Hospital Inpatient Quality Reporting (IQR) Program

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

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.11a 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
Behavioral Development and Inpatient and Outpatient
Measure Maintenance Support Contractor

Moderator

Candace Jackson, AND
Project Lead, Hospital IQR Program
Inpatient VIQR Outreach and Education Support Contractor

February 8, 2022
1:00 p.m. Eastern Time (ET)

Candace Jackson: Good afternoon. Welcome to the *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure), Version 5.11a, Measure Updates* webinar. My name is Candace Jackson, and I am with 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, along with the question-and-answer summary from the questions for today, will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks. If you are registered for this event, links to the slides were sent out a few hours ago. If you did not receive that email, you can download the slides. Again, that is www.QualityReportingCenter.com. The webinar has been approved for 1.5 continuing education credits. If you would like to complete the survey for today's event please stand by after the event. We will display a link for the survey that you would need to complete for continuing education. The survey will no longer be available if you leave the event early, but if you do need to leave prior to the conclusion of the event ,a link to the survey will be available in the summary email one to two business days after the event. If you have questions as we move through the webinar, please type the questions into the Ask a Question window with the slide number associated, and we will answer questions as time allows after the event. If we do not get to your question during the question-and-answer session, please submit your question to the QualityNet Inpatient Question and Answer Tool, which will be addressed later in this presentation. Our speakers for today's event are Noel Albritton, the Lead Solutions Specialist, and Jennifer Witt, the Senior Health informatics Solutions Coordinator for the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor.

The purpose of this webinar is to clarify the changes and rationale behind the update to the SEP-1 measure and guidance in version 5.11a of the specifications manual and to provide responses to the frequently asked questions.

At the conclusion of this webinar, participants will be able to understand and interpret the updated guidance in version 5.11a in the specifications manual to ensure successful reporting of the SEP-1 measure.

This slide just lists the acronyms and abbreviations that are used in today's presentation.

I would now like to turn the presentation over to Noel and Jennifer. Noel and Jennifer, the floor is yours.

Jennifer Witt: Thanks, Candace. Hello, everyone. Thank you for joining us. For this presentation, we will be reviewing the updated guidance for this SEP-1 measure in specifications manual version 5.11a. Updated guidance to manual version 5.11a 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. We encourage you to review these updates in the release notes and data elements.

To begin, the *Transfer from Another Hospital or ASC* data element received updates to align with CMS's plain language standards. The updates do not change the intent of the guidance. They are only meant to clarify the language. The plain language updates on this slide clarify at the beginning of these bullet points which allowable value to select.

The *Administrative Contraindication to Care, Septic Shock and Severe Sepsis* data elements were updated to clarify the appropriate allowable value to select. The new guidance states: Select Value 1 if there is more general documentation of a refusal of care or documentation of patient non-compliance with care that could result in the following not being administered. Select Value 1 if any of the following are administered but occur after the specified time window due to refusal of care or patient non-compliance: blood draws, IV or IO fluid administration, IV or IO antibiotic.

This updated guidance reflects that a documented refusal within the specified time frame continues to be acceptable for selecting Value 1 (Yes) for the *Administrative Contraindication to Care, Septic Shock and Severe Sepsis* data elements even if blood was later collected or IV fluids or antibiotics were later administered. Next, we would like your participation in answering a question related to this scenario that we frequently receive via the online Q&A tool.

Which value would you select if *Severe Sepsis Presentation Time* was 1600, the PA documented at 1900 that "patient disoriented and pulled out IV," and 30 milliliters per kilogram volume was completed at 2230? A. Value 1 (Yes) or B. Value 2 (No)? We will give you a few more seconds to select your answer.

Select A. Value 1 (Yes) because the PA documentation within the specified time frame includes the patient's non-compliance that could result in not being able to administer IV fluids or antibiotics. You would exclude this case due to the documentation of patient non-compliance with care even though the patient later received the 30 milliliter per kilogram volume.

Next, let's review updates made to the *Severe Sepsis Present* data element in version 5.11a. Clarification was added to the example related to disregarding service criteria or a sign of organ dysfunction that is due to an acute condition with a non-infectious source. The example now states: Lactate 4.3 related to seizure. Post brain injury seizure is acute condition, and brain injury is the non-infectious source. The lactate level is due to the brain injury and not severe sepsis. The updated guidance in this example clarifies that the elevated lactate level is due to the acute condition with a non-infectious source and not due to severe sepsis. Let's review another scenario to clarify documentation that reflects a sign of organ dysfunction is due to an acute condition with a non-infectious source.

This question asks: Would you use the initiation of mechanical ventilation is a sign of organ dysfunction based only on the documentation below? MD note: Intubated in ED for airway protection following overdose. Now ventilated in ICU.

The answer is No. You would not use the initiation of mechanical ventilation as a sign of organ dysfunction because the mechanical ventilation is attributed to the acute condition airway protection with a non-infectious source overdose. I would also like to point out here, that although the documentation in this example includes intubated, intubation is not the sign of organ dysfunction; therefore, any documentation referring to intubating the patient alone can be disregarded. Rather, for establishing the presence of organ dysfunction based on acute respiratory failure, we are looking for the time invasive or non-invasive mechanical ventilation was started.

The example on the slide was also updated with clarifying information for the abstraction of thirst criteria or a sign of organ dysfunction documented as due to an acute condition. The example now states: Progress note: Lactate 4.3 related to seizure. There is an acute condition seizure, but the source isn't known. This seizure could be due to sepsis and the lactate value should be used to indicate severe sepsis is present. Since the elevated lactate is attributed to the seizure and no further documentation is available to determine if the seizure was caused by sepsis or a non-infectious source, the elevated lactate should be used in this case. Let's take a look at another scenario that also reflects the criterion is due to an acute condition.

This question asks: Would you use the elevated heart rate as a search criterion based only on the documentation below? The MD notes: Tachycardia related to shortness of breath. The answer is No because the elevated heart rate is attributed to the acute condition, shortness of breath, without further documentation of a non-infectious source.

The *Severe Sepsis Presentation Date and Time* data elements were also updated in manual version 5.11a. The updated guidance pertains to establishing the severe sepsis presentation date and time based on documentation that severe sepsis or septic shock was documented as present on admission. The updated guidance states: If physician/APN/PA documentation states severe sepsis or septic shock was present on admission or indicates the patient was admitted with severe sepsis or

septic shock, use the earliest date of the following for the physician/ APN/PA documentation of severe sepsis or septic shock: the physician/ APN/PA note, the admit order, disposition to inpatient, arrival to floor or unit. While documentation of septic shock has previously been acceptable for establishing the severe sepsis presentation date and time, the updated guidance provides instruction for which date and time to use when severe sepsis is met by documentation of septic shock as present on admission or indicating second shock was present on admission. Let's review a scenario regarding this guidance.

This question asks: Which time would you use as a *Severe Sepsis Presentation Time* based only on the documentation below? At 0600, you have an admit order. At 0700, all three severe sepsis clinical criteria are met. At 0930, the MD noted that patient admitted with septic shock. The answer is that you would use 0600 as a *Severe Sepsis Presentation Time* because the documentation indicates the patient was admitted with septic shock, and the admit order reflects the earliest presentation time available. If you recall from the previous slide, when the documentation indicates septic shock present on admission, you would use the earliest time of either the physician/APN/PA note, admit order, disposition to inpatient arrival to the floor or unit. In this scenario on this slide, the MD note at 0930 indicates the patient was admitted with septic shock and the admit order at 0600 is the earliest time from the options listed in the guidance.

The *Repeat Lactate Level Collection* data element received updates to align with CMS plain language standards. These updates did not change the intention of the guidance or implement new guidance. Rather, they only clarified the language. To review, the first bullet point on the slide states: Select Value 2 if a repeat lactate level was not drawn within the specified time frame. The next one states: Use supportive documentation that indicates the repeat lactate was wrong if there is no documentation indicating the repeat lactate was drawn or collected. Use the earliest supportive documentation if there are multiple instances of supportive documentation. The final bullet point states: Select Value 1 if a repeat lactate level is ordered and there's an attempt to collect it but the attempt

results in failure to collect the specimen (too dehydrated to get a vein) or the specimen was contaminated during or after the draw. Regarding the second and third bullet points on the slide, we often receive questions asking if the note open time can be used for supportive documentation or documentation of a failed attempt. The guidance in the data element does not refer to using the note open time in these circumstances. So, the note open time would not be abstracted. You would use the time specifically associated with the documentation in these cases.

The definition and the *Initial Hypotension Date and Time* data element has also been updated in version 5.11a. The definition in version 5.10 included a target ordered volume of 30 millimeters per kilogram for up to 10 percent less than 30 milliliters per kilogram. The definitions were updated in version 5.11 to remove the reference to 30 milliliters per kilogram for up to 10 percent less than 30 milliliters per kilogram due to the updates in the *Crystalloid Fluid Administration* data element in which a volume less than 30 milliliters per kilogram can be acceptable. The time for the *Initial Hypotension Date and Time* data elements has not changed. For the next part of the presentation, I will turn it over to Noel.

Noel Albritton: Thanks, Jennifer. There's quite a few new updates we will discuss for the *Crystalloid Fluid Administration* data element. This slide includes updates to two bullet points and the first states: Crystalloid fluid volumes ordered that are equivalent to 30 milliliters per kilogram or a lesser volume with a reason for the lesser volume specifically documented by the physician APN/PA are the target ordered volume. The updates to this bullet point were made based on other updates in the *Crystalloid Fluid Administration* data element that allow for volumes less than 30 milliliters per kilogram to suffice as the target ordered volume with acceptable physician/APN/PA documentation. The second bullet point on this slide states a physician/ APN/PA order for a volume of crystalloid fluids that is within 10 percent less than 30 milliliters per kilogram is acceptable for the target ordered volume. Documentation of a reason for a volume that is within 10 percent less than 30 milliliters per kilogram is not required. The updates to this bullet point are to clarify that it is not required to have physician/APN/PA

documentation of a reason for ordering a volume within 10 percent less than 30 milliliters per kilogram. Let's review an example of acceptable documentation for using the volume within 10 percent less than 30 milliliters per kilogram.

This question asks: The patient weighs 90 kilograms. Ninety kilograms multiplied by 30 milliliters per kilogram equals 2700 milliliters. The physician only ordered 2500 milliliters of normal saline over two hours. What is the target ordered volume of crystalloid fluids for this patient? Use 2500 milliliters as the target ordered volume. The physician only ordered 2500 milliliters of crystalloid fluid. Since 2500 milliliters is within 10 percent less than 30 milliliters per kilogram, the target ordered volume would be 2500 milliliters. We receive a number of questions related to determining the target ordered volume based on a volume within 10 percent less than 30 milliliters per kilogram. To clarify, this guidance only applies when the volume of fluids ordered is only within 10 percent less than 30 milliliters per kilogram.

We'll discuss the next updates for the *Crystalloid Fluid Administration* data element on the following five slides. This new guidance begins with a physician/APN/PA order for less than 30 milliliters per kilogram of crystalloid fluids is acceptable for the target ordered volume if all of the following criteria are met: There is a physician/APN/PA order for the lesser volume of crystalloid fluids as either a specific volume such as 1500 milliliters or a weight-based volume such as 25 milliliters per kilogram. This update was made due to questions received via the online Q&A tool. This updated guidance is to clarify that the volume ordered can be a specific volume such as 1 500 milliliters or it can be a weight-based volume such as 25 milliliters per kilogram.

The new guidance continues with the ordering physician/APN/PA documented within a single note in the medical record all of the following: The volume of fluids administered as either a specific volume or a weight-based volume. So, the physician/APN/PA documentation must include the required documentation within a single note.

This is referring to the physician documentation occurring within the same note or documentation. It's not referring to the required physician documentation only occurring within a document labeled as a note.

The guidance continues with the requirements: and a reason for ordering a volume less than 30 milliliters per kilogram of crystalloid fluids. Reasons include but are not limited to a concern for fluid overload, heart failure, renal failure, blood pressure responded to a lesser volume, and 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. The guidance in version 5.11a has been updated to allow for further reasons for administering less than 30 milliliters per kilogram. You will recall the previous guidance in manual version 5.10 only included advanced or end stage renal failure or heart failure. The updated guidance continues to allow for advanced or end stage renal disease or heart failure to suffice as a reason for administering less than 30 milliliters per kilogram, but the guidance no longer requires further documentation of a stage or NYHA class. We'll review several examples of these scenarios in a few minutes.

This portion of the updated guidance of the *Crystalloid Fluid Administration* data element concludes with the guidance: All other applicable requirements for the *Crystalloid Fluid Administration* data element are met. The guidance includes the example on this slide that has been updated slightly in manual version 5.11a. The example states: Physician documentation of lactate 5.0, heart failure concerns, 20 milliliters per kilogram normal saline start now, then re-evaluate. 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 with a start time of 1500 and completion time of 1700. Select Value 1 based on the physician documentation meeting the requirements and identifying 20 milliliters per kilogram as a target ordered volume of crystalloid fluids for this patient. We often receive questions about whether some of the documentation in the example is required.

For example, in the example on this slide, it includes the lactate value; however; if you refer to the guidance, the physician/APN/PA documentation is not required to include the lactate value. The examples will simply include documentation to create a somewhat realistic example scenario that abstractors may see in the medical records. When abstracting, you can disregard documentation that does not suffice the guidance in the specifications manual. The updated guidance also includes a new example that we will discuss next.

This new example states: Physician documentation: septic shock, renal failure, 1500 milliliters normal saline, evaluate for response. There's an order for 1500 milliliters of normal saline IV at 1000 milliliters per hour. On the MAR: IV normal saline, 1500 milliliters at 1000 milliliters per hour, was started at 0800. The patient's weight is 74 kilograms. The 30 milliliters per kilogram volume is 2220 milliliters. Select Value 1 based on the physician documentation meeting the requirements for a lesser volume and identifying 1500 milliliters as the target ordered volume of crystalloid fluids for this patient. This example includes renal failure and a specific volume of fluids for the patient to receive, which, along with meeting the other requirements of the data element, allows Value 1 (Yes) to be selected for *Crystalloid Fluid Administration*. Again, this example includes other documentation by the physician, such as septic shock and evaluate for a response; however, these can be disregarded because they are not part of the required documentation for meeting the *Crystalloid Fluid Administration* guidance. Let's review a few Q&As regarding this guidance.

This question asks: Which value would you select for *Crystalloid Fluid Administration* based on the physician documentation below? Physician documentation: Patient has hypotension but concern for fluid overload, will give 15 milliliters per kilogram of normal saline. Orders: Normal saline 0.9 percent IV, 15 milliliters per kilogram over two hours. On the MAR: normal saline 0.9 percent IV 1200 milliliters, which is 15 milliliters per kilogram for this patient, with a start time of 1500 and completion time of 1700. Select Value 1 in this case because the physician documentation includes a reason for the volume less than 30 milliliters per kilogram.

It includes the specific volume and the order, as well as further documentation of fluid administration on the MAR. Let's review another example.

We often see questions related to this type of scenario where the documentation reflects no crystalloid fluids were administered. This question asks: Which value would you select for *Crystalloid Fluid Administration* based on the physician documentation below? Physician documentation: Patient has heart failure, will give 0 milliliters of fluids at this time. Select Value 2 (No) in this case because the guidance states a physician/APN/PA order for a lesser volume of crystalloid fluids is acceptable. The documentation on this slide including 0 milliliters would not suffice as an order for a lesser volume. The guidance to use a volume less than 30 milliliters per kilogram is not intended to accept zero fluid administration for septic shock patients. Rather, the guidance allows for the abstractor to use a lesser volume in the particular cases based on the documented reason. To select Value 1 for the *Crystalloid Fluid Administration* data element, the other guidance must also be met including an order and documentation of fluid administration. So, as far as abstraction, not having an order and not administering any fluids within the time frame for acceptable fluids would not be acceptable for selecting Value 1. Let's review one more scenario related to this updated guidance.

This question asks: Which value would you select for *Crystalloid Fluid Administration* based on the physician documentation below? Physician documentation: Ordering 1000 milliliters of Albumin with 500 milliliters. That's a colloid and 500 milliliters of normal saline. Orders: Albumin 5 percent 500 milliliters IV over 30 minutes. Normal saline 0.9 percent IV 500 milliliters at 1000 milliliters per hour. On the MAR: Albumin 500 milliliters was started at 0800 and ended at 0830. Normal saline 500 milliliters was started at 0830 and ended at 0900. Select Value 1 in this case based on the physician documentation meeting the requirements and identifying 1000 milliliters as a target ordered volume colloid and crystalloid for this patient. The guidance for administration of a lesser volume based on a portion of the target ordered volume being a colloid

does not require a documented reason for the lesser volume; therefore, documentation such as in this example is acceptable because the specific target volume is documented and there are orders and documentation of fluid administration to determine when the target ordered volume was completely infused. I also wanted to note while we are discussing colloids that the guidance does not provide a list of acceptable colloid fluids, just like it does not provide a complete list of acceptable crystalloids or balanced crystalloid solutions. Abstractors may reference medical resources to determine the type of a particular fluid. Also, we sometimes receive questions about the volume of an infusion when the fluid is ordered as a unit. Since the data element and other parts of the measure are dependent upon establishing the target ordered volume and determining when that volume was completely infused, the fluids ordered as a unit alone would not suffice. If the medical record included the milliliters for the unit, the abstractor could apply that volume toward the target ordered volume. Otherwise, if the fluid is only documented as a unit, that infusion would not be used toward the target ordered volume. Next, we would like your participation in answering the following question.

What is the target ordered volume of crystalloid fluids for this patient who weighs 80 kilograms? Eighty kilograms multiplied by 30 milliliters per kilogram equals 2 400 milliliters. The physician ordered 1500 milliliters and documented: Patient's hypotension responded to 1500 milliliters of LR. A. 2400 milliliters B. 1500 milliliters C. 2160 milliliters D. 2300 milliliters. We'll give you a few more seconds to select your answer. Select B. 1500 milliliters because the physician documentation includes a reason for the target ordered volume of 1500 milliliters.

Further updates to the *Crystalloid Fluid Administration* data element were made to the guidance for establishing the target ordered volume. The updated guidance addresses how to calculate the target ordered volume when ordered as a weight-based unit. This guidance was updated due to the other updates within the data element that allow for a volume less than 30 milliliters per kilogram to be acceptable.

So, if the physician/APN/PA documented a reason for administering a volume, such as 20 milliliters per kilogram, this guidance applies to how to determine the target ordered volume based on 20 milliliters per kilogram.

This example under the guidance for rounding the fluid volume was also updated. The example states: Patient weight is 160 pounds, and 160 divided by 2.2 equals 72.72 kilograms. Round to 73 kilograms and 73 kilograms multiplied by 30 milliliters per kilogram equals 2190 milliliters. The physician order is to give 1000 milliliters Lactated Ringers over four hours. This is not acceptable because 1000 milliliters is less than 2190 milliliters, and a reason for ordering less than 30 milliliters per kilogram was not documented. In this example, the target ordered volume would be 2190 milliliters based on 30 milliliters per kilogram. Even though the physician and documentation include 1000 milliliters, for the guidance we discussed earlier, there would need to be a reason documented to use the volume that is less than 30 milliliters per kilogram.

Also, for the *Crystalloid Fluid Administration* data element, new guidance was added for abstracting fluids when multiple orders are used. The new guidance states: If crystalloid fluids are initiated via multiple physician/APN/PA orders, begin with extracting the earliest crystalloid fluids ordered that are initiated within the specified time frame. Evaluate all crystalloid fluids ordered and include the fluids if they contribute to the target ordered volume and are initiated within the specified time frame. This guidance was added to the data element based on questions from hospitals and abstractors. The guidance clarifies that the earliest acceptable fluids ordered within the time frame should be used toward the target ordered volume. This applies even if there is a later order for the 30 milliliters per kilogram volume. Let’s review a scenario.

This question asks: Would you use the fluids ordered in both orders below for the target ordered volume if the below orders and infusion start times were within the specified time frame? Orders: At 1300, normal saline IV 1000 milliliter bolus, at 1500 normal saline IV, 30 milliliters per kilogram, based on a weight of 90 kilograms at 999 milliliters per hour.

On the MAR: Normal saline 1000 milliliters bolus was started at 1315 and ended at 1415, normal saline 2700 milliliters (which is the 30 milliliters per kilogram volume) was started at 1510 and ended at 1745. Yes, use the fluids ordered in both orders toward the target ordered volume because both were ordered and initiated within the specified time frame. Although there is a second order specific to the 30 milliliters per kilogram volume, you would also include the fluids ordered at 1300 because this order and infusion start time were also within the specified time frame. In the scenario with the target ordered volume being 2700 milliliters, you would use 1000 milliliters from the first order and 1700 milliliters from the second order to determine when the target ordered volume was completely infused.

Lastly, for the *Crystalloid Fluid Administration* data element, I want to point out a slight update to the guidance pertaining to fluids administered in the operating room. Volume was added to the guidance to clarify that physician/APN/PA documentation of fluids administered in the OR are acceptable without an order if there's documentation of the fluid type, the volume, an infusion start time, and an infusion rate or end time. This update was made based on questions received via the online Q&A tool. Therefore, the volume was added to clarify the documentation requirements for extracting fluids received in the OR.

A slight revision was made to the *Persistent Hypotension* data element to clarify the example under the guidance to select Value 1 if only one blood pressure was documented within the time frame that was low and a vasopressor was administered. The example now states: A one-hour time frame is 1300 to 1400. Blood pressure, only one documented, at 1325 was 87 over 53. On the MAR: Levophed was started at 1500. Select Value 1. This example clarifies the scenario when Value 1 should be selected for *Persistent Hypotension* when there is only one blood pressure documented in the hour and that blood pressure is hypotensive and the vasopressor was administered. In the scenario, Value 1 is selected because there is a hypotensive blood pressure reading and the administration of the vasopressor indicates hypotension persists. Also, we've received quite a few questions from abstractors regarding a time frame for the vasopressor

administration to meet this guidance. The *Persistent Hypotension* data element does not provide a specified time frame for the vasopressor administration. The concept here is that severe sepsis with hypotension or septic shock is present. The patient has a hypotensive reading after fluid resuscitation and a vasopressor was started. In this scenario, the case would proceed to the *Vasopressor Administration* data element where the vasopressor would need to be started within the specified time frame provided that data element to pass the measure. Some cases based on questions we've received include vasopressor administration outside of the time frame in relation to septic shock; however, regardless of when the vasopressor was started in relation to persistent hypotension, Value 1 (Yes) would still be selected per the guidance on this slide. Then, the case will proceed to the *Vasopressor Administration* data element where a vasopressor must be administered within the specified time frame in relation to septic shock presentation. Next, we would like your participation in the following question.

Which level value would you select for *Persistent Hypotension* if the hour to assess for persistent hypotension is from 1400 to 1500? There's a single MAP reading of 60 at 1415, and a vasopressor was started at 1500. A. Value 1 (Yes) Persistent hypotension present. B. Value 2 (No or UTD) Persistent hypotension not present. C. Value 3 (No) Persistent hypotension not assessed. We'll give you a few more seconds to select your answer.

Select A. Value 1 (Yes) Persistent hypotension present. There's a single hypotensive blood pressure in the hour to assess for *Persistent Hypotension* and a vasopressor was administered.

Further plain language updates for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element include these two bullet points. Again, these updates do not change the intention of the guidance. The first bullet point on this slide specifies the time frame for this data element and states: The specified time frame for the repeat volume status and tissue perfusion assessment begins at the *Crystalloid Fluid Administration Date* and *Crystalloid Fluid Administration Time* and in six hours after the *Septic Shock Presentation Date and Septic Shock*

Presentation Time. The time frame remains the same as in previous versions of the manual, but it is clearly stated in this update. The second bullet point on this slide was updated to clarify the selection of Value 2 when there is no repeat volume status and tissue perfusion assessment performed within the specified time frame. Let's review a scenario pertaining to this guidance.

This question asks: Which allowable value would you select based on the below documentation? Crystalloid fluid administration time is 0300. Septic shock presentation time is 0300. An APN note at 0930: Reassess patient at 0430 after fluid resuscitation. Select Value 1 due to the APN note attesting to performing the reassessment within the specified time frame. In this scenario, we can see that the APN documentation occurred at 0930 which is more than six hours after the septic shock presentation time; however, the APN documentation at 0930 reflects the reassessment was performed within the specified time frame at 0430. Therefore, it is acceptable to select Value 1 (Yes) for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element in the scenario.

Other plain language changes for the *Vasopressor Administration* data element were made in the notes for abstraction section. I'd like to specifically point out the specified time frame is included in the first bullet point. Specify time frame for the *Vasopressor Administration* data element has not changed, rather it is now included in this single bullet point rather than included in multiple sections throughout the data element. So, the specified time frame for the administration of a vasopressor starts at the *Septic Shock Presentation Time* and then six hours after the *Septic Shock Presentation Time.* Other plain language updates were also made within the notes for abstraction as reflected in the second bullet point on this slide. We will not review every plain language revision to the notes for abstraction. So, we would encourage you to review the complete data element. Lastly let's review one final question related to the *Vasopressor Administration* data element that we frequently receive via the online Q&A tool.

This question asks: Which allowable value would you select based on the below documentation? MAR: Levophed infusion started at 800 and ended at 1300. Septic shock presentation time is 0915. Select Value 1 because the vasopressor was infusing at the time of septic shock presentation. In this scenario, you would select Value 1 for the *Vasopressor Administration* data element. In further guidance in the data element, you would use the start time of the vasopressor at 0800 as the *Vasopressor Administration* time.

That concludes our review of specifications manual version 5.11a updates. Thank you for participating in our review of the updates. Next, let's review how to submit questions via the inpatient Q&A tool.

First, if we do not get to your question during the webinar please submit your question to the QualityNet Inpatient Q&A Tool via the link on this slide. If your question is about a specific slide, please include that slide number when you submit 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 the 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&A 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 based on the discharge period you're abstracting. We're continually reviewing and updating the existing Q&As, so it's also important to review the existing Q&As often to ensure the responses continue to apply to your questions. Also, from the QualityNet Inpatient Q&A Tool, 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 which 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 Measure and 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 Measure and Data Element Abstraction.

After selecting the Inpatient Measures and 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 listed are by the data element 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 the answers to your questions may vary slightly depending on the manual version. Next, you'll add the subject for your question in the subject field. Then, enter your question into the Please Describe your Question Field. It's important that no PII or PHI is included in your submitted questions. Also, we are unable to receive screenshots or attachments. Submitted abstraction questions should be concise and only include the 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 and submit a question to the support team. Candace, I will turn it back over to you.

Candace Jackson: Thank you, Noel. Thank you, Jennifer, for presenting for us today. As Noel did say, we will have a Q&A session now as long as time allows. The questions are in no particular order or priority or anything. So, we'll go ahead and get started with our Q&As.

Since we still have the COVID-19 Public Health Emergency, we'll start out with a couple questions related to COVID-19. So, the first question is: Does a COVID-19 test and/or the results to the test give ground to select Value 2 for the *Severe Sepsis Present* data element, or does the physician need to document the suspicion of COVID-19?

Noel Albritton: Hi, Candace. This is Noel. I can answer that one. So, a COVID-19 test or test result itself would not suffice selecting Value 2; however, if there is physician documentation that the COVID test result was positive, then that would work for selecting Value 2 because that's physician documentation that COVID-19 is present. If you had a COVID-19 test that returned positive from the lab, that alone would not suffice for the physician documentation requirement.

Candace Jackson: Great. Thank you, Noel. Along with that, if COVID was suspected later in the stay and not within severe sepsis or septic shock, do we exclude the whole case or does it have to be within time 0?

Noel Albritton: This is Noel again. The guidance related to selecting Value 2 if there's documentation that COVID-19 is present or suspected does not contain a time frame for that documentation. So, physician documentation that COVID-19 is present or suspected truly anywhere within the medical record you're abstracting would work to select Value 2 (No) for *Severe Sepsis Present* and exclude the case.

Candace Jackson: Thank you. Just a general question before we get into specifics. Can you reiterate what month or discharge time period that these changes begin?

Noel Albritton: Sure. Yes, this is Noel. So, this is manual version 5.11a, and it begins, or it began January 1, 2022, through June 30, 2022. So, we've just started in January or with discharges from January 1, 2022.

Candace Jackson: All right. Thank you, Noel. In regard to the data element *Transfer from Another Hospital or ASC*, if your standalone ED shares the same CMS Certification Number, would this still be considered a transfer?

Noel Albritton: This Noel again. Yes. So, the guidance for the *Transfer from Another Hospital or ASC* data element allows for Yes to be selected for that data element regardless if the hospital or that satellite emergency department is a part of your hospital system. If it's a satellite or off-site ED and the patient is received to your hospital as a transfer, you would continue to select Yes for the data element.

Candace Jackson: Thank you, Noel. We have a couple of questions in regard to patient refusals. Can the lab document patient refusal?

Noel Albritton: This Noel, again. So, the data element requires physician/APN/PA or nursing documentation of a refusal. So, generally, a phlebotomist from the lab would not suffice that documentation, would not suffice selecting Yes for the *Administrative Contraindication to Care* data element. It would have to be physician/APN/PA or nursing documentation.

Candace Jackson: Great. Thank you. That then addresses our next questions about refusal that asked: Can it be nursing documentation? So, you did clarify that. Yes, it can. I'm going on here. Does the organ dysfunction used to meet criteria need to be a new occurrence during the six-hour time frame? So, for example, if a patient is intubated and started on mechanical ventilation but does not meet surge criteria until seven hours after this, can we not use the respiratory organ dysfunction for severe sepsis criteria?

Noel Albritton: Good question. This is Noel again. So, for the measure for the *Severe Sepsis Present* data element, we're only using that initiated time or start time of the mechanical ventilation to establish organ dysfunction by that criterion. So, if the start time of mechanical ventilation is not within six hours of the criteria and documentation of an infection, then you would not use the start time of mechanical ventilation to establish your organ dysfunction.

Candace Jackson: Great. Thank you, Noel. Along those same lines, do we need class or stages for heart rate and end stage renal disease?

Noel Albritton: This is Noel. Again, I am thinking that question is related to crystalloid fluid administration and the previous requirements for documentation of advanced or end stage heart failure or renal disease. With that assumption, if I'm wrong, please submit the question through the online Q&A tool. Assuming you're talking about crystalloid fluid administration, the guidance in version 5.11a no longer requires documentation of advance or end stage heart failure or renal disease with the NYHA class or stage.

However, that, for heart failure or renal disease, could be a documented reason for the physician ordering a volume less than 30 milliliters per kilogram, but those aren't the only reasons in the version.

Candace Jackson: I have another question here on vitals. There's criteria and low blood pressure used as OD. I apologize because I don't know what OD stands for. When patient is in PACU and POHA also, do not use or do we use those? We do not use SIRS vitals and low BP as OD if a patient is in OR, but do we exclude when in POHA and PACU?

Noel Albritton: Yes. This is Noel again. For your SIRS criteria and organ dysfunction, the guidance specifically only refers to not using those criteria obtained in the OR. So, SIRS criteria and evidence of organ dysfunction that's obtained in the PACU or after leaving the OR would continue to be used unless there's further physician documentation, you know, attributing those values or abnormal values to a medication or chronic-condition type thing. So, just vital signs or criteria obtained in the PACU, you would continue to use those values for establishing sepsis.

Candace Jackson: Thanks, Noel. Since we are talking about the OR, can you use OR end time as IV fluid end time, as in the OR they don't document a stop time for the last IV bag running prior to OR end time.

Noel Albritton: This is Noel again. For crystalloid fluid administration and the exception for fluids administered in the OR, there would need to be a documented end time or rate of those fluids to use them toward the target ordered volume. The OR end time alone would not be used just based on, you know, it being documented as OR end time. For the fluid, there would need to be specific documentation of the rate they were given or the end time to use those toward the target ordered volume.

Candace Jackson: Thank you, Noel. Since we kind of were talking about organ dysfunction, for organ dysfunction, acute respiratory failure as evidenced by a new need for invasive or non-invasive mechanical ventilation, is high flow nasal cannula considered mechanical ventilation?

Noel Albritton: This Noel again. No, hyponasal cannula would not be used to establish organ dysfunction as mechanical ventilation. It would need to be intubated and started on invasive mechanical ventilation or non-invasive mechanical ventilation like CPAPs or BIPAPs.

Candace Jackson: Thanks, Noel. Changing a little. If severe sepsis on admission is documented on day 27 of a 30-day stay, would you still use this documentation?

Noel Albritton: Hey. This is Noel again. Yes, I believe I'm understanding that correctly. So, if the patient stayed in the hospital 30 days and severe sepsis was identified on day 27, yes, you would continue to abstract the severe sepsis presentation time on day 27. You would use the earliest severe sepsis presentation time possible. So, if that occurred on day 27, then that's the severe sepsis presentation date and time that you would abstract.

Candace Jackson: Thank you, Noel. Of course, there's been a lot of questions submitted on crystalloid fluid administration, so we'll go ahead and ask some of those questions. If a patient has a normal blood pressure in the hour after fluid administration, but they were also started on a vasopressor during this time, do we answer Yes to *Persistent Hypotension* or no?

Noel Albritton: This is Noel. I can answer that one also. So, if the patient had a normal blood pressure reading in the hour after the target ordered volume completed, assuming that the only blood pressure documented was the one normal blood pressure, then you would select Value 2 for *Persistent Hypotension* because persistent hypertension is not present and it's not Unable to be Determined. So, they don't have persistent hypotension in that case. The vasopressor involved there for the *Persistent Hypotension* data element would not be relevant because there's a normal blood pressure documented, and persistent hypotension is not unable to be determined. So, with the normal blood pressure documented, you would select Value 2 (No) for *Persistent Hypotension.*

Candace Jackson: Our next question: Advanced or end stage heart failure or renal failure, and that 30 milliliters per kilogram would be detrimental to the patient to eliminate them, is that documentation required?

Is just documentation of concern for fluid overload enough to order less than 30 milliliters per kilogram fluid? Let me know if you need that repeated, Noel.

Noel Albritton: Thanks. I think I got it. It kind of it goes back to what I had answered earlier on a question. The documentation for advanced or end stage heart failure or renal disease is not required for version 5.11a, although it is still acceptable as a reason if the physician needed to use that for administering less than 30 milliliters per kilogram. The new guidance in version 5.11a has some example reasons included in the guidance such as that concern for fluid overload, but it's no longer only heart failure or renal disease as being acceptable.

Candace Jackson: So, on that same line with the new fluid guidance is there a time limit for the provider to document the reason for a volume less than 30 milliliters per kilograms IV fluids? Does the ordering provider have to be the one to document the reason?

Noel Albritton: Yeah. This is Noel again. So, the guidance does not provide a time frame for the physician to document these requirements. So, they could be documented at any point in the medical record you're abstracting. Then, as far as the documentation from the ordering position, yes. So, the ordering physician to meet the requirements must document in a single note the reason for ordering less than 30 milliliters per kilogram and the volume that they're ordering.

Candace Jackson: What's the change to fluids? Would the elements of bundle compliance be met then if a prescribing practitioner documents rationale for a lower volume than 30 milliliters per kilogram? I think you addressed that. Just to confirm, would that be correct?

Noel Albritton: Yes. If I'm understanding that correctly, and if the required documentation is present and the required documentation includes a reason for ordering the lesser volume, and the volume that the physician is ordering, if that's present then that would suffice for physician documentation requirements.

Then, there would also need to be complete order documentation the fluids were administered, otherwise you would select Value 1 (Yes) for the *Crystalloid Fluid Administration* data element.

Candace Jackson: So, on that same line, Noel, can fluids be omitted completely if there is a documented concern or reason why they should not be given, or is there a specific lowest amount of volume that is allowed?

Noel Albritton: Yeah, that's a good question. That's asked fairly often. The guidance does not provide a minimum volume to suffice the *Crystalloid Fluid Administration* data element; however, there would still need to be a volume documented and a volume ordered and that volume would need to be administered at greater than 125 milliliters per hour to meet the remaining requirements of the *Crystalloid Fluid Administration* data element. So, even if there is a reason documented and the physician wrote ordering 0 milliliters, that still wouldn't be acceptable for the guidance because there has to be an actual volume documented that would be ordered and be documented and administered with that rate greater than 125 milliliters per hour. So, Candace, did I hit all the points of that question?

Candace Jackson: I believe you did. Thank you, Noel. We have some slide-specific questions. So, let's go to them, and let's go to slide 19, please. For the *Severe Sepsis Presentation Date and Time*, which time do we use? Do we use arrival to unit and not the earliest arrival to ED, if sepsis was present on admission?

Noel Albritton: Can you back up the slide 18 here. I just wanted to show where the guidance is. For the documentation that severe sepsis was present on admission, we would use the earliest of the available options that are in the guidance. That's what's on the slide 18. If the arrival time to the floor unit was the earliest of these times then that would be used as the *Severe Sepsis Presentation Date and Time*; however, if it was the admit order or physician note time, that would be used if it was the earliest. Basically, the earliest of these times should be used.

Candace Jackson: Great. I think our slide numbers may be off slightly from what maybe the presenter or submitters are asking, so I'll kind of leave the slide numbers off at this point. Next question: To confirm, the time frame for repeat lactate is between collection of first lactate, not the result time and collection of the second light lactate. Is that correct?

Noel Albritton: This is Noel again. For the repeat lactate level collection, the specified time frame is from the initial lactate level collection time through six hours after the severe sepsis presentation date and time, repeat lactate level selection time through six hours after severe sepsis presentation time.

Candace Jackson: Does target fluid volume still allow for using ideal body weight if the BMI is greater than 30?

Noel Albritton: This is Noel again. The guidance is still in the *Crystalloid Fluid Administration* data element that allows for the ideal body weight to be used to determine the target ordered volume when there's physician documentation that the patient has obesity, or their BMI is greater than 30. Yes, that is still in the guidance and available.

Candace Jackson: To clarify for the volume to be administered, if it's taking the place of the 30 milliliters per kilogram, must an actual volume document be documented order or would 0 milliliters be acceptable documentation?

Noel Albritton: This is Noel. We kind of hit on the ordering 0 milliliters or documenting 0 milliliters earlier. So, no, that part's unacceptable. As far as the physician documentation requirement for document of a volume less than 30 milliliters per kilogram, that's updated in the guidance for version 5.11a. The volume has to be documented in there for the lesser volume and that can be documented as milliliters or it can be documented as a weight-based volume such as milliliters per kilogram. Either would be acceptable for the physician documentation.

Candace Jackson: Since we're on the line of talking about the physician documentation for less than the required amount of fluids, is there a time frame as to when the provider must document the reason for not providing the 30 milliliters per kilogram?

Noel Albritton: This Noel again. No, there's no time frame and we kind of hit on that earlier. The guidance does not provide a time frame for the required physician documentation.

Candace Jackson: I'm going to a little bit different question about crystalloid fluids. To meet the crystalloid fluids requirements, to select Value 1 will giving colloids only meet the requirement, or do you have to also administer crystalloids with the colloids?

Noel Albritton: This Noel again. The *Crystalloid Fluid Administration* data element guidance refers to a portion of the crystalloid fluid volume being administered as colloid. So, colloids administered by themselves or alone wouldn't meet the guidance in the *Crystalloid Fluid Administration* data element. Only a portion of the target ordered volume would be colloids. The other the other portion of that would need to be crystalloid.

Candace Jackson: Along that same line with colloid administration, will colloid administration require rates of above 125 milliliters per hour to be able to use it toward the fluid calculation?

Noel Albritton: Yes. All fluid use toward your target ordered volume has to be administered at greater than 125 milliliters per hour.

Candace Jackson: Since we're talking about time limits for fluid administration, is the crystalloid fluid administration time the time in which the target fluid volume was initiated or the time in which the entire volume completed infusion?

Noel Albritton: This is Noel again. The crystalloid fluid administration time will not be when the fluids completed; however, it can vary just slightly depending on if there's a single order for fluids or multiple orders, assuming that there's a single order for your target ordered volume of fluids. Then, you would use the start time of the first infusion when there's that single order. Now, if there's multiple fluid orders that are being used to meet the target ordered volume, then the guidance says use the start time of the infusion that completed the target ordered volume. If there was three bags of normal saline to meet the target ordered volume, you would use the start time of the third bag in that case.

It's in the *Crystalloid Fluid Administration* data element if you need further clarification on that. It's hard to explain on the phone.

Candace Jackson: Thank you, Noel. Just a couple of questions regarding the reassessment. If a physician completes a physical exam in the time frame for repeat volume status and tissue perfusion assessment, does that suffice for assessment performed?

Noel Albritton: Candace, will you repeat the first part of that question?

Candace Jackson: If a physician completes a physical exam, and that is in parentheses, in the time frame for repeat volume status and tissue perfusion assessment, does that suffice for assessment performed?

Noel Albritton: This is Noel again. First, if the physician documented that they completed a physical exam, then that would suffice the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element because that would be physician documentation attesting to performing an exam. Also, if there is documentation of physical exam and then a list of findings underneath that, then that would not be used as physician documentation attesting to performing an exam. However, that list of findings may be used to meet the parameters that are included in the data element. So, for this data element in particular, there are three different ways that it can be met or selected Value 1. So, if there's a list of findings, it should include five of the eight parameters that are included in the data element. That would also allow you to select Value 1 if those five are met.

Candace Jackson: Then, on that same line, does the reassessment note have to specify that it is a sepsis reassessment, or is just the word "reassessment" acceptable?

Noel Albritton: The physician documentation doesn't or isn't required to include "sepsis reassessment." There are some examples in the guidance that refer to review of systems completed, or a reassessment performed, that do not reference sepsis in there. So, it does not have to include "sepsis" for it to be acceptable.

Candace Jackson: I'm assuming this next question is related to either initial hypotension or persistent hypotension for the blood pressure ratings. Can an arterial line rating be used?

Noel Albritton: Yes. The guidance doesn't specify or restrict which type of blood pressure is being used. So, as long as it's documented as a systolic blood pressure or a MAP, then it would be able to be used to meet criteria, whether that's an invasive or non-invasive reading.

Candace Jackson: This one is related to persistent hypotension. How do we determine persistent hypotension when multiple bolus orders are in the MAR?

Noel Albritton: There are some examples in the *Persistent Hypotension* data element that may be helpful. You would use either the rate duration or end times documented for those orders along with the start times to determine when the target volume completed. So, if it took two of those multiple orders to complete the target volume, then you would determine when that target volume was completed, and that completion time of when the target volume was completed would determine the start time of the hour to assess for persistent hypotension. Depending on how fluids are ordered and administered you may be required to do some calculation to determine exactly when that target ordered volume completed. There's some guidance in the manual to help with that. You can submit questions as needed regarding how to calculate that. That's probably as detailed as I can get without an example, I guess, in front of me.

Candace Jackson: Thanks, Noel. I have a question on antibiotics. I am not finding the antibiotic medication list for monotherapy and A and B choices as in the past. Are their new changes related to antibiotics that I am missing?

Noel Albritton: Good question. We're receiving several of these coming through the online Q&A tool. The *Broad Spectrum or Other Antibiotic Administration Selection* data element was previously removed from the measure. The tables that you're referring to, the monotherapy and the combination therapy antibiotic tables, were used in that data element that was removed. You no longer are required to determine what antibiotics the patient

received. At this point, we are only abstracting the *Broad Spectrum or Other Antibiotic Administration* data element. That looks at what time the antibiotic is received in the 24 hours before through three hours after severe sepsis presentation. The tables are no longer needed with the removal of that old data element.

Candace Jackson: We have time for maybe one or two more questions. So, the next question is about vasopressors. What if the patient is already on a vasopressor at septic shock time? What should be used as the start time of the vasopressor, septic shock time or the original start time of the vasopressor?

Noel Albritton: So, if the vasopressor is already infusing at the time of septic shock presentation, then you will abstract the start time for the vasopressor that was already infusing when septic shock was met.

Candace Jackson: Our last question: For initial hypotension, do you use the second blood pressure reading?

Noel Albritton: Yes. For the initial hypotension date and time, you'll use that second hypotensive blood pressure reading to establish the date and time.

Candace Jackson: Wonderful. Thank you, Noel. Again, I'd like to thank Noel and Jennifer for presenting today. If we could go to the next slide, please.

As noted earlier, this webinar has been approved for 1.5 CEUs. You can attain your continuing education credit by clicking on the link in this slide. Next slide.

Again, we thank you for joining us today. We hope that you have a good rest of your day. Thank you.