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) v5.12 Measure Updates Presentation Transcript

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Candace Jackson: Good afternoon. Welcome to the *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.12 Measure Updates* webinar. My name is Candace Jackson, and I am 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 a 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, the slides was sent out a few hours ago. Again, this 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 earlier, 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 your question as time allows after the event. If we don't get to your questions during the question-and-answer session, please submit your question to the QualityNet Inpatient Question and Answer Tool, and it will be addressed later in this presentation. Our speakers for today's event are Noel Albritton, Lead Solutions Specialist, and Jennifer Witt, 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 5.12 of the specifications manual, which is effective for July 1 through December 31, 2022, discharges, 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 5.12 of the specifications manual to ensure successful reporting of the SEP-1 measure.

This slide lists the acronyms and abbreviations used in the presentation.

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

Noel Albritton: Thanks, Candace. Hello, everyone. Thank you for joining us. For this presentation, we will be reviewing the updated guidance for the SEP-1 measure and specifications manual, version 5.12. Updated guidance to 5.12 is noted in yellow highlights throughout the manual. We also made changes throughout the manual in line with CMS plain language standards. Plain language updates in the specifications manual are in yellow highlights 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 the data elements.

The SEP-1 algorithm was updated in manual version 5.12 to include a new data element, *Pregnant 20 Weeks Through Day 3 Post-Delivery*. This new data element is included after the *Clinical Trial* data element and prior to reaching the *Severe Sepsis Present* data element in the SEP-1 algorithm. This data element is used to identify patients that are 20 weeks pregnant through three days post-delivery. Upon selecting Yes or No to this data element, the case will continue to the *Severe Sepsis Present* data element. If the patient was 20 weeks or more pregnant, or if the *Severe Sepsis Presentation Time* was within three days after delivery, you will use clinical criteria specific to this patient population, which we will review in a few minutes. Based on the published evidence for pregnant and post-partum patients, some of the clinical criteria for meeting sepsis is slightly different; therefore, the updates to manual version 5.12 incorporate the abnormal values that meet severe sepsis clinical criteria for this patient population.

For the new data element, *Pregnant 20 Weeks Through Day 3 Post-Delivery*, the definition states: Documentation the patient is at least 20 weeks pregnant or within three days after delivery at the *Severe Sepsis Presentation Time*. The suggested data collection question asks, "Is there documentation the patient is at least 20 weeks pregnant or within three days after delivery in the time severe sepsis is identified?" Also, for the new *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element, the allowable values state: Value 1 Yes: There is documentation the patient is at least 20 weeks pregnant or within three days after delivery at the time severe sepsis is identified. Value 2 No: There is no documentation that the patient is at least 20 weeks pregnant or within three days after delivery at the time severe sepsis is identified, the patient is not pregnant, or unable to determine.

Next, let's review the guidance provided for *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. The guidance states: Select Value 1 Yes if there is medical record documentation that the patient is at least 20 weeks pregnant or within three days after delivery at the *Severe Sepsis Presentation Time*. Day of delivery is day 0. The day after delivery counts as day 1, post-delivery, regardless of the time of delivery. Guidance also includes an example to demonstrate when Value 1 Yes would be selected. The example states: The delivery date is 7/1. The severe sepsis presentation date is 7/4. Select Value 1 because severe sepsis presentation occurred within three days after delivery. As you can see by the example, the delivery day on 7/1 is day 0. The day after delivery is day 1. In this example, day 1 would be July 2. Day 2 would be July 3, and day 3 would be July 4. Therefore, the severe sepsis presentation time is within three days post-delivery. So, you would select Value 1 Yes for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element.

The notes for abstraction in the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element also included guidance for when to select Value 2 No. It states: Select Value 2 No for any of the following: Allowable value M or Male was selected for the *Sex* data element; there is documentation the patient had a partial or complete hysterectomy; there is documentation

the patient is not pregnant; there is documentation the patient is less than 20 weeks pregnant; there is documentation indicating severe sepsis was identified more than three days after delivery; and there is no documentation confirming that the patient is at least 20 weeks pregnant or within three days after delivery at the time severe sepsis was identified. In these scenarios, you would select Value 2 No and continue abstracting the medical record. The case would not fail the measure, nor be excluded from the measure population based on selecting Value 2 No for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element.

Lastly, for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element updates, the guidance includes suggested data sources and inclusion guidelines for abstraction. The suggested data sources include any physician/APN or PA documentation; the entire ED record; OB/labor and delivery documentation; and nurse notes. It is important to note that the suggested data sources provided in the data element are not all inclusive. Rather, these are suggested sources to review during the abstraction to determine the appropriate allowable value to select for the data element. Elements also include gestational age and post-partum as inclusion guidelines for abstraction. Terms can be used during abstraction of the data element to determine if the patient was 20 weeks or more pregnant or within three days post-delivery after the severe sepsis presentation time. Also, the inclusion guideline for abstraction for the data element are not all inclusive. So, further terms or documentation could also be acceptable when abstracting the data element. Next, we would like your participation in answering the following question.

Which value would you select if there is APN documentation that the patient had a c-section on 9/15/2022 at 0800 and severe sepsis presented at 9/18/2022 at 0500? A, Value 1 Yes, or B, Value 2 No. We will give you a few more seconds to select an answer.

Select A, Value 1 Yes, because the severe sepsis presentation time is within three days after delivery. If you recall from the guidance that we discussed earlier, the day of the delivery is day 0. In this example, day 1 would be September 16.

Day 2 would be September 17, and day 3 would be September 18. Therefore, severe sepsis presentation occurred within three days post-delivery. You would select Value 1 Yes for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element.

Next, let's review updates made to the *Severe Sepsis* data element in manual version 5.12. First, the guidance related to selecting Value 2 No when there is physician/APN/PA documentation that COVID-19 is present or suspected was updated. The updated guidance states: Select Value 2 if there is physician, APN, or PA documentation that coronavirus or COVID-19 is suspected or present. Documentation of COVID-19 or coronavirus, qualified with a term synonymous with possible, probable, likely, or suspected, is acceptable. Do not use the positive and negative qualifier table for COVID-19 documentation. This update was made due to questions and feedback received from abstractors at facilities. Updated guidance related to COVID-19 specifically includes terms such as possible, probable, likely, or suspected to further clarify documentation that would be acceptable for selecting Value 2 No. However, abstractors frequently asked whether the positive and negative qualifiers table, found in the *Severe Sepsis Present* data element, should be used when determining if there is acceptable documentation of COVID-19 to select Value 2 No for the *Severe Sepsis Present* data element. This updated guidance clarifies that the positive and negative qualifiers table should not be used when determining if the documentation of COVID-19 would suffice in selecting Value 2 No. The positive and negative qualifier table consists of specific guidance, which includes using the table to determine if documentation of an infection, severe sepsis, or septic shock should be used. The guidance for the positive and negative qualifiers table does not refer to using this table to determine if documentation or a viral infection is acceptable.

Based on collaborative efforts by the California Maternal Quality Care Collaborative (CMQCC), CMS, and the SEP-1 measure stewards, the SEP-1 measure is now implementing clinical criteria for meeting severe sepsis based upon non-pregnant and pregnant 20 weeks through day 3

post-delivery patients. The clinical criteria implemented in manual version 5.12 are based upon the CMQCC sepsis tool kit. The tool kit specifically addresses sepsis screening and diagnosis in maternal and post-partum patients. Based on the tool kit, the *Severe Sepsis* data element was updated to include new tables for SIRS criteria and evidence of organ disfunction based on non-pregnant and pregnant 20 Weeks through day 3 post-delivery patients. The updated guidance for SIRS criteria states: For SIRS criteria, use the table below. Use non-pregnant criteria if Value 2 was selected for *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. Use pregnant 20 weeks through day 3 post-delivery criteria if Value 1 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. As you can see on this slide, the clinical criteria values vary slightly dependent on non-pregnant versus pregnant 20 weeks through day 3 post-delivery. For example, for the non-pregnant patients, a heart rate greater than 90 would be used as SIRS criteria. However, if the patient was pregnant 20 weeks through day 3 post-delivery, the heart rate would need to be greater than 110 to meet SIRS criteria. If there is a patient is 20 weeks pregnant through day 3 post-delivery with a heart rate of 95, that heart rate would not be used as a SIRS criterion for establishing severe sepsis.

Let's review a scenario. This question asks: Would you use the respiratory rate as a SIRS criterion based only on the information below? The MD notes that the patient is 37 weeks pregnant. Vitals signs flowsheet: Respiratory rate is 22. No. The patient is more than 20 weeks pregnant, and the respiratory rate of 22 is not greater than 24. If you recall from the previous slide, if Yes was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element, you would use criteria under the column for 20 weeks pregnant through day 3 post-delivery patients. Under that column, the respiratory rate would need to be greater than 24 to meet SIRS criteria. Therefore, the respiratory rate of 22 in this scenario would not be used in SIRS criteria.

As we discussed earlier, the updates to the *Severe Sepsis Presentation* data element also included a table for evidence of organ disfunction based on

non-pregnant and pregnant 20 weeks through day 3 post-delivery patients. Criteria included for pregnant 20 weeks through day 3 post-delivery patients is also based on the CMQCC sepsis tool kit and the collaboration between CMQCC, CMS, and measure steward. The new guidance states: For criteria C organ disfunction, use non-pregnant criteria if Value 2 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. Use the pregnant 20 weeks through day 3 post-delivery criteria if Value 1 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. The table is now included in the data element that contains the signs of organ disfunction used by the measure to establish clinical criteria. Similar to the table containing the SIRS criteria, this table is divided by non-pregnant and pregnant 20 weeks through day 3 post-delivery patients. The slide contains three of the clinical criteria that can be used to meet organ disfunction. Also, similar to updated guidance for SIRS criteria, the criteria values used to establish sever sepsis may vary depending on whether Value 1 or Value 2 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. For example, for non-pregnant patients, systolic readings less than 90 can be used to meet for criteria C. However, if the patient was 20 weeks pregnant through day 3 post-delivery, the systolic blood pressure reading would need to be less than 85 to meet criteria C.

The next slide contains the remainder of the table that includes the criteria for establishing organ disfunction. The values that meet criteria C for non-pregnant patients have not changed, but, again, you will notice some of the values for the pregnant 20 weeks through day 3 post-delivery patients are different, such as the creatinine value. A creatinine value greater than 1.2 in pregnant 20 weeks through day 3 post-delivery patients would be acceptable for criteria C, but you would continue to only use creatinine values greater than 2 in non-pregnant patients. Also, I want today to point out specifically here the guidance noted for the lactate greater than 2 for pregnant 20 weeks through day 3 post-delivery patients. The note in the table states: Do not use lactate obtained during active delivery defined as documentation by uterine contractions resulting in cervical change, such as dilation or effacement, through delivery or childbirth.

In these instances, if the elevated lactate was obtained or collected while the patient was having uterine contractions that resulted in cervical change through delivery, you would disregard the elevated lactate value, and the elevated lactate would not be used to establish criteria C organ disfunction. The criteria for pregnant 20 weeks through day 3 post-delivery patients includes PTT greater than 60 seconds as a criterion for establishing organ disfunction. This is slightly different from the guidance for non-pregnant patients, where an aPTT can be used.

Let's review another scenario regarding these criteria. This request asks, "Would you use the systolic blood pressure reading as a sign of organ disfunction based only on the information below?" Then, it notes a patient is 22 weeks pregnant. Vital Signs Flowsheet: BP of 86 over 54. No. The patient is more than 20 weeks pregnant and the systolic pressure of 86 is not less than 85. In the scenario, the patient is more than 20 weeks pregnant, and the systolic blood pressure is not less than 85. Even though the systolic pressure is less than 90, it would not be used to establish criteria C because only systolic blood pressure readings of less than 85 would be used when the patient is 20 weeks pregnant through day 3 post-delivery. Let's review another scenario.

This question asks, "Would you use the systolic blood pressure reading as a sign of organ disfunction based only on the information below?" In this progress note, delivery 10/1/2022 without complication and a lab result at 10/3/2022 at 0800 is a creatinine of 1.8. Yes. The patient is within three days post-delivery and the creatinine result is greater than 1.2. If you recall from the table containing the sign of organ disfunction, the creatinine value greater than 1.2 can be used to establish organ disfunction in patients who are 20 weeks pregnant through day 3 post-delivery.

Next, you can participate in an answering the following question. Would you use the lactate value as a sign of organ disfunction based on the documentation below? On 7/15/2022 and 1600: Contractions five minutes apart. Dilation three centimeters, 60 percent effaced. On 7/15/2022 at 1800, a lactate was collected. On 7/15/2022 at 1900, a lactate result: 3.5. A Yes. B No.

I'll give you a few more seconds to select an answer. Select B. No. The lactate was obtained during active delivery as noted by the uterine contractions resulting in dilation and effacement. In this scenario, the lactate of 3.5 would be disregarded and not used to establish criteria C organ disfunction.

The guidance on this slide was updated in the manual version 5.12 to include PTT due to the inclusion of PTT as a possible sign of organ disfunction in pregnant 20 weeks through day 3 post-delivery patients. The updated guidance states: Do not use an elevated INR, aPPT, or PTT value as organ disfunction if the medical record documentation shows the patient received an anticoagulant medication in Appendix C, Table 5.3, before the elevated INR, aPTT, or PTT value. Physician documentation is not required. Use the elevated INR, aPTT, or PTT value if the patient only received the following: heparin flushes. Along with elevated INR and aPPT, an elevated PTT value would also be disregarded if the patient received an anticoagulant from Appendix C, Table 5.3, before the elevated INR, aPTT, or PTT value. Also, there were further language and formatting updates to the guidance under the table containing the criteria for organ disfunction. Due to time limitations, we are unable to review all of the updates under criteria C. So, we encourage you to review all the updates in the data element.

Next, let's review several new examples added to the *Severe Sepsis Present* data element. It addresses SIRS criteria and a sign of organ disfunction documented as normal for the patient due to a chronic condition or due to a medication. The first new example we will review states: Chronic A fib with RVR. Do not use the heart rate reading greater than 90 since the chronic condition is in the same sentence. The documentation of chronic A fib with RVR attribute the term defining the abnormal value, RVR, to the chronic condition A fib. Therefore, you would not use the heart rate greater than 90 in non-pregnant patients as a SIRS criterion.

Two more new examples were also included under this guidance. The example on this slide states: ED note history of A fib chronic

anticoagulation. On the admit H&P: A fib with tachycardia. Do not use the heart rate readings greater than 90 due to the documentation indicating A fib as a chronic condition and a documentation of the chronic condition in term defining the abnormal value in the same sentence. In this example the term defining the abnormal value is tachycardia, and tachycardia is attributed to A fib. The documentation in the ED note reflects A fib as a chronic condition for this patient. Therefore, the documentation A fib with tachycardia is attributing the elevated heart rate to the chronic condition. The next example states: Post-partum 48 hours, bilirubin remains elevated at 2.5, related to chronic liver disease. Don't use the value since the bilirubin and the chronic condition are in the same documentation. In this example, the bilirubin of 2.5 is clearly attributed to the chronic condition; therefore, the bilirubin value of 2.5 would not be used to establish criteria C organ disfunction.

A new example was also added to the *Severe Sepsis Present* data element. It adds guidance to not use SIRS criteria or signs of organ disfunction if it is documented as due to an acute with noninfectious source. The new example states: MD note: 39 weeks gestation, contractions every four minutes, heart rate 125. Contractions are the acute condition and 39 weeks gestation is the noninfectious source. In this example, the heart rate of 125 is clearly attributed to the contractions which are caused by the patient's pregnancy. Therefore, the heart rate of 125 and less severe values will not be used to meet SIRS criteria.

A new example was also added to the *Severe Sepsis Present* data element under the guidance to use the abnormal value if it is documented due to an acute condition. The new example states: Progress note: A fib with heart rate of 96. In the example, A fib is not documented as a chronic condition for the patient nor due to a noninfectious source. Rather, the heart rate of 96 is attributed to A fib. In this case, you would use the elevated heart rate to meet SIRS criteria. Let's review another scenario related to this guidance.

This question asks: Would you use the elevated heart rate as SIRS criteria based only on the documentation below? The MD note includes tachycardia related to anxiety. Yes.

The elevated heart rate is attributed to the acute condition of anxiety without further documentation of the noninfectious source.

This slide was updated in the version 5.12 to address acute conditions and acute and chronic conditions along with addressing 20 weeks pregnant through day 3 post-delivery patients. The updated guidance states: Physician/APN/PA documentation of a term that is defined by SIRS criteria or a sign of organ disfunction is acceptable in place of the abnormal value when the term is documented as normal for the patient due to a chronic condition, a medication, acute conditions, acute on chronic condition, or due to an acute condition that has a noninfectious source or process. Examples include but are not limited to use non-pregnant criteria if Value 2 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element and use pregnant 20 weeks through day 3 post-delivery criteria if Value 1 is selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element, or use the updated examples of the next slide. However, this guidance is referring to documentation of a term defining an abnormal value that is documented as normal for the patient due to a chronic condition, a medication, acute condition, acute on chronic condition, or due to an acute condition that has a noninfectious source or process is acceptable in place of an abnormal value. That means if hypotension is documented as due to a medication, inclusion of hypotension in the documentation will suffice in place of having the actual value included in the documentation. Acute conditions and acute on chronic conditions were added to this guidance due to questions received via the online Q&A tool, asking how a term documented due to an acute condition or an acute on chronic condition should be abstracted. You would use the abnormal value if it was documented as due to acute condition or an acute on chronic condition unless there was further documentation of a noninfectious source. Also, with the addition of the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element, this

guidance also delineates the example based upon Value 1 or Value 2 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. Let's review the new examples.

The table on this slide includes updated examples of the terms that define the abnormal values. The updates include the value associated with the terms patients who are 20 weeks pregnant through day 3 post-delivery. The use of the terms will vary slightly depending on whether Value 1 or Value 2 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. For example, the term tachycardia for non-pregnant patients refers to heart rates greater than 90. However, if Value 1 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element, tachycardia would refer to heart rates greater than 110. Let's review another example.

This question asks: Would you use the systolic blood pressure reading for organ disfunction based only on the documentation below and select Value 1 Yes for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. The PA notes hypertensive after pain meds. The vital signs flow sheet notes a blood pressure of 81 over 49. No. The documentation includes the term that defines the abnormal value hypotension and the medication.

Let's review another scenario. This question asks: Would you use the low platelet count as a sign of organ disfunction based only on the documentation below? The PA notes thrombocytopenia may be related to ETOH intake and the lab result has a platelet count of 75,000. Yes. The documentation attributes the term defining the abnormal platelet count thrombocytopenia to acute condition. In this scenario, the term defining the low platelets is thrombocytopenia which is attributed to the patient's ETOH or alcohol intake. Without further documentation of this being chronic or due to a noninfectious source, you would continue to use the low platelet count in this case.

The abstraction guidance related to conflicting guidance documentation was updated in *Severe Sepsis Present* data element. The new guidance

states: Abstract based on the latest piece of documentation before the severe sepsis presentation time or within 24 hours after if there is conflicting information within two or more separate pieces of physician/PA/APN documentation indicating SIRS criteria or sign of organ disfunction is normal for the patient due to chronic condition or medication or due to an acute condition with noninfectious source and due to possibly due to infection through sepsis or septic shock.

You may recall in previous manual versions, there were separate bullet points providing instruction for conflicting documentation within separate sources. The guidance was updated in version 5.12 to provide the instruction within the single bullet point. For the next part of the presentation, I will turn it over to Jennifer.

Jennifer Witt: Thanks, Noel. Moving on to the *Discharge Disposition* data element, this bullet point was updated to state: Select Value 8 UTD if the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged. You may recall from previous manual versions this guidance stated to select Value 1 Home in this particular scenario. However, since the documentation in this case does not address the place or setting the patient is being discharged to, you would select Value 8 UTD in this scenario.

These bullet points from the *Blood Culture Collection* data element were also updated in the manual version 5.12. New examples were added to the first bullet point on the slide to clarify acceptable documentation for selecting Value 1 Yes based on documentation of a failed attempt to collect the blood culture. The guidance states: Select Value 1 if a blood culture was ordered and there was an attempt to collect it, but the attempt resulted in the failure to collect the specimen (too dehydrated to get a vein), or the specimen was contaminated during or after the draw. Examples include blood culture attempted, blood culture times three attempts, unable to collect BC. The second bullet point on the slide clarifies the need for a time to be documented to suffice as documentation indicating the blood culture was collected.

The updated guidance states: Select Value 1 if there is a time associated with documentation indicating that a blood culture was collected during the specified time frame. Example: Blood culture sent to lab; blood culture received time. Use the earliest mention of a blood culture. We received questions via the online Q&A tool asking if the note open time should be used or if a specified time is needed for this type of documentation. Since the guidance in the *Blood Culture Collection* data element does not refer to using the note open time, a time directly associated with the documentation is needed.

Guidance was also added to the *Initial Lactate Level Result* data element regarding lactates obtained during active delivery. Active delivery is where there are uterine contractions can result in an increased lactate. The updated guidance states that, if the lactate greater than 2 was obtained during active delivery, do not use it. Select Value 1. For purposes of the measure, active delivery is determined by documentation of uterine contractions resulting in cervical changes, dilation, or effacement, through delivery or childbirth. In this scenario, if the initial lactate level collection occurred during active delivery, you would select Value 1 for *Initial Lactate Level Result* data element. This guidance was added because active delivery where there is uterine considerations can result in increased lactate values. Therefore, these lactate values are not used to meet the criteria of the measure.

Also, updated in the *Initial Lactate Level Result* data element is the addition of select Value 1 in the two bullet points on the slide. You may recall, this guidance was updated in the manual version to state: Do not use it. However, we've received further questions via the online tool asking which value to select when the initial lactate value is not used. Therefore, the guidance on this slide was updated to clarify the appropriate value to select in these scenarios.

We also updated the *Initial Hypotension* data element criteria for 20 weeks pregnant through day 3 post-delivery patients. As we mentioned previously, the criteria included for pregnant 20 weeks through day 3 post-delivery patients are based on the CMQCC sepsis tool kit and the

collaboration between CMQCC, CMS, and the measure steward. Similar to the tables we discussed earlier in the *Severe Sepsis Present* data element, the table on the slide provides the criteria for meeting initial hypotension based on whether Value 1 or Value 2 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. For patients that are pregnant 20 weeks through day 3 post-delivery, hypotensive systolic readings less than 85 suffice the initial hypotension criteria. Systolic readings of less than 85 is used because it is normal for blood pressure to decrease during pregnancy. The guidance was updated in the *Initial Hypotension* data element to address terms that define the abnormal value. Similar to what we previously discussed, the table on the slide also differentiates between non-pregnant and pregnant 20 weeks through day 3 post-delivery.

The guidance in the *Initial Hypotension* data element received the update that addresses conflicting documentation and separate sources. Rather than two separate bullet points as in two previous versions of the manual, the single bullet point instructs to abstract based on the latest piece of documentation before the severe sepsis presentation time or within 24 hours after if there is conflicting information within two or more separate pieces of physician/APN/PA documentation.

For the *Crystalloid Fluid Administration* data element, a new example was added to the guidance. The guidance states: If crystalloid fluids are initiated via multiple physician/APN/PA orders, begin with abstracting the earliest crystalloid fluid ordered that are initiated within the specified time frame. Evaluate all fluids ordered and include the fluids if they contribute to the target ordered volume and are initiated within the specified time frame. The new example goes onto state: The time frame for acceptable crystalloid fluid is 0800 through 1700. The target ordered volume 30 millimeters per kilogram is 3750 milliliters. The IV fluid orders are, at 1200, NaCL 0.9 percent, the IV volume of 1000 mL, bolus wide open. At 1300, NaCL 0.9 percent IV volume of 3,750 milliliters at a rate of 909 milliliters an hour. On MAR, at 1200, there is a new bag of 1000 milliliters the staff time at 12:30.

At 1300, there is a new bag of 1000 milliliters at 999 milliliters an hour. At 1400, a new bag of 1000 milliliters at 999 milliliters an hour. At 1500, a new bag of 1000 milliliters at 999 milliliter an hour. Use the crystalloid fluid infusion beginning at 1200. We frequently received questions via online Q&A tool regarding this guidance as well as which crystalloid fluid administration time to abstract. First, keep in mind, the *Crystalloid Fluid Administration Time* data element provides the instructions for which times to abstract for the crystalloid fluid administration time when there are multiple orders used. The guidance on this slide pertains to which fluid you should use towards the target ordered volume when there were multiple orders. In the example, you would use a fluid that started at 1200 towards the target ordered volume because these fluids were ordered and initiated within the specified time frame.

This question asks: Would you use the infusion ordered at 0800 towards the target ordered volume? The time frame for acceptable crystalloid fluid is 0600 through 1700. The target ordered volume for 30 milliliters per kilogram is 2000 milliliters. You have IV fluid orders at 0800 of normal saline at 0.9 percent, IV volume at 1000 milliliters over one hour. At 0930, normal saline IV volume 30 milliliters per kilograms at a rate of 999 milliliters per hour. On the MAR, at 0805, a new bag of 1000 milliliters with a stop time at 0905 and at 0940, a new bag of 1000 milliliters of 999 milliliters an hour. Yes, use fluids that were ordered at 0800 because this infusion was ordered and initiated within the specified time frame.

Also, due to questions and feedback we have received from abstractors, the guidance regarding the infusion rate was also updated for clarification. Only include crystalloid fluid or colloids given at a rate greater than 125 milliliters an hour towards the target ordered volume. Don't use crystalloid fluids or colloids given at 125 milliliters an hour or less toward the target ordered volume. Although all fluids used toward the target ordered volume must be administered at greater than 125 milliliters an hour, this bullet point was updated to ensure this is clear in the notes for abstraction.

The guidance in the *Persistent Hypotension* data element was also updated to incorporate the criteria for pregnant 20 weeks through day 3 post-delivery. Similar to the table we discussed earlier in the *Severe Sepsis Present* data element, the table on the slide provides the criteria for meeting persistent hypertension based on upon whether Value 1 or Value 2 was selected for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. Also, prior to what we previously discussed, the systolic blood pressure value used for non-pregnant versus 20 weeks pregnant through day 3 post-delivery patients varies slightly as noted in this table.

The guidance was also updated in the *Persistent Hypotension* data element that addresses the selection of Value 1 when there is only one blood pressure documented and a vasopressor was administered. The guidance states: Determining presence of persistent hypotension: If there were no blood pressures or only one blood pressure recorded within the hour, select Value 1 if the only blood pressure within the hour is low and a vasopressor was administered. Also, a new example was added to clarify this scenario. The example states: The one hour time frame is 1300 to 1400. The blood pressure, the only one documented, at 1325 was 87 over 53. The MAR has Levophed started at 1500. Select Value 1 because there is only one blood pressure reading but it is low and a vasopressor was administered.

The guidance was also updated in the *Persistent Hypotension* data element that addresses the selection of Value 1 when there are two or more blood pressures documented. The guidance states: If two or more blood pressures are documented, refer to last two consecutive blood pressures within the hour. Select Value 1 if there is a low blood pressure followed by another low blood pressure. Select Value 1 if there is a normal blood pressure followed by a low blood pressure and a vasopressor was administered. A new example for this guidance states: The one-hour time frame is 0800 to 0900. Blood pressures were documented at 0830 of 95 or 60 and at 0845 of 86 over 54. The MAR has Vasopressin started at 0930. Select Value 1 because there is a normal blood pressure followed by a low blood pressure but a vasopressor was administered.

Now, we would like your participation in the following question. Which allowable value would you select for persistent hypotension if the hour to assess persistent hypotension is from 1800 to 1900, a single MAP of 70 at 1815, and Vasopressin was started at 1730? 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. I'll give you a few more seconds to select the answer. Select B, Value 2 No or UTD, hypertension not present, because there is a single normal MAP reading in the hour to assess for persistent hypotension.

The guidance was also updated in the *Persistent Hypotension* data element to address terms specifying an abnormal value. Similar to what we previously discussed, the table on the slide also differentiates between non-pregnant and pregnant 20 weeks through day 3 post-delivery.

The guidance in the *Persistent Hypotension* data element also received the updates that addresses conflicting documentation and separate sources. Rather than two separate bullet points, as in previous versions of the manual, the updated guidance in a single bullet point instructs to abstract based on the latest piece of documentation before the severe sepsis presentation time or within 24 hours after, if there is conflicting information within two or more separate pieces of physician/APN/PA documentation.

Also, to note, the *Septic Shock Present* data element received similar updates regarding the use of terms that define abnormal value based on non-pregnant and pregnant 20 weeks through day 3 post-delivery criteria.

Lastly, *Septic Shock Present* data element also received updates that addresses the conflicting documentation and separate sources. That concludes the review of the specifications manual version 5.12 updates. Thank you for participating in our review of the updates. Next, I will turn it over to Noel to review how to submit questions via the Inpatient Question and Answer Tool.

Noel Albritton: Thanks, Jennifer.

First, 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 the slide. If your question is about a specific slide, please include that slide number also.

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 data element or topic into the search box and select Search. All Q&A pertaining to the topic will appear, and you can review the existing Q&A to find your answer. Existing Q&As are for educational purpose, and it's important to ensure that the Q&As you are referencing agree with the current manual guidance based on the discharge period you are abstracting. We are continually reviewing and updating the existing Q&As, so it's important to review Q&As often to be sure the 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, 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 this SEP-1 measure, the correct program is Inpatient Measure and Data Element Abstraction. Questions are often submitted to other programs by mistake, and it may take longer to a get response if the question has to be rerouted to the correct support team. So, again, for the SEP-1 abstraction questions, the program to select is Inpatient Measure and Data Element Abstraction.

After selecting the Inpatient Measure 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 are listed by the data element that are included in the measure.

The next required field is the discharge period. It's important to select the appropriate discharge period because answers to your questions may vary slightly depending on the manual version. Next, you will add the subject for your question in the subfield. Then, enter your question in the Please Describe Your Question field. It's important to note no PII or PHI should be included in submitting questions. Also, we're unable to receive screen shots or attachments. Submit a question that is concise. Only include information specific to the topic being questioned. After you've entered your question, you click the Submit Question button. The support team will respond to the abstraction question as quickly as possible. So, that's how you submit a question or look at existing Q&As. Candace, I will turn it back over to you.

Candace Jackson: Thank you, Noel, and thank you, Jennifer, for providing all that useful information. We do now have time for a brief Q&A question. So, we will get go ahead and get started with that. Our first question is going to go with the pregnancy data element and guidelines throughout the manual. So, the first question we have is: If you selected Yes for 20 weeks pregnant or within 3 days post-delivery, is the case then excluded?

Noel Albritton: Hi, Candace. This is Noel. So, no. Whether you've selected Value 1 Yes or Value 2 No for the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element, the case will not be excluded. The selection of Value 1 or Value 2 will be used in the *Severe Sepsis Present* data and *Initial Hypotension* and those following elements to determine which criteria values you would use to meet those data elements.

Candace Jackson: Thank you, Noel. Our next question is: Are there any changes to the SEP-1 patient population, for example, related to pregnancy? We haven't seen many pregnant patients before. Are we going to see more due to a change in patient population?

Noel Albritton: So, for this question, the answer also is no. Prior to manual version 5.12, the SEP-1 measure did not delineate between pregnant and non-pregnant patients. So, pregnant patients could have been pulled in the patient population if they met the SEP-1 initial patient population criteria.

So, the same will continue as far as the initial patient population criteria. Those haven't changed. Then, once you meet the initial population, each case will go through the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element to determine, you know, if they are pregnant 20 weeks or day 3 post-delivery or not, but it will not bring in new patients or a new patient population that we not previously included in the measure.

Candace Jackson: Thank you, Noel. Our next question: Are we still looking for two SIRS criteria for pregnant 20 weeks through day 3 postpartum?

Noel Albritton: Yes. For establishing severe sepsis, there is a number of criteria. So, you have criteria A, all patients acquired an infection, two SIRS criteria for criteria B, and one sign of organ disfunction for criteria C. The inclusion of *Pregnant 20 Weeks through Day 3 Post-Delivery* data element doesn't change the number of criteria needed to meet or select Value 1 Yes for *Severe Sepsis*, just some of those individual SIRS criteria or evidence of organ disfunction values may be slightly different depending on pregnant 20 weeks through day 3 post-delivery or non-pregnant.

Candace Jackson: Our next question: What if you have an elevated lactate on day 2 post-delivery? Will we use it to meet severe sepsis criteria?

Noel Albritton: Yes. The elevated lactate on day 2, I believe you said, post-delivery would be used, with the exception of the lactate was obtained during active delivery. If it was obtained during active delivery, then you would not use that value to establish severe sepsis.

Candace Jackson: Thank you, Noel. The next question is: The pregnant 20 weeks table refers to a temp greater than or equal to 100.4 rather than 100.9. Is that correct?

Noel Albritton: Yes. Good point to make. This is where some of the values for SIRS criteria or evidence of organ disfunction are slightly different, depending on non-pregnant versus pregnant 20 weeks through day 3 post-delivery, and the temperature is one of those. If non-pregnant, it would be 38.3 degrees Celsius or 100.9 Fahrenheit for non-pregnant.

For pregnant 20 weeks through day 3post-delivery, the temperature would meet criteria if it was above 38 degrees Celsius or 100.4 Fahrenheit for those pregnant patients.

Candace Jackson: Next question: Are the ICD-10 codes for 20 weeks pregnancy– 3 days postpartum population listed anywhere? If there were ICD-10 codes listed, are we able to use those in abstraction?

Noel Albritton: So, the update does not include any new ICD-10 codes related to pregnancy or the *Pregnant 20 Weeks Through Day 3 Post-Delivery* data element. That is simply because the initial population does not use those codes to pull patients in based on pregnant 20 weeks through day 3 post-delivery. As far as meeting the data element, the guidance refers to documentation of the patients are pregnant 20 weeks through day 3 post-delivery. It doesn't refer to using the ICD-10 codes to determine if Value 1 Yes or no should be selected for that data element. For abstraction purposes, we would look for documentation of the patient being 20 weeks pregnant through day 3 post-delivery.

Candace Jackson: Thank you. A couple questions on crystalloid fluids: What determines the acceptable time frame for crystalloid fluids?

Noel Albritton: So, for crystalloid fluid administration, the guidance refers to the specified time frame as being 6 hours before to 3 hours after the triggering event. That would either be your initial hypotension date and time or septic shock presentation date and time, and that would determine your specified time frame, depending on which one of those is pregnant [present]. If both are pregnant, sorry, if both are present, we talked a lot about pregnancy lately. So, if both initial hypotension and septic shock are present, then you would use the earliest of those two triggers of events for fluids to determine your specified time frame for the *Crystalloid Fluid Administration* data element.

Candace Jackson: Next question. A physician/APN or PA can order less than the 30 milliliters per kilogram of crystalloid fluid if the ordering physician documented an acceptable reason in the same note and there is a physician

order for the lesser volume. Does the order for the lesser volume have to be the exact volume documented in the note or can it be greater?

Noel Albritton: Yes, thanks. This is a good question that we see pretty often, as well. The guidance does not require that the volume ordered be the exact volume documented in the physician's note. So, if the physician wrote in the notes 500 milliliters for this reason, and they ordered 1,000 milliliters, as long as that physician ordered those fluids, they would still meet the 500 milliliters they are planning to give based or not the documented reason.

Candace Jackson: Before the documentation of the "less than 30 milliliters per kilograms," could a statement like "less than 30 milliliters per kilogram given because the patient condition warrants" [be used]?

Noel Albritton: So, I believe this question is asking or is getting at this: Does volume need to be included, or can the physician simply write "less than 30 milliliters per kilogram given" based on a documented reason? The answer for that would be no. The guidance requires the volume to be documented by the physician and the reason for that volume. Basically, it needs to be specific like that especially for abstraction because we will then use the volume documented by the physician to determine the target ordered volume for the patient.

Candace Jackson: Thank you, Noel. If fluid is ordered at a rate less than the 30 milliliters per kilograms with the reason documented, but it is running at a rate less than 125 milliliters per hour, does that pass the fluids measure?

Noel Albritton: No. So, all fluids that we use or count toward the target volume for the patient would need to be running at 125 milliliters per hour or greater. I'm sorry, at greater than 125 liters per hour. If they're running at 125 milliliters per hour or less, then we disregard those fluids. So, regardless of whether the volume is based on a documented reason, or the full 30 kilogram volume, or based on the ideal body weight, regardless of those, the fluids will need to run at greater than 125 milliliters per hour to be used toward our target volume.

Candace Jackson: Thank you. We have several questions regarding EMS records and documentation. So, with the change of many EMS records from those printed and scanned to a patient's chart to records that are electronically assessed and not necessarily printed, is there any guidance on ways in which hospital can get credit for fluid bolus given by EMS prior to the patient's arrival?

Noel Albritton: So, the *Crystalloid Fluid Administration* data element provides guidance for fluid administered prior to arrival, such as by EMS. So, those fluids would be allowed. The documentation of that fluid administration would need to be in the medical record that you are abstracting at the time of abstraction, and it would need to suffice the guidance of the *Crystalloid Fluid Administration* data element.

Candace Jackson: So, I'm not sure, Noel, if that will answer this next question also, which is, "What is the minimum requirements for EMS fluid documentation?"

Noel Albritton: Sure. Those requirements are in the *Crystalloid Fluid Administration* data element, like I said. Basically, you need the type of fluid volume, the start time, and rate duration, or any time for the fluid administered by EMS, or, it could be a clinic or a nursing facility, any type prior to arrival, but that would be the requirement.

Candace Jackson: We have several questions regarding the mean arterial pressure. So, the first one is: For abstraction purposes, is mean arterial pressure and blood pressure synonymous or synonyms?

Noel Albritton: So, mean arterial pressure, or MAP, or BP mean, the guidance refers to mean arterial pressure, or MAP. It doesn't include BP mean within the guidance. So, that's slightly difficult to say. We would likely refer you to the intro to the data dictionary, where it provides guidance that you can use hospital abbreviations per your facility policy when you are abstracting. So, if BP mean is one of those, and you can tell that's the abbreviation at your facility or EHR uses for mean arterial pressure, then it would be synonymous with the MAP. Most likely it would be synonymous with the MAP reading in most cases.

It is slightly difficult for us to tell, especially in a general case like this. I would probably refer you back to the intro to the data dictionary to use that guidance about hospital abbreviations.

Candace Jackson: Thank you. Are there criteria for MAP for pregnant cases?

Noel Albritton: Yes. The guidance includes systolic blood pressure and MAP readings for pregnant 20 weeks through day 3 post-delivery patients, while the systolic for pregnant 20 weeks through day 3 post-delivery patients is slightly different. The MAP value is the same, so less than 65 MAP reading for non-pregnant and pregnant 20 weeks through day 3 post-delivery would apply.

Candace Jackson: Thank you. I think the next few questions that we have are maybe related to *Severe Sepsis Present.* No, the first one we have is for coronavirus. So, we'll go with those first. I have a patient noted by the physician to have coronavirus, but, also within the same documentation, it was noted that they had a possible bacterial component, as well. Can I still review the case for SIRS organ disfunction since there is a positive qualifier for a bacterial infection?

Noel Albritton: So, in this case with the physician documentation that the patient has coronavirus, we would select Value 2 No for the *Severe Sepsis Present* data element. Regardless of the documentation of the bacterial infection, because the measure pulls those patients out that have coronavirus for COVID-19, because the treatment requirement for that can conflict depending on the scenario with the severe sepsis and septic shock treatment, these cases where the physician documented the patient has coronavirus or COVID-19, you would select Value2, and they would be excluded from the measure.

Candace Jackson: Noel, is COVID acceptable, or does it have to say COVID-19? What if they have a positive COVID test only and no physician documentation of COVID?

Noel Albritton: So, for the first question, documented COVID versus COVID-19, the guidance refers to coronavirus or COVID-19. The documentation of those two terms would be clearer.

COVID is synonymous with COVID-19. Physician documentation that COVID was present or suspected should also suffice for selecting Value 2 for *Severe Sepsis Present* data element. Excuse me. If there is a positive lab test for COVID, and there is no physician documentation that COVID is present or suspected, then you would continue to select Value 1 or abstract for severe sepsis. You would not select Value 2 No for the *Severe Sepsis Present* data element based only on the positive lab test. That's because the guidance requires physician/APN or PA documentation that COVID-19 is present or suspected.

Candace Jackson: Thank you, Noel. The next few questions are related to atrial fib. The first one asks about new onset of atrial fib and does it have to be chronic.

Noel Albritton: So, if there is simply documentation of new onset A fib, that alone would not disregard your SIRS criteria. If there was documentation of new onset A fib with tachycardia, that would likely not disregard your elevated heart rate because your tachycardia is being documented as due to an acute condition, the new onset A fib. You mentioned chronic in that question. If there is documentation that A fib is chronic, and tachycardia is also documented with that, then you can disregard the elevated heart rate. If there is documentation of A fib alone, documentation of a chronic condition alone would not disregard your abnormal criteria.

Candace Jackson: Why does a history of atrial fib indicate current atrial fib?

Noel Albritton: So, I think this question was referring to one of the examples. The documentation of history of A fib is, I believe, in the example in the slide. Can we go to slide 30?

Candace Jackson: Yes, we can go to slide 30. It says slide 37, but I know we're off slides because those are polling questions.

Noel Albritton: Sorry. This looks good. Thank you. In this scenario, we have history of A fib and A fib with tachycardia, so we're not attempting to make A fib current, but the H&P is saying that A fib with tachycardia, tachycardia due to A fib. We can see in the ED note that this is a chronic condition, that A fib is chronic for the patient.

So, we are not attempting to make A fib current. We're attempting to see if the tachycardia is due to the chronic condition or a chronic condition. That's where this example comes from.

Candace Jackson: Then, for this next one, can we go to slide 37? This question asks: Is alcohol intake now considered an infectious source?

Noel Albritton: Yes. So, in this scenario, thrombocytopenia documented due to alcohol intake, alcohol intake in this case is our acute condition. We don't have anything in here that determines it will be chronic or we don't have anything saying it's an acute condition due to a noninfectious source. So, the guidance tells us, in this case, the abnormal value documented due to acute condition, we would use the abnormal value. If we had documentation here that alcohol intake was a chronic condition for this patient, then we could likely disregard the low platelet count. Based simply on what's documented here, thrombocytopenia documented due to acute condition alone, we would still use those low platelet counts. [Note from the Behavioral Development and Inpatient and Outpatient Measure Maintenance Support Contractor: A corrected response to this question will appear in the Question and Answer Summary Document for this presentation. That document will appear on www.QualityReportingCenter.com at a later date.)

Candace Jackson: Thank you, Noel. We have time for a couple more questions. Could we go to slide number 39? This asks: Does it need to be physician documentation or can it be included in the RN discharge notes?

Noel Albritton: So, for the *Discharge Disposition* data element, it can be physician or nursing documentation. The guidance in this data element doesn't specify any particular physician or nurse or other credential as needing to be documenting the discharge disposition. So, this could be anyone documenting a medical record, I guess.

Candace Jackson: For our next question, could we go to slide 40, please? This asks: Can this documentation be by lab personnel, for example, hemolyzed specimens?

Noel Albritton: Yes. Candace. I just mentioned what we went over with the physician. This guidance with the *Blood Culture Collection* data element also doesn't require a specific person to document. It could be lab, nursing, or physician; there is no requirement here.

Candace Jackson: A couple more questions here. The next one is: What is the allowable time frame for Vasopressin administered?

Noel Albritton: I think this is referring to the *Persistent Hypotension* data element in administration of a vasopressor. I hope that's right. We'll address both of them. For persistent hypotension, if there is low value, or low hypotensive reading, or a single low hypotensive reading, and a vasopressor is administered, the guidance in the *Persistent Hypotension* data element doesn't provide a specified time frame for that vasopressor. The specified time frame will be addressed in the *Vasopressor Administration* data element. So, we're abstracting persistent hypotension. We're strictly looking at the blood pressure reading and whether a vasopressor was received. The next data element, if Value 1 is selected for *Persistent Hypotension*, the next data element will be *Vasopressor Administration*. At that point, we'll determine if the vasopressor was administered within the specified time frame based on *Septic Shock Presentation.*

Candace Jackson: Thank you, Noel. Our last question for today: If there are four blood pressures in the time frame for persistent hypotension, the last two blood pressures in the hour were normal, do they have persistent hypotension?

Noel Albritton: No. You have multiple blood pressure readings, such as four documented during the hour, you would refer to those last two blood pressures obtained during the hour. If both of those were normal, or if the last one was normal, you would select Value 2 No for *Persistent Hypotension* and proceed on with abstraction.

Candace Jackson: Thank you, Noel. That ends our Q&A session. As a reminder, if we did not get your question today, you can please submit those to the Q&A tool, and they will be answered. Next slide, please.

Again, I'd like to thank Noel and Jennifer for presenting today. As we stated earlier, this webinar has been approved for 1.5 continuing education credits. You can obtain those credits by going to the link on the slide. Next slide, please.

We would like to thank you all for joining us today. I hope you found this information beneficial. Gave a great afternoon. Thank you.