conflicting information before the *Severe Sepsis Presentation Time* within two or more separate pieces of physician/APN/PA documentation indicating the hypotension is normal for the patient, due to a chronic condition or medication, or due to an acute condition with a non-infectious source and due to or possibly due to an infection, severe sepsis, or septic shock. Like the previous scenarios we've discussed, you would use the documentation close to the *Severe Sepsis Presentation Time* to determine if the hypotensive readings would be used to establish *Initial Hypotension* when there is conflicting documentation in multiple sources before severe sepsis indicating the hypotension is normal for the patient due to a chronic condition or medication or an acute condition with a non-infectious source and due to an infection. Let's review another scenario related to this guidance.

This question asks, "Would you use the hypotensive blood pressure readings for the *Initial Hypotension* data element based on the documentation below if severe sepsis was met at 1800?" There's an APN note at 1530 stating, 'Dehydrated due to decreased PO intake causing hypotension." Another APN note at 1645 states, "Now suspecting systemic infection may be present based on fever, hypotension, and labs." The answer is Yes. Use the hypotensive blood pressure readings because the documentation closest to the *Severe Sepsis Presentation Time* indicates the hypotension is due to an infection.

The guidance related to hypotension documented in pre-hospital records and the *Initial Hypotension* data element was also updated. The updated data guidance states, "To determine the presence of *Initial Hypotension*,

you may use documentation and pre-hospital records that are considered part of the medical record. Select Value 2 if the criteria for determining *Initial Hypotension* were met prior to arrival and the first blood pressure reading upon arrival to the ED or hospital was not hypotensive."

The clarification to review the first blood pressure reading upon arrival to the ED hospital was added to this guidance due to questions from abstractors and hospitals. This guidance in previous manuals only referred to the patient not being hypotensive upon arrival to the ED or hospital. The previous guidance was replaced with the clarifying guidance to review the first blood pressure upon arrival to the ED or hospital if *Initial Hypotension* criteria were met prior to arrival to the ED or hospital. Next, we would like your participation in the following question.

Which value would you select for *Initial Hypotension* if two hypotensive readings were documented by EMS prior to arrival and the first blood pressure reading on arrival to the ed was 93 over 51? A. Value 1 (Yes) B. Value 2 (No). We'll give you a few more seconds to select your answer.

The correct answer is B. Value 2 (No). Select Value 2 (No) because criteria to establish *Initial Hypotension* were met prior to arrival, and the first blood pressure on arrival to the ED was not hypotensive.

New guidance was added to the *Crystalloid Fluid Administration* data element that allows for Value 1 (Yes) to be selected in specific scenarios when less than 30 milliliters per kilogram of crystalline fluids were ordered. This guidance was added based on clinician and obstructor feedback. Due to the variances within current literature, the updated guidance allows the physician/APN/PA to individualize fluid administration based on a specific patient situation. Of note, the updated guidance includes specific documentation requirements that must be met to use a volume less than 30 milliliters per kilogram. We'll discuss the complete new guidance on the following three slides.

Again, the new guidance on this slide states, “Select Value 1 if less than 30 milliliters per kilogram were ordered and given and if all of the following criteria were met. The ordering physician/APN/PA must have documented within a single note in the medical record that the administration of 30 milliliters per kilogram of crystalline fluids would be detrimental or harmful for the patient despite having hypotension, a lactate greater than or equal to four, or documentation of septic shock.

The new guidance continues with “and the patient has one of the following conditions or that a portion of the crystalloid fluid volume was administered as colloids. (If a portion consisted of colloids, there must be an order and documentation that colloids were started or noted as given.) Advanced or end-stage heart failure (with documentation of NYHA class III or symptoms with minimal exertion, or NYHA class IV or symptoms at rest or with any activity). Advanced or end-stage chronic renal disease (with documentation of stage IV or GFR 15 to 29 milliliters per minute, or stage V or GFR less than 15 milliliters per minute or ESRD) and the volume of crystalloid fluids in place of 30 milliliters per kilogram that the patient was to receive.”

The new guidance continues to require “and an order for the volume of fluids in place of 30 milliliters per kilogram to be administered” along with “all other applicable requirements for the *Crystalloid Fluid Administration* data element are met.” The new guidance also includes an example for this scenario: Physician documentation of the lactate 5.0, advanced CHF symptomatic with minimal exertion, concerned 30 milliliters per kilogram of normal saline may be harmful despite lactate elevation, 20 milliliters per kilogram normal saline now, then reevaluate.” There’s an order for normal saline 0.9 percent IV, 20 milliliters per kilogram over two hours. On the MAR: normal saline IV, 20 milliliters per kilogram was started at 1500 and documented as completed at 1700. Select Value 1 based on physician documentation meeting the requirements and identifying 20 milliliters per kilogram as the target ordered volume of crystalloid fluids for this patient. Let’s review a few scenarios related to this new guidance.

What would you use for the target ordered volume based on the physician documentation below? Physician documentation: 30 milliliters per kilogram of normal saline may be harmful even with septic shock. Advanced renal disease stage IV, begin with 10 milliliters per kilogram of normal saline based on weight of 80 kilograms. There's an order for normal saline 0.9 percent IV, 10 milliliters per kilogram, which is 800 milliliters for this patient over two hours.

MAR: Normal saline IV 800 milliliters is documented with a start time of 0600 and completed time of 0800. The answer is: Use 800 milliliters as the target ordered volume based on the physician documentation and the patient's weight of 80 kilograms.

This question asks, "Which value would you select for *Crystalloid Fluid Administration* based on the physician documentation below?" Physician documentation: Patient has hypotension but a fluid volume of 30 milliliters per kilogram would be detrimental. End stage heart failure NYHA class III. Will give 1500 milliliters of normal saline. There's an order for normal saline 0.9 percent IV, 1500 milliliters at 1000 milliliters per hour. MAR: Normal saline IV, 1500 milliliters with a start time of 1700 and completed time of 1830. The answer in this case is select Value 1 based on the physician documentation meeting the requirements and identifying 1500 milliliters as the target ordered volume of crystalloid fluids for this patient.

This question asks, "Which value would you select for *Crystalloid Fluid Administration* based on the physician documentation below?" Physician documentation: Septic shock is present. 30 milliliters per kilogram IV fluid would overload and be harmful. Administering total of 1500 milliliters including Albumin 500 milliliters with 1000 milliliters of normal saline. There's an order for albumin 5 percent, 500 milliliters IV over 30 minutes and normal saline 0.9 percent IV, 1000 milliliters at 1000 milliliters per hour. On the MAR, Albumin 500 milliliters is documented as started at 0530 and ended at 0600, and normal saline IV 1000 milliliters is documented as started at 0600 and ended at 0700.

The answer is select Value 1 based on the physician documentation meeting the requirements and identifying 1500 milliliters as the target ordered volume of colloid and crystalloid fluid for this patient. As you can see in this scenario, the required physician documentation is present. There's a complete order for the colloid and crystalloid fluids and complete documentation of fluid administration. This documentation must be present to use the colloid and crystalloid fluid to suffice the data element.

Also updated for the *Crystalloid Fluid Administration* data element was the guidance related to determining if the target ordered volume was completely infused. This guidance states, "To determine if the target ordered volume was completely infused, one of the following must be documented along with the infusion start time. If one of the following is not documented, do not use the fluids toward the target ordered volume: An infusion rate (for example, 1000 milliliters over one hour); an infusion duration or time over which to infuse (for example, 1000 milliliters over 30 minutes); or an infusion end or completion time (for example, MAR documentation of 1000 milliliters and end time 1200.) The highlighted updates on this slide were added for clarification to demonstrate an infusion rate, duration, or time or an infusion end time or completion time. Next, we would like your participation in the following question.

Would you determine the target ordered volume to be completely infused based off this MAR documentation? NS 1000 milliliters, start time 0800, continuous bolus. A. Yes B. No. We'll give you a few more seconds to select your answer.

The correct answer is B. No. Select B. No because the MAR documentation does not include a rate, duration or time over which to infuse or an end time or completion time.

Guidance was also added to the *Crystalloid Fluid Administration* data element to further clarify and authorize a patient advocate. This guidance also states, "For the purpose of abstraction only, an authorized patient advocate is someone who is authorized to make decisions on behalf of the patient when the patient is not able to.

This includes someone who is legally designated and empowered to make medical decisions on the patient's behalf when the patient is unable to themselves." Examples include family members, medical power of attorney, healthcare power of attorney, durable power of attorney for health care, someone documented as an agent for the patient, or attorney in fact. In cases where there is documentation of the refusal of crystalloid fluids by an authorized patient advocate that is legally designated to make medical decisions for the patient, you would select Value 2 (No) for the *Crystalloid Fluid Administration* data element.

These two bullet points were updated in the *Crystalloid Fluid Administration Date & Time* data elements. The first bullet point now states, "Crystalline fluid volumes ordered that are equivalent to 30 milliliters per kilogram, within 10 percent less than 30 milliliters per kilogram, or a volume less than 30 milliliters per kilogram with the required physician/APN/PA documentation are considered the target ordered volume." This bullet point was updated to incorporate the guidance that a volume less than 30 milliliters per kilogram with the required physician/APN/PA documentation due to the new guidance added to the *Crystalloid Fluid Administration* data element in which specific physician/APN/PA documentation may allow for a volume less than 30 milliliters per kilogram to be acceptable. The second bullet point on this slide states, "If using multiple orders toward the target ordered volume, use the start time of the crystalloid fluid infusion that completed the target ordered volume." This guidance was updated to clarify how to determine the crystalloid fluid administration date and time when there are multiple orders. This update was based on questions received from hospitals and abstractors. Let's review a scenario related to this guidance.

This question asks, "What time would you select for the *Crystalloid Fluid Administration Time* based on the documentation below?" Target ordered volume is 2500 milliliters. The first order is for 2000 milliliters of normal saline IV at 1000 milliliters per hour. Second order is 500 milliliters normal saline IV bolus. MAR: 2000 milliliters of normal saline IV over two hours with a start time of 0900 and 500 milliliters of normal saline

over 30 minutes with a start time of 1030 and an end time of 1100. The answer in this case is to use 1030 as the *Crystalloid Fluid Administration Time* because there are multiple orders and the infusion that completed the target ordered volume was started at 1030.

Like other data elements we previously discussed, further guidance was also added to the *Persistent Hypotension* data element for the abstraction of hypotensive readings when there is conflicting documentation in separate sources before severe sepsis is met.

This new guidance states, "Abstract based on the documentation closest to the *Severe Sepsis Presentation Time* if there is conflicting information before the *Severe Sepsis Presentation Time* within two or more separate pieces a physician/APN/PA documentation indicating hypotension is normal for the patient due to a chronic condition or medication or due to an acute condition with a non-infectious source and due to or possibly due to an infection, severe sepsis, or septic shock.

Further guidance was also added to the *Septic Shock Present* data element for the abstraction of hypotensive readings when there's conflicting documentation and separate sources before severe sepsis is met. Similarly this new guidance states, "Abstract based on the documentation closest to the *Severe Sepsis Presentation Time* if there's conflicting information before the *Severe Sepsis Presentation Time* within two or more separate pieces a physician/APN/PA documentation indicating hypotension as normal for the patient due to chronic condition or medication or due to an acute condition with a non-infectious source and due to or possibly due to an infection, severe sepsis, or septic shock. Like the previous scenarios we've discussed, you would use documentation closest to the *Severe Sepsis Presentation Time* to determine if the hypotensive readings would be used to establish septic shock when there is documentation in multiple sources before super sepsis is met indicating the hypotension is due to a chronic condition, medication, or acute condition with a non-infectious source and due to an infection. Let's review a scenario related to this guidance.

This question asks, “Would you use the hypotensive blood pressure to establish *Septic Shock Present* based on the documentation below if severe sepsis was met at 2100?” There’s an MD note at 1900 that states, “Possibly septic with hypotension.” There’s also an MD note at 2020: “Hypotension after morphine.” The answer in this case is No. Do not use the hypotensive blood pressure readings because the documentation closest to the *Severe Sepsis Presentation Time* indicates the hypotension is due to a medication.

That concludes our review of specifications manual version 5.10 updates. Thank you for participating in our review of SEP-1 measure updates.

If we did not get to your question during the webinar, please submit your question to the QualityNet Inpatient Question and Answer Tool via the link on this slide. If your question is about a specific slide, please include the slide number in your question.

From the QualityNet.CMS.gov website, you can search for existing questions and answers or submit a new question. To search for an existing Q&A, type this topic or data element into the search box and select Search. All Q&As pertaining to that topic will appear, and you can review the existing Q&As to find your answer. The existing Q&As are for educational purposes, and it’s important to ensure the Q&A you are referencing is in agreement with the current manual guidance based on the discharge period you are extracting. We are continually reviewing and updating the existing Q&As, so it’s important to review the existing Q&As often to ensure responses continue to apply to your questions. Also, from the quality question-and-answer tool page, you can submit your own question by selecting the Ask a Question button.

When submitting a question to the support team, you must complete the form that includes your name and contact information. The response to your question will be sent via email to the email address you include on this form.

Next, you will select the program. For abstraction questions for the SEP-1 measure, select Inpatient-Measures & Data Element Abstraction. Questions are often submitted to other programs by mistake, and it may take longer to get a response if the question has to be rerouted to the correct support team. So, for SEP-1 abstraction questions, the program to select is Inpatient-Measures & Data Element Abstraction.

After selecting the Inpatient-Measures & Data Element Abstraction program, you will then select the topic. For SEP-1 abstraction questions, you can select one of the topics under Hospital Inpatient-Sepsis. The topics are listed by data elements that are included in the SEP-1 measure.

The next required field is the discharge period. It's important to select the appropriate discharge period because your answer to your question may vary slightly depending on the manual version. Next, you will add the subject for your question in the Subject field. Then, enter your question into the Please Describe Your Question field. It's important to note that no PII or PHI should be included in your submitted questions. Also, we are unable to receive screenshots or attachments. Submitted abstraction questions should be concise and only include information specific to the topic being questioned. After you have entered your question, you would next click the Submit Question button. The support team will respond to your abstraction question as quickly as possible. So, that's how you can review existing Q&As or submit a new question to the support team. Candace, I will turn it back over to you now.