Inpatient Quality Reporting (IQR) Program

Support Contractor

SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock: v5.2 Measure Updates

Questions & Answers

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Intravenous Fluids (IVF)

Question 1: **If we have a policy regarding fluid administration rate/time for possible sepsis patients, such as crystalloid fluids, 0.9% normal saline (NS) or Lactated Ringer's (LR), for possible sepsis/septic shock patients to run at 1000 ml/hr, can this be used to determine fluid administration end time?**

Physician/advanced practice nurse (APN)/physician assistant (PA) orders with the type of fluid, volume of fluid, and the terms "bolus" or "wide open" are acceptable without a rate or infusion duration, if a rate or time over which the IV fluids are to be given **or** the fluid bolus completed time or end time is documented in the medical record. If a rate or time over which the IV fluids are to be given is not written in the order or not documented by nursing **or** the fluid bolus completed time or end time is not documented, choose Value "2."

Question 2: **How can we account for crystalloid fluids given by emergency medical services (EMS)? Many times they are given prior to arrival (PTA) and the emergency department (ED) provider takes these amounts into account when calculating the 30 mL/kg.**

It is acceptable to use documentation of infusion of crystalloid fluids in prehospital records, e.g., ambulance records, nursing home records, that are considered part of the medical record. However, a physician's order and documentation of fluid administration remains a requirement. If the required information is not available to assess how much was given, the guidelines do not currently allow its use.

Question 3: **With crystalloid fluid administration being accepted if within 10% of 30 mL/kg, what is end time of crystalloid fluid administration? Is it when patient gets entire bolus or when 90% has been administered?**

The allowance for crystalloid fluid volumes within 10% of the 30 mL/kg calculated volume applies to the order for fluids. Therefore, the completion time of the infusion would be when the fluids ordered are completely infused.

Question 4: **Slide 28: In order to say "Yes" to Crystalloid Fluid Administration, is 30 mL/kg required to be infused within three hours of sepsis presentation time?**

In order to select "Yes" for the Crystalloid Fluid Administration data element, crystalloid fluids must be given (started) within six hours prior to, or within six hours following, the presence of initial hypotension, an initial lactate level result of greater than or equal to 4 mmol/L, or physician/APN/PA documentation of septic shock are acceptable to count toward the 30 mL/kg volume. The Crystalloid Fluid Administration data element does not have a time frame attached to the severe sepsis nor septic shock presentation times. There is no time frame within which the crystalloid fluids must be completely infused.

Question 5: **Slide 33 states, "It is acceptable to use documentation of infusion of crystalloid fluids in prehospital records, e.g., ambulance, nursing home records, that are considered part of the medical record." Does the rate need to be documented in these prehospital records?**

To use prehospital fluids, there must be an order with the fluid type, volume, and rate. In the order, the terms "bolus" or "wide open" are acceptable in place of the rate. An infusion start time must be documented. To determine how much fluid was completely infused, a rate is necessary unless there is a documented end time.

Question 6: **Slide 9: Is this expanded guidance intended to help with the physician concern of giving fluid resuscitation with someone with a chronic condition like congestive heart failure (CHF), renal failure?**

Slide 9 is meant to help with abstracting clinical criteria "c" of the Severe Sepsis Present data element.

Question 7: **With crystalloid fluid administration, can crystalloid fluids with electrolytes added, such as potassium (K), calcium (Ca), or magnesium (Mg) still be used? It was allowed in the prior version's additional notes for abstraction.**

Yes, please refer to page 2 of the *Additional Notes for Abstraction for the Sepsis (SEP-1) Measure, Version 5.2a*.

Question 8: **To further explain question on slide 9: If medical doctor (MD) documents no fluid resuscitation because of renal failure, will this patient be excluded from measure?**

Currently, there are no exclusions to the administration of crystalloid fluids for chronic conditions. For purposes of the measure, if crystalloid fluids are triggered, they should be administered. Measures are designed to address appropriate care for the majority of cases. There may be outliers or unique situations in which a physician feels procedures or medications are indicated, which do not follow a measure's standardized guidelines. CMS is aware of this and does not expect 100 percent as there are instances where clinically appropriate care does not fall within the measure's guidance.

Question 9: **Slide 47: Is intraosseous an acceptable route for crystalloid fluids and vasopressor administration or only for vasopressor administration?**

Vasopressor only.

Question 10: **Slide 28: Does the 30 mL/kg of crystalloid fluids need to be in a certain time frame related to severe sepsis presentation?**

In order to select "Yes" for the Crystalloid Fluid Administration data element, crystalloid fluids given (started) within six hours prior to, or within six hours following, the presence of initial hypotension, an initial lactate level result greater than or equal to 4 mmol/L, or physician/APN/PA documentation of septic shock are acceptable to count toward the 30 mL/kg volume. The Crystalloid Fluid Administration data element does not have a time frame attached to the severe sepsis nor septic shock presentation times. There is no time frame within which the crystalloid fluids must be completely infused.

Question 11: **Does IVF given by EMS count towards the 30 mL/kg requirement?**

It is acceptable to use documentation of infusion of crystalloid fluids in prehospital records, e.g., ambulance records, nursing home records, that are considered part of the medical record.

Question 12: **Is bolus acceptable for infusion rate?**

Yes.

Question 13: **Slide 30: If the order is written to infuse 1000 cc at 999/hr, would we just add one hour to the start time?**

Yes.

Question 14: **Is there any exception allowed for patients with history of CHF or chronic kidney disease (CKD)? Exceptions related to volume of fluids…**

There are currently no exceptions for this data element.

Question 15: **Slide 31: What if there is no weight documented in the chart at all?**

In the *Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.2a*, page 1-84 of the Alphabetical Data Dictionary states:

> Use the patient's actual weight. Use estimated weight only if actual weight is not available to determine the volume of crystalloid fluids the patient should receive. Do not use ideal weight.

If no weight is documented, then "No" would be selected for Crystalloid Fluid Administration.

Question 16: **What if the patient goes to the operating room (OR) after sepsis onset time and after/during the time crystalloid fluids were started? How do we navigate this as the OR is an entirely different entity with regard to fluid administration and IV antibiotics, etc., and the order sets are not as they are on the inpatient floor/ED.**

Crystalloid fluid administration would continue to be abstracted per the documentation of fluid administration in the medical record. While the OR may document fluid administration differently, the documentation of fluids administered in the OR are acceptable.

Question 17: **If a patient has initial hypotension that resolves prior to complete infusion of the 30 mL/kg, does the entire volume need to be infused by guidelines? If the fluids are stopped prior to completion, is that deemed a fallout?**

Yes, the entire volume has to be infused in order for the case not to fall out.

Question 18: **So if you have an actual weight two hours before fluids, and an estimated weight one hour before, use the actual weight?**

Use the weight documented closest to and prior to the order for crystalloid fluids. If a weight is not documented prior to the crystalloid fluid order, use the weight recorded closest to and after the crystalloid fluid order. If an actual weight is not available, estimated weight may be used.

Question 19: **Does the six-hour time frame for fluids apply to physician/APN/PA documentation of septic shock (as well as, severe sepsis with initial hypotension or elevated lactate)?**

For crystalloid fluid administration, fluids given (started) six hours prior to six hours following initial hypotension, an initial lactate greater than or equal to 4, or documentation of septic shock, are acceptable.

Question 20: **If multiple bags are ordered to reach 30 mL/kg, do we use the weight prior and closest to the last bag ordered to reach 30 mL/kg?**

Use the weight documented prior to the first crystalloid fluid order. Calculating the weight after some fluids have been infused will increase the total 30 mL/kg volume due to the weight of the fluids previously infused.

Question 21: **Do you have to round the weight for weight-based IVF if you have an exact weight?**

If the order for 30 mL/kg includes the exact weight as the basis for the total volume, rounding is not necessary. However, if the order for 30 mL/kg is not based on the patient's exact weight, rounding should be performed.

Question 22: **Is it correct to say that IVF administration time frame would be six hours before initial hypotension to three hours after septic shock date and time?**

For crystalloid fluid administration, fluids given (started) six hours prior to six hours following initial hypotension, an initial lactate greater than or equal to 4, or documentation of septic shock, are acceptable to abstract. In order to pass the Crystalloid Fluid Administration Time calculation in the algorithm, the crystalloid fluid administration time is required to be within three hours of septic shock presentation.

Question 23: **Does the fluid resuscitation need to be started within three hours after severe sepsis/septic shock presentation?**

In order to pass the Crystalloid Fluid Administration Time calculation in the algorithm, the crystalloid fluid administration time is required to be within three hours of septic shock presentation. Fluids are not required to be started within three hours of severe sepsis nor septic shock to select "Yes" for the Crystalloid Fluid Administration.

Question 24: **Can you use intake/output (I/O) to determine amount of IVF infused?**

Yes, documentation on the I/O record could be used.

Question 25: **If 30 mL/kg is ordered, but the amount of the bolus given is less than that and within 10% of the 30 mL/kg, will that pass the measure?**

No, the 10% allowance is only for what is ordered.

Question 26: **If the ED MD documents only that the patient received 500 cc PTA; but, there is no further information regarding fluid type/rate, do we disregard, or do we have to mark as unable to determine, or can we disregard and only review our record since the ambulance data is not complete?**

You can disregard and view your record.

Question 27: **Do you have to see the actual prehospital crystalloid fluid order in order to accept the pre-arrival crystalloid fluid in your 30 mL/kg fluid calculation?**

The complete order for fluids and documentation of pre-arrival fluid administration is required to be in the medical record.

Question 28: **How can we meet the order requirement for fluids given prior to arrival if given by EMS? There is no order on the ambulance records and they are not giving fluid based on a hospital protocol.**

Since an order is required for all crystalloid fluids, including pre-arrival fluids, a protocol reflecting a physician's standing order or an ED physician order that includes the pre-arrival fluids may be used to suffice the order requirement.

Question 29: **Slide 33: Are we able to use infusion of crystalloid fluids in prehospital records; does the order for those fluids need to be within the medical record?**

Yes, you can use crystalloid fluids infused in prehospital records; and, yes, an order for those fluids needs to be within the medical record.

Question 30: **If the patient's stated weight is 50 kg prior to crystalloid fluids, but the patient's actual weight shows to be 60 kg the day after, or even two days after fluid administration, are we supposed to take the actual weight? If yes, how far after fluid administration should we check for actual weight, e.g., three days? Does the measure take into consideration that the additional fluid administration may cause increased fluid retention, which can be reflected in a possible temporary weight gain?**

Use the weight documented closest to and prior to the order for crystalloid fluids. If a weight is not documented prior to the crystalloid fluid order, use the weight recorded closest to and after the crystalloid fluid order.

Question 31: **If ED nurse triage documents a volume of fluids that was given to the patient en route to ED by EMS, can that be counted toward total volume of fluid bolus? More specifically, EMS reports to the nurse the total volume, but the EMS record may not be part of the hospital's medical record.**

Yes, you can use crystalloid fluids infused in prehospital records, if they are part of the medical record, or if documented in the hospital's medical record; but, an order is required for those fluids.

Question 32: **If ED doctor documents that the patient received one liter en route, can that be counted? My question relates to the use of prehospital records.**

An order is required to use the prehospital fluids. There must also be an infusion start time and an infusion rate (written in the order or documented by nursing), or infusion end time must be known, in order for it to be accepted.

Question 33: **Slide 33: Are we able to use infusion of crystalloid fluids in prehospital records if the order for those fluids is not within the record?**

An order is required to use the prehospital fluids. There must also be an infusion start time and an infusion rate (written in the order, or documented by nursing), or infusion end time must be known, in order for it to be accepted.

Question 34: **Does the fluid resuscitation need to be started within three hours after severe sepsis/septic shock presentation?**

In order to pass the Crystalloid Fluid Administration Time calculation in the algorithm, the crystalloid fluid administration time is required to be within three hours of septic shock presentation. Fluids are not required to be started within three hours of severe sepsis nor septic shock to select "Yes" for the Crystalloid Fluid Administration data element.

Question 35: **If the MD orders a fluid bolus of NS 0.9% 30 mL/kg (2500 ml) to be given over 30 minutes and the registered nurse (RN) only documents a start time and does not include an end time or total volume infused, can the order be used to report the end time was 30 minutes after the start time and the volume given was 2500 ml?**

Yes.

Question 36: **Are you including intraosseous route for crystalloid volume replacement, as well?**

Intraosseous is not accepted at this time for crystalloid fluid administration. This may potentially be revised in a future version of the *Specifications Manual for National Hospital Inpatient Quality Measures*.

Question 37: **If more than 30 mL/kg fluids ordered, once the full amount has been infused, this time would be the time of completion of fluids? Or should we take the minimum amount of fluids required have been infused?**

If 30 mL/kg is ordered, the completion time of the full 30 mL/kg volume would be used to begin the hour to assess for persistent hypotension. The minimum amount of fluids would be 30 mL/kg per the order.

Question 38: **If there is one systolic blood pressure (SBP) of less than 90, and all of the other SBPs are greater than 90, patient meets severe sepsis criteria within six hours; does the patient still need all of the 30 mL/kg of crystalloid fluid [even if the blood pressure (BP) improves?**

Yes, if initial hypotension is documented within six hours of severe sepsis presentation, 30 mL/kg of crystalloid fluids would be required.

Question 39: **Slide 29: Does the "within 10%" acceptable IVF volume apply to what is ordered or just administered?**

It applies only to what is ordered; thanks for clarifying!

Question 40: **Can IV fluid given in the operating room or post anesthesia care unit/recovery room (OR/PACU) be used? There is usually no order to use.**

In order to use the fluids in the OR/PACU, an order must be present. Otherwise, fluids administered without an order would be disregarded.

Question 41: **If fluids are administered through multiple orders, which time do you use to decide the time frame for tissue perfusion assessment? For the crystalloid fluid element, the last order is supposed to be used. Is it the same for tissue perfusion?**

Yes, you would use the time the last order was initiated if there are multiple orders.

Question 42: **If a patient is administered multiple orders of fluid at a rate of at least 125 cc/hr, within six hours of initial hypotension that total more than 30 cc/kg, would this fulfill the crystalloid fluid administration requirement?**

If crystalloid fluids were administered via multiple physicians' orders at an acceptable rate, all fluid infusions started within six hours prior to six hours after initial hypotension could be used toward the 30 mL/kg total volume.

Question 43: **For the prehospital fluids, is it acceptable for the physician to order 30 mL/kg crystalloid fluid, to include EMS fluids, if the EMS record in the chart meets all requirements except for a physician order or protocol prior to the EMS fluids administered?**

If the physician's order for 30 mL/kg included reference to the pre-arrival fluids, e.g., normal saline 0.9% IV 30 mL/kg bolus, one liter given via EMS, then the pre-arrival fluids could be used. Documentation of fluid administration is also required to be in the medical record.

Question 44: **Does the weight have to be rounded to the nearest whole number?**

If the order for 30 mL/kg includes the exact weight as the basis for the total volume, rounding is not necessary. However, if the order for 30 mL/kg is not based on the patient's exact weight, rounding should be performed.

Question 45: **If the medical record contains EMS records and nursing home records, are we mandated to use them?**

You are not mandated to use them, but it is acceptable to use them to meet the guidelines of the measure.

Question 46: **Do you use ideal or actual weight when calculating the fluid bolus?**

Use the patient's actual weight. Use estimated weight only if actual weight is not available to determine the volume of crystalloid fluids the patient should receive. Do not use ideal weight.

Question 47: **If you don't have a start time for your fluids but have a completion time, do you go back an hour for the start time for the bolus, or use the completed time?**

There are no exceptions; start time has to be present. You cannot accept without the start time.

Question 48: **Other than a patient meeting the criteria for septic shock, is there any other incidence when the crystalloid fluid administration of 30 mL/kg is required?**

Yes, severe sepsis patients meeting initial hypotension, initial lactate greater than or equal to 4, or documentation of septic shock should receive 30 mL/kg of crystalloid fluid resuscitation.

Question 49: **Are we able to use the nurse's "volume infused" amount as sufficient documentation for a time/volume infused/rate requirement?**

No, you need a start time, and rate or end time. Nurse's documentation would not suffice.

Question 50: **Are there any guidelines specific to fluid volume for renal failure patients?**

No, for the current version, there are no specific guidelines.

Question 51: **Are you saying there is no time limit for the fluids to be complete?**

Yes, there is only a time limit for when they have to be initiated by.

Question 52: **If initial hypotension occurs five hours from severe sepsis presentation, how is the initiation of 30 mL/kg fluid resuscitation administration measured, since it is already more than three hours from the severe sepsis presentation time.**

For crystalloid fluid administration, fluids given (started) six hours prior to six hours following initial hypotension, an initial lactate greater than or equal to 4, or documentation of septic shock are acceptable. The crystalloid fluid administration time will be based on how the orders for fluids were written (single vs. multiple). In order to pass the Crystalloid Fluid Administration Time calculation in the algorithm, the crystalloid fluid administration time is required to be within three hours of septic shock presentation.

Question 53: **Estimated weight in the ED is 50 kg and 1500 cc NS is ordered over one hour in the ED, and is infusing in transfer to intensive care unit (ICU) where the actual weight is 55 kg. Which weight is used?**

Use the weight documented closest to and prior to the order for crystalloid fluids. If a weight is not documented prior to the crystalloid fluid order, use the weight recorded closest to and after the crystalloid fluid order. Since the estimated weight is documented prior to the crystalloid fluid order, the estimated weight would be used.

Question 54: **For crystalloid fluid element, if the order is for a bolus but has no rate/time over which to give, does this mean we must answer "No" to Crystalloid Fluid Administration?**

Physician/APN/PA orders with the type of fluid, volume of fluid, and the terms "bolus" or "wide open" are acceptable without a rate or infusion duration, if a rate or time over which the IV fluids are to be given **or** the fluid bolus completed time or end time is documented in the medical record.

Question 55: **If you have NS one liter ordered at 1000 ml/hr and the completion time is noted two hours later, would we take the calculated end time of one hour or the documented time of one hour later?**

You absolutely need the start time; you would use the end time documented that most accurately reflects the time the 30 mL/kg infusion completed. Since the completion time is documented two hours after initiation, this time would be used to begin the hour to assess for persistent hypotension.

Antibiotic (ABX)/Blood Culture (BC)

Question 56: **On slide 18, wouldn't IV ABX given more than 24 hours prior to severe sepsis, exclude that case?**

Slide 18 is about blood culture collection date and time, not antibiotic administration.

Question 57: **Is *C. diff* PO antibiotic administration still acceptable?**

Yes, the administration of oral (PO) vancomycin is acceptable for the Broad Spectrum or Other Antibiotic Selection data element when *Clostridium difficile* (*C. difficile*, *C. diff*) is the causative organism. The patient still has to receive an IV antibiotic to suffice the Broad Spectrum or Other Antibiotic Administration data element.

Question 58: **Scenario: Patient was given IV ABX during/before surgery and then nothing given after surgery. Two days after surgery, patient meets criteria for severe sepsis, and antibiotics are started. Which antibiotic should be extracted, the one from pre-op or the one when criteria was met?**

To choose Value "1," there must be at least one dose of an IV antibiotic given or started in the 24 hours preceding or three hours after the severe sepsis presentation date and time. If the pre-op dose was more than 24 hours prior to severe sepsis presentation, it should not be abstracted, unless there was a dose of the same antibiotic given during the 24 hours prior to severe sepsis presentation.

Question 59: **Can we use the medication administration record (MAR) to determine the route of antibiotics? If not, what other documentation can be used?**

Yes, documentation of the medication route on the MAR is acceptable.

Question 60: **For antibiotics started greater than 72 hours prior to presentation time, should we abstract the earliest time within the 72-hour time frame?**

Do not review for antibiotic doses given more than 72 hours prior to severe sepsis presentation.

Question 61: **Are patients excluded from the measure who have received antibiotics for more than 24 hours prior to severe sepsis time? Logic in our data-collection system is indicating a missed measure if another lactate is not collected at severe sepsis time, even though one may have been collected on the day antibiotics was initiated.**

Yes, patients with a broad spectrum administration time greater than 24 hours prior to severe sepsis presentation will be excluded at the Broad Spectrum Antibiotic Time calculation in the algorithm. However, if an initial lactate was not collected within the specified time frame, the Broad Spectrum Antibiotic Time calculation will not be reached in the algorithm. Therefore, the case would not be excluded due to the point of exclusion not being reached.

Question 62: **Does it have to be the same antibiotic for the entire period before time zero?**

If the patient received any IV antibiotic within the 24 hours preceding or three hours following the severe sepsis presentation date and time, choose Value "1."

Question 63: **Slides 17 and 18: You stated that for the blood culture collection, we can go back 48 hours from severe sepsis presentation; but how would that work if the patient's first dose of the antibiotic received within 24 hours prior to severe sepsis presentation had been given more than 72 hours prior to presentation? If the blood culture was drawn 96 hours prior to severe sepsis presentation, just prior to antibiotic administration, would this then fail the measure?**

While the time frame for the blood culture collection is 48 hours prior to three hours after severe sepsis presentation, the blood culture must also be collected within the 24 hours before the broad spectrum or other antibiotic administration time. Therefore, if a broad spectrum or other antibiotic administration time is greater than 24 hours before severe sepsis presentation, the case would be excluded prior to reaching blood culture collection.

Question 64: **If a patient is on IV antibiotics at home and then present to the hospital in severe sepsis or septic shock, can you use the antibiotic exclusion rule?**

The antibiotic exclusion rule applies if the same antibiotic that was given the 24 hours prior to presentation was also given earlier than 24 hours prior to presentation. If documentation is present demonstrating actual IV antibiotic administration prior to arrival and greater than 24 hours prior to severe sepsis presentation, the case may be excluded at the Broad Spectrum Antibiotic Time calculation.

Question 65: **Slide 18: New guidance does not include ABX given by IV. Is this correct?**

No, it does include IV antibiotics.

Question 66: **Has oral vancomycin for known *C. diff* been added to the acceptable antibiotic choices?**

If the causative organism is identified as *C. difficile*, susceptibility testing is not required, and if the patient is receiving oral vancomycin with or without oral or IV metronidazole (Flagyl), choose Value "1" for the Broad Spectrum or Other Antibiotic Administration Selection data element.

Question 67: **If dual antibiotic therapy (not monotherapy) is used, do both antibiotics have to be infused within three hours?**

For combination antibiotic therapy, both must be started within the three hours following presentation. They do not need to be completely infused within this time frame.

Question 68: **If an antibiotic is not on the monotherapy list, but the MD has documented, such as, daptomycin given for suspected gram positive organism cellulitis, will this meet be using this guideline?**

If an IV antibiotic from Table 5.0 or an appropriate combination of IV antibiotics from Table 5.1 is not started or given within the three hours following presentation of severe sepsis, but there is a lab report or physician/APN/PA documentation indicating the causative organism and susceptibility is known (see exception for *C. difficile*), and an IV antibiotic identified as appropriate to treat the causative organism is given within three hours following presentation of severe sepsis, choose Value "1."

Organ Dysfunction

Question 69: **Did I understand you correctly that if a patient has Coumadin documented as a home med and has an elevated International Normalized Ratio (INR) documented in the same physician note, we will not use INR as organ dysfunction?**

Yes, that is correct.

Question 70: **Slide 10: We are told to "not infer" other causes for systemic inflammatory response syndrome (SIRS) or organ dysfunction criteria unless explicitly stated. Does that mean that we have to have the MD specifically state elevated creatinine is due to end stage renal disease (ESRD) on patients that are currently on dialysis? Same for low platelets on patients currently receiving chemotherapy?**

If the abnormal value or reference to it, and the condition or medication are documented in the same note, the value should not be used. Explicit documentation stating the abnormal value is specifically due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, is not required.

Question 71: **Slide 10: Is there a time frame for a sign of organ dysfunction similar to if infection is present? Example: Physician A documents new onset hypotension at 0100; Physician B states hypotension baseline for patient at 0700.**

Physician/APN/PA documentation that SIRS criteria or a sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, should be documented prior to or within 24 hours after severe sepsis presentation.

Question 72: **If a physician documents that the patient is a chronic renal failure patient and is on dialysis, and the patient's blood urea nitrogen (BUN) and creatinine are elevated, but the physician doesn't document that the renal failure is the reason, should we not use the creatinine of 3.2 as a sign of organ dysfunction?**

If the abnormal value or reference to it, and the condition or medication are documented in the same note, the value should not be used. Explicit documentation stating the abnormal value is specifically due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, is not required.

Question 73: **If physician documents ESRD in record, but doesn't refer to the elevated creatinine, can we not use that for organ dysfunction?**

The documentation must also include either the abnormal value or reference the abnormal value under consideration. If the value or reference to the value is not included in the documentation, inferences should not be made that the documentation pertains to the abnormal value.

Question 74: **Is septic encephalopathy considered organ dysfunction?**

No, please refer to the *Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.2a*, page 1-211 of the Alphabetical Data Dictionary for a list of all organ dysfunction clinical indicators.

Question 75: **Can I consider creatinine greater than 2 level due to renal injury from hydronephrosis and ureteral stenosis acquired two months prior to admission as an organ dysfunction or it has to be chronic greater than six months?**

Physician/APN/PA documentation that SIRS criteria or a sign of organ dysfunction is normal for that patient, is due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, should be documented prior to or within 24 hours after severe sepsis presentation. The documentation must also include either the abnormal value or reference the abnormal value under consideration. If the value or reference to the value is not included in the documentation, inferences should not be made that the documentation pertains to the abnormal value.

Question 76: **If the provider documents the patient is on pre-arrival warfarin and later documents in the note that the INR is elevated, can an abstractor disregard this as an organ dysfunction variable or does there have to be a direct link?**

If the abnormal value or reference to it, and the condition or medication are documented in the same note, the value should not be used. Explicit documentation stating the abnormal value is specifically due to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, is not required.

Question 77: **If patient uses a CPAP or BiPAP at home and is placed on one in hospital, would that be considered chronic and not acute, and therefore, not eligible for organ failure?**

If the patient is on home bilevel positive airway pressure (BiPAP) or continuous positive airway pressure (CPAP) during sleep only, and is placed on continuous BiPAP or CPAP in the hospital, this is a new need. If the patient is on continuous mechanical ventilation at home, it cannot be used for a sign of organ dysfunction.

Question 78: **To clarify, there has to be documentation of acute respiratory failure and patient placed on mechanical ventilation/CPAP/BiPAP for organ dysfunction (clinical criteria "c"), correct?**

Yes, that is correct, thanks.

Question 79: **Acute respiratory failure with new need for mechanical ventilation must be documented within six hours of each other. Does this mean that acute respiratory failure must be documented within six hours of the initiation of the new mechanical ventilation for it to be used for organ dysfunction; or, can we use progress notes that reflect the patient is intubated/ventilated and has acute respiratory failure even if the intubation/ventilation began more than six hours prior to the note?**

Documentation of both "acute respiratory failure" and initiation of mechanical ventilation must be within six hours of criteria "a" and "b." The documentation of "acute respiratory failure" or the time mechanical ventilation is initiated may be used if in a progress note, but the documentation must be within six hours of criteria "a" and "b."

Question 80: **If a patient is placed on new mechanical ventilation and the first documentation of "acute respiratory failure" is greater than six hours after initiation of mechanical ventilation, however the patient is still on mechanical ventilation, is this still acceptable to use for organ dysfunction? And if yes, would you use the documentation of acute respiratory failure time? Thank you for your assistance.**

No, it is not. Both have to be within six hours.

Question 81: **If there is no mention of elevated creatinine, but there is documentation, such as, ESRD, patient on hemodialysis Monday, Wednesday, Friday, will this make it not acceptable for organ dysfunction?**

There has to be a mention of either the elevated creatinine or of the actual creatinine. Explicit linkage is not required. Please refer to the *Additional Notes for Abstraction for the Sepsis (SEP-1) Measure, Version 5.2a*. for more detailed information.

Question 82: **If the provider documents "respiratory arrest," can we take that as a "Yes" to acute respiratory failure? Thank you.**

Yes, you can.

Question 83: **If there is MD documentation of acute respiratory failure but no mention of BiPAP on their note, but you can find BIPAP documentation on respiratory flow sheet, can you still take this as your organ dysfunction?**

Yes; as long as there is documentation of the time the BiPAP or mechanical ventilation was initiated, you can accept it.

Question 84: **If a physician documents ESRD, do they have to link this to the elevated creatinine to have it be considered a preexisting organ dysfunction?**

Yes, they do, but the documentation doesn't have to be explicit. Please refer to the *Additional Notes for Abstraction for the Sepsis (SEP-1) Measure, Version 5.2a*. for more details.

Question 85: **If a physician documents in one place ESRD under current problems, and then later list the labs, with an increased creatinine, then we can consider it a link?**

As long as both are on the same piece of documentation, yes, you can. Please refer to the *Additional Notes for Abstraction for the Sepsis (SEP-1) Measure, Version 5.2a*. for more details.

Question 86: **If a patient comes into the ED with a BP of 86/52, can this be used for organ failure? Or does the doctor have to document it?**

Yes. The clinician doesn't have to document it.

Question 87: **On slide 9, please clarify if the MD must specifically document that the need for mechanical ventilation is a "new" need. Or does the fact that the patient was not already on the CPAP work?**

The clinician does not have to specifically document it; the latter works.

Question 88: **Is it acceptable if the physician documents low platelets are not due to severe sepsis?**

Yes, it is; that is the ideal level of documentation.

Question 89: **With a patient has an elevated INR is a maintenance of Coumadin intake is sufficing reason to exclude this as an organ dysfunction? Thank you.**

There has to be clinician documentation linking the two; it does not have to be explicit. Please refer to the *Additional Notes for Abstraction for the Sepsis (SEP-1) Measure, Version 5.2a*. for more information.

Question 90: **For bullet point 3: If there's documentation of elevated creatinine and patient has a history of ESRD or INR is greater than 2 and patient is on Coumadin, does it have to be explicitly documented in order to exclude, for example, INR greater than 2 due to Coumadin? Or can it just be inferred since chronic condition is present? Thank you for your clarification.**

There has to be a mention of either the elevated creatinine or of the actual creatinine. Explicit linkage is not required. Please refer to the *Additional Notes for Abstraction for the Sepsis (SEP-1) Measure, Version 5.2a*. for more detailed information.

Question 91: **If a patient has ESRD in dialysis and creatinine greater than 2 is the only abnormal value, does a physician need to document the reason for elevated creatinine is due to ESRD in order to not fall into population?**

There has to be a mention of either the elevated creatinine or of the actual creatinine. Explicit linkage is not required. Please refer to the *Additional Notes for Abstraction for the Sepsis (SEP-1) Measure, Version 5.2a*. for more detailed information.

Question 92: **If patient arrives to ER using CPAP from home, does that count if respiratory failure is documented?**

If the patient is on home BiPAP or CPAP during sleep only, and is placed on continuous BiPAP or CPAP in the hospital, this is a new need. If the patient is on continuous mechanical ventilation at home, it cannot be used for a sign of organ dysfunction.

Examination

Question 93: **For the septic shock reassessment, if the provider documents "sepsis focused exam done," will that suffice to complete the septic shock focused exam?**

Yes.

Question 94: **To clarify, for Skin Examination Performed, the reference must include one of any of the three (color, appearance, or condition)?**

Yes, that is correct.

Question 95: **Slide 49: Does the provider have to state sepsis focused exam or is sepsis exam acceptable?**

That would be acceptable, too, thanks.

Question 96: **Clarification for slide 49: If record has a progress note that says, sepsis focused exam or similar, does it need the four components (cardiopulmonary evaluation, capillary refill, peripheral pulse, and skin examination findings) also?**

No, it does not. Documentation indicating a physician/APN/PA has performed, or attested to performing, a physical examination, perfusion (reperfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam is acceptable.

Question 97: **Slide 49: Do they have to reiterate the vital signs?**

No, they do not. Documentation indicating a physician/APN/PA has performed, or attested to performing, a physical examination, perfusion (reperfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam is acceptable.

Question 98: **On the focused reassessment, do the data elements still have to be documented all in the same note?**

Vital Signs Review Performed is the only focused exam data element that required all components (temperature, BP, respiratory rate, and heart rate) be documented in the same note. There never has been a requirement that all data elements making up the focused exam (vital signs, cardiopulmonary evaluation, capillary refill, peripheral pulse, and skin examination) be within the same note.

Question 99: **Does the word "focused" have to appear in conjunction with the statement, "sepsis exam performed"?**

No, it does not, thanks.

Question 100: **Must the documentation of exams done by the MD/APN/PA be documented within six hours of presentation?**

No, the date and time documented by the clinician of when the exam was performed must be before the six hours within presentation deadline.

Question 101: **Slide 50: I interpret it to mean that I only have to use the time of the physician's documentation when the physician does not document the date and time the RN performed the focused exam. Is this correct?**

You should use the time of the physician note that indicates they reviewed nursing documentation of a focused exam data element, unless the physician note includes the time they (the physician) reviewed the nursing documentation.

Question 102: **Is a retrospective attestation of performing the focused exam data element acceptable if date and time are documented?**

Yes, what matters is when it was performed.

Question 103: **Slide 50: What if the start date and time the note was started was the initial note of when the physician evaluated the patient, is that okay to use if the same date and time of the focused exam does not have a date and time?**

If the documentation of a focused exam or a focused exam data element is in a physician note without a specific time documented within the note, use the time the note was started or opened.

Question 104: **Is the history and physical (H&P) acceptable as a focused exam?**

The H&P itself is not acceptable as a focused exam. If there is documentation within the H&P that the physician performed, or attested to performing, a physical examination, perfusion (reperfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam, then that is acceptable.

Question 105: **Can a nurse document that the physician performed the focused exam or does it still have to be the physician?**

Nursing documentation cannot be substituted for physician documentation. Only the physician can document they have performed, or attested to performing, a physical examination, perfusion (reperfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam. The physician can document they have reviewed nursing documentation of specific focused exam data elements, but this still has to be documented by the physician.

Question 106: **Does the focused exam performed need to be within the six-hour time frame? Or can the doctor say it was done within that time frame, say eight hours later?**

Yes, it can be documented outside of the six-hour deadline, as long as the actual exam was performed within six hours. However, the documentation needs to clearly note the date and time of when the exam was performed.

Question 107: **If the physician documents a "sepsis reassessment focus exam was completed," this is sufficient for all five elements to be answered "Yes"?**

Yes, it is. Along with what you mentioned, the date and time are also required**.**

Question 108: **If the focused exam or the blanket statement for the focused exam is made in the physician's H&P, does this count towards the measure?**

It depends, as long as it is clear that the focused exam was performed in the time period beginning after crystalloid fluids and ending six hours after septic shock presentation.

Question 109: **Is it acceptable for the physician to attest to reviewing nursing documentation of the various components of the assessment/reassessment?**

Yes, it is acceptable.

Question 110: **If nursing checks capillary refill, can the physician use this information in their focused exam? (Similar to vital signs review?)**

Yes, the physician can attest to reviewing any of the focused exam elements performed by an RN.

Question 111: **Slide 49: For the focused physical exam elements, would "vital signs reviewed" be acceptable, or must the documentation explicitly state that BP-temperature-pulse-respirations reviewed?**

The former, "vital signs reviewed," would be acceptable.

Question 112: **Slide 49: Does the physician attestation of a nursing assessment have to reference the date and time of the nursing assessment in their attestation?**

Documentation indicating a physician/APN/PA has performed, or attested to performing, a physical examination, perfusion (reperfusion) assessment, or sepsis (severe sepsis or septic shock) focused exam is acceptable. The time of the physician's documentation must be within the specified time frame.

Question 113: **Slide 49: To clarify, if a physician documents "severe sepsis focused exam performed," then we can abstract "Yes" to each element [vitals, cardiopulmonary (CP), capillary refill, pulse, etc.] of the focused exam, without requiring the physician to refer to each element?**

Yes, as long as the clinician also documents the date and time**.**

Question 114: **So instead of documenting the single components of the focused exam, e.g., vital signs, capillary refill, skin examination, peripheral pulse evaluation, the provider can document they completed a severe sepsis/septic shock exam, and that will pass?**

Yes, that will pass.

Question 115: **So, if there is provider documentation that says, "a severe sepsis/septic shock focused exam has been performed," with an acceptable date/time, this will meet for all needed elements of a repeat tissue perfusion assessment?**

Yes, that is correct, thanks.

Question 116: **Clarification of slide 49: If the MD documents focused exam data elements done, abstractor doesn't need to have a date and time for each element?**

Physician documentation that they reviewed each of the focused exam data elements is acceptable, but they need to specify that they reviewed each of them: vital signs, cardiopulmonary evaluation, capillary refill, peripheral pulse, and skin examination. Alternatively, the physician may document that they performed a focused exam. In each case, the physician needs to document the time they performed the review or exam. That single time may be used as the time for each of the focused exam data elements abstracted.

Question 117: **So, relative to focused exam, the MD does not have to document results of each, as long as "sepsis focused exam completed"?**

Correct, thanks!

Question 118: **ED physician documents on septic shock patient after fluids, "reperfusion exam is improved." Would this work for the focused exam?**

Yes, this would, as long as the clinician documents when said focused exam was conducted.

Question 119: **On slide 52, there are elements that must be included in the skin assessment. But on slides 49 and 50, it appears that documentation "skin examined" would be sufficient.**

Yes, that is true. Clinician has multiple options; they do not have to document one of the three characteristics.

Question 120: **Slide 52: Are we able to use this to say "Yes" to focused exam if documentation of the title of "PE" or "physical exam" with documented exam elements following it, but not necessarily including all the focused exam elements?**

A form or section titled "physical exam" is not acceptable. The content within that form or section is what matters. There would need to be a note within the form or section of a form indicating a physical exam was completed, performed, or done. If documented in this manner, the clinician does not have to document all the elements of the focused exam. "PE" would not work, as that acronym can refer to other conditions like pulmonary embolism.

Question 121: **For the focused exam attestation, would the physician document each element of the focused exam, or make a general statement that the focused exam elements were reviewed?**

Physician documentation that they reviewed each of the focused exam data elements is acceptable, but they need to specify that they reviewed each of them: vital signs, cardiopulmonary evaluation, capillary refill, peripheral pulse, and skin examination. Alternatively, the physician may document that they performed a focused exam.

Question 122: **Can RN document tissue perfusion exam and MD documents having reviewed it? For instance, if it occurs in the middle of night.**

Yes, as long as the date and time of when the exam was conducted is clearly documented.

Question 123: **Skin Examination Performed – Can the physician document skin color is normal? Will this have met the measure?**

Yes, that would, thanks. As a bare minimum, the doctor can also note that the skin examination was performed with a date and time.

Question 124: **If the patient is transferred into inpatient before the focused exam is due and the admitting physician documents the elements of a focused exam in their H&P, but does not call it a focused exam, can we count that as meeting the requirement?**

If they are documenting elements of the focused exam and there are appropriate date and times, then yes, it could meet the requirement for each of those data elements separately**.**

Question 125: **Does there have to be evidence in the medical record of the focused exam and its elements if the provider just states they performed an exam or reviewed an exam?**

The clinician stating it would work as long as the date and time are properly documented and within the required time frame.

Question 126: **In reference to the focused exam, a simple physician statement stating, "I have completed a sepsis focus exam," without specifying any additional details about the elements within the exam is sufficient?**

Yes, that is correct, thanks.

Severe Sepsis/Septic Shock Present

Question 127: **Slide 11: Regarding Severe Sepsis Present, if ambulance records can be used to help determine the presence of severe sepsis, can EMS worker, i.e., paramedic, emergency medical technician (EMT), documentation of impression of infection, e.g., cellulitis, sepsis, pneumonia (PNA), etc., be used as a source of infection?**

Only physician/APN/PA or nursing documentation of an infection will suffice as this particular criterion is specified in the data element.

Question 128: **Slide 12: At our hospital, infections are documented as POA a lot. My question is, If, on day two, a physician writes, "sepsis, POA or UTI POA, or PNA POA or some other infection POA," and the patient has severe sepsis clinical criteria met both at admit and when the physician wrote, "sepsis POA and/or etc.," do I take the documented time the physician wrote, "sepsis POA, and/or etc." or the triage time from the ED?**

The abbreviation, POA, is not acceptable to identify severe sepsis presentation date and time because it can mean either present on arrival or present on admission.

Question 129: **If the physician documents severe sepsis later in record that sepsis was present on arrival, and the ED is not documenting sepsis, but patient would meet criteria if infection was suspected, then at what point is sepsis present?**

If severe sepsis is present on arrival to the ED, or severe sepsis is identified in triage (all three clinical criteria must be met or documented during triage), the severe sepsis presentation date and severe sepsis presentation time is the date and time the patient was triaged in the ED. If more than one triage date or time is documented, e.g., "Triage started," and "Triage completed," use the later date or time reflecting triage is completed.

Question 130: **Slide 11: What if our prehospital records are not available for two to three days after arrival. We have been using just the hospital records. Do we have to go back and reference the prehospital records?**

The Introduction to the Data Dictionary section of the *Specifications Manual for National Hospital Inpatient Quality Measures, Version 5.2a*, indicates documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction is acceptable to use.

Question 131: **Slide 8: To clarify, does an admission order with a diagnosis that does not list an infection count as an indication infection is not present? Or does the physician/APN/PA need to state in their documentation that infection is not present?**

The clinician needs to explicitly state that infection is not present.

Question 132: **If the ER practitioner documents no suspicion of infection in the presence of SIRS and organ dysfunction, but the admitting practitioner a few hours later disagrees and documents likely infection, would the time of severe sepsis presentation be when the admitting practitioner documents likely infection?**

As long as all the criteria are within six hours, then yes, the time would be when the admitting clinician documents likely infection**.**

Question 133: **Slide 11: Patient had labs drawn at 945a as an outpatient in hospital lab. Sent to ED in the evening for leukocytosis by primary care physician. Would you use the leukocytosis drawn as outpatient for determining severe sepsis? Next complete blood count (CBC) done next day. Is this considered prehospital record? Use result time?**

Based on the very limited information you have shared, yes, that is correct, and you would use result time of the white blood cell (WBC) count(s) documented in the prior-to-arrival documentation as long as the documentation was part of the medical record.

Question 134: **Is it acceptable for a pharmacist to document an infection?**

Nursing or pharmacist documentation indicating a patient is being treated with an antibiotic for an infection that is within six hours of criteria "b" or "c" is acceptable as a suspected infection, e.g., Levaquin is documented in the medication administration record (MAR) for pneumonia and nursing documentation indicates a dose was given within six hours of criteria "b" and "c," pharmacy note that patient is on vancomycin for pneumonia.

Question 135: **To clarify slide 12, if there's a situation where clinical criteria were not met until six hours after arrival; however, there's physician/ APN/PA documentation in a progress note that states, "patient has severe sepsis POA," would I take the arrival time or the time that the clinical criteria were met? In other words, would the documentation of POA take precedence over the actual clinical criteria?**

The abbreviation, POA, is not acceptable to identify severe sepsis presentation date and time because it can mean either present on arrival or present on admission. If the physician documents "present on arrival," follow the guidance in the severe sepsis time specifications that indicates to use triage time. If the physician documents "present on admission," follow the guidance in the severe sepsis time specifications that indicates to use the earliest documented hospital admission time. If, however, the clinical criteria are met prior to admission, you should use the earlier time.

Question 136: **Slide 11: If an ED physician documents severe sepsis ruled out even though the patient meets criteria, do you select Value "2" for Severe Sepsis Present?**

Yes, that is correct.

Question 137: **Slide 27: If septic shock is only documented after six hours of meeting severe sepsis criteria and clinical criteria for septic shock is not clear, can this be excluded according to the guidelines?**

No, it cannot be excluded. Value "2" would be selected for the Septic Shock Present data element, and the case would be in the numerator rather than excluded.

Question 138: **When nursing homes are within the same hospital system and share an electronic medical record (EMR) system, how should the prehospital records be used? This may change the severe sepsis presentation time if there is SIRS and organ dysfunction criteria met at the nursing home.**

Documentation that is dated prior to arrival to the ED/acute inpatient hospitalization may be used to identify the presence of severe sepsis. The criteria would still need to be met within six hours of each other, and the documentation would need to be part of the medical record. If clinical criteria for severe sepsis is met at the nursing home, this would represent that severe sepsis was present on arrival to the ED, in which case, triage time would be used for presentation time.

Question 139: **Slide 27: Does the documentation have to be after the documentation of severe sepsis/septic shock? For example, surgery documentation indicates hypotension and elevated lactic acid are related to hemorrhagic shock. Four minutes later, intensivist documents cannot rule out severe sepsis/septic shock. Would surgery invalidate this documentation? Surgery documentation was prior to.**

Yes, the conflicting documentation would have to be after.

Question 140: **What if the physician documents initially and/or repeatedly, that the patient does not have severe sepsis or septic shock, but if I take it through the criteria, it meets as one or both?**

If physician documents no severe sepsis/septic shock initially, but patient meets criteria after said documentation, you would abstract that case. If the documentation of no severe sepsis/septic shock is after the criteria are met, you should disregard the criteria.

Question 141: **If severe sepsis is present with persistent hypotension, is the shock time the time of the second low BP?**

Use the time at which the last sign of septic shock was noted**.**

Question 142: **Slide 27: If patient has hypotension one hour after crystalloid fluids or lactate level greater than 4, can providers document that the patient did not have septic shock?**

If there is documentation of clinical criteria being met or physician/ APN/PA documentation of septic shock, and within six hours there is additional physician/APN/PA documentation indicating the patient does not have septic shock, choose Value "2."

Question 143: **To be clear, if the BP criteria for shock are not met, but the lactic acid (LA) is greater than 4, is this considered septic shock?**

As long as severe sepsis is present, an initial lactate level result greater than or equal to 4 mmol/L is acceptable for meeting criteria for septic shock.

Question 144: **If the physician documents no to septic shock, but the initial lactate is greater than 4, do we disregard the lactate of greater than 4 and say no to septic shock?**

If there is documentation of clinical criteria being met or physician/ APN/PA documentation of septic shock and within six hours, there is additional physician/APN/PA documentation indicating the patient does not have septic shock, choose Value "2."

Question 145: **If a nurse states on triage, patient recently diagnosed with [upper respiratory tract infection] URI, started on Levaquin, but ER MD states infection ruled out; however, admitting MD states, no source of infection found, but will treat for possible infection with ABX, do you revert back to triage time for suspicion of infection? Or use the time admitting MD documented cover for possible infection?**

If the ED physician documentation stating infection ruled out is within six hours of the nursing documentation, you would disregard the nursing documentation. You would use the later time the admitting physician documented a possible infection.

Question 146: **Slide 38: To determine septic shock, do you have to have one BP in the hour after fluid administration, or do you have to have two?**

Determination of septic shock based on documentation supporting severe sepsis **and** persistent hypotension requires two consecutive documented low BP readings.

Question 147: **What if you have two doctors saying infection and one says it's not? I had that happen and wasn't sure what to do.**

If there is documentation of clinical criteria being met or physician/ APN/PA documentation of severe sepsis, and within six hours there is additional physician/APN/PA documentation indicating the patient does not have severe sepsis, choose Value "2."

Question 148: **Slide 37: What if there is documentation prior to septic shock that there was not septic shock. The slide says, "within six hours" and does not indicate only using documentation in the six hours following septic shock. Is it six hours before to six hours after?**

If clinical criteria are met after clinician documentation, then you can abstract for septic shock present.

Question 149: **My question is whether the lab notation of hemolysis constitutes a questionable finding?**

If this was physician/APN/PA or nursing documentation, the lab could be considered questionable.

Question 150: **When the physician documents "septic shock" and the patient does not meet clinical criteria for severe sepsis, is the documentation of "septic shock" considered the severe sepsis presentation time?**

If clinical criteria for severe sepsis are not documented, and there is not physician/APN/PA documentation of severe sepsis, but there is physician/APN/PA documentation of septic shock, choose Value "1." Presentation time for severe sepsis and septic shock would be the same.

Question 151: **Can a septic shock/severe sepsis physician order set be used to determine septic shock/severe sepsis present?**

A presence of sepsis, severe sepsis, or septic shock order set should not be used for a suspected infection or documentation of severe sepsis unless an infection, severe sepsis, or septic shock is clearly documented within the order as present or suspected.

Question 152: **If a physician documents septic shock in reference to the past, i.e., "patient developed septic shock overnight," but their basis for documentation is in relation to a drop in BP and the patient did not meet severe sepsis criteria, would it be considered "Yes" to septic shock because the physician documented it; and would you be required to take the timing of shock as the time of the note?**

If clinical criteria for severe sepsis are not documented and there is not physician/APN/PA documentation of severe sepsis, but there is physician/APN/PA documentation of septic shock, choose Value "1." Presentation time for severe sepsis and septic shock would be the same. If the note does not include a specific presentation time, use the note time. If the note references a time prior to arrival, consider severe sepsis and septic shock present on arrival, and follow abstraction guidance in the Severe Sepsis Presentation Time data element.

Question 153: **Presentation time confuses me. If patient arrives in ED at 0800, WBC lactate drawn at 1000 and resulted at 1100; and WBC is greater than 12 and lactate is greater than 4, does that mean presentation time is time patient triaged in ED? 0800?**

Severe sepsis presentation time is the time at which the last criterion was met to establish the presence of severe sepsis. If all criteria were met prior to or in triage, use triage time.

Question 154: **To be clear, if the patient meets criteria in category "b" and "c" for severe sepsis at triage and the MD note (which states sepsis) is not signed until four hours later, do we use the triage time as the start time?**

Severe sepsis presentation time is the time at which the last criterion was met to establish the presence of severe sepsis.

Question 155: **If, within six hours, a subsequent provider documents that septic shock is possible explanation for hypotension, but that a more likely cause is a noninfectious process, is that adequate to disregard the first documentation?**

No, since the physician documented "septic shock is possible," then "Yes" could be selected for septic shock present. Also, since the documentation does not indicate septic shock is not present, the latter documentation would not be used to disregard the documentation of septic shock.

Question 156: **If a patient presents to ED with normal vital signs (VS), and develops severe sepsis during ED stay, example one to two hours later, hypotension, tachycardia, elevated temp, is the triage time still considered the time of severe sepsis?**

Severe sepsis presentation time is the time at which the last criterion was met to establish the presence of severe sepsis.

Question 157: **If the physician documents a specific time for severe sepsis in their note, can we use that time or do we have to use the time the note was started?**

The former; you would use the time the clinician documents.

Question 158: **Just to clarify, if "severe sepsis POA" is documented, it's not acceptable to use the triage time for the severe sepsis time? It has to be spelled out "present on arrival" or "present on admit"?**

Yes, that is correct.

Question 159: **Is an order for hourly output acceptable? Or does it need to be documentation that hourly output was actually done?**

Documentation must clearly indicate that urine output is being monitored hourly to be able to use this as organ dysfunction.

Question 160: **If documented septic shock by MD, but no SIRS criteria or evidence of severe sepsis or documentation, would [this] qualify for a severe sepsis case only?**

If clinical criteria for severe sepsis are not documented and there is not physician/APN/PA documentation of severe sepsis, but there is physician/APN/PA documentation of septic shock, the case will qualify for both Severe Sepsis Present and Septic Shock Present data elements.

Question 161: **When the MD ED note is signed off hours after the patient leaves the ED, should the time seen be used?**

If a suspected infection, severe sepsis, or septic shock is in a physician note without a specific date documented within the note, use the date the note was started or opened. Guidance to abstract a note-signed time is not provided.

Please follow up if necessary, and ask the question through the *QualityNet* website for clarification of your question and a more complete response, located at https://cms-ip.custhelp.com/app/utils/login_form/redirect/ask.

Question 162: **Slide 12: Severe sepsis present on arrival. If this is documented six hours after other documentation of severe sepsis, would this be disregarded or do we go back and take triage time?**

You would go back and take the time the patient was triaged in the ED.

Question 163: **Slide 37: So, we have a lactate of greater than 4, but the physician says no to septic shock; we disregard the lactate of greater than 4?**

If there is documentation of clinical criteria being met or physician/ APN/PA documentation of septic shock, and within six hours there is additional physician/APN/PA documentation indicating the patient does not have septic shock, choose Value "2."

Question 164: **So all patients with a final diagnosis related group (DRG) of "sepsis" or related condition, "severe sepsis, etc." upon discharge, will be looked at by CMS, correct? We have a lot of patients admitted for sepsis, but it was either ruled out or found to be another diagnosis, not sepsis-related.**

Yes, that is correct.

Question 165: **Initially, if all three criteria for severe sepsis were not met, but blood cultures and lactates were performed, then 12 hours later the provider documents severe sepsis or septic shock, does that documentation qualify? Or since that is not within the six-hour window, it doesn't qualify?**

Because the lactate in this case was drawn more than six hours prior to presentation (12 hours) the lactate cannot be used for abstraction of the Initial Lactate Level Collection data element. The blood culture is still acceptable because they are also tied to antibiotic start time and there is a longer time frame prior to presentation for blood culture draws.

Question 166: **If I have a chest x-ray (CXR) that is read by a physician that states infiltrates both lower lobes, PNA cannot be ruled out or suspicious for PNA, but there is no indication for the test stating suspected infection, and the patient has two SIRS and lactic acid level greater than 2.0, can I use this CXR documentation to start severe sepsis?**

The documentation including pneumonia or suspicious for pneumonia by the physician would be acceptable. Results of tests without documentation of a suspected infection, e.g., infiltrates on chest x-ray, positive cultures, are in the exclusion guidelines for infections.

Question 167: **If you have an infection documented early on, and later in stay, they meet severe sepsis, but had not had infection documented within six hours, do we assume infection is still present?**

You cannot assume; criteria require documentation of all three criteria within a six-hour period.

Question 168: **Is atrial fibrillation (Afib) with rapid ventricular response (RVR) hr. 130s adequate to exclude heart rate from SIRS criteria, or should there be documentation that the Afib is not related to infection?**

If there is physician/APN/PA documentation that SIRS criteria or a sign of organ dysfunction is due to an acute condition that is not an infection, it should not be used. Inferences should not be made; physician/APN/PA documentation is required.

Question 169: **If an emergency care (EC) MD documents sepsis or an infection as a differential diagnosis, and the admitting MD does not document anything about sepsis in their admitting H&P, should this be considered negated?**

Because this is physician documentation, it is acceptable. It would not be used if the admitting physician were to document sepsis or infection is not present or has been ruled out.

Question 170: **A blood culture is ordered and the order states, "Is infection suspected?" Can this be used for documentation of infection?**

If the order for the blood culture indicates the reason for the culture is suspected infection or there is an order reason required, such as, "Is infection suspected?" with a response of "Yes," this is sufficient documentation of a suspected infection for criteria "a."

Question 171: **If there is a positive nursing screen followed by MD documentation that there is no infection, then later (but within six hours), another MD documents that he suspects infection, should the initial nursing screen be used for the time of suspicion?**

The physician documentation there is no infection that occurs within six hours of the nursing screening will result in disregarding the nursing documentation. The later physician documentation of suspected infection should be used.

Question 172: **Slides 12 and 40: If MD signs a query stating severe sepsis was present on arrival, are we required to use the time of arrival for severe sepsis time, even if criteria is not entered in the record until later?**

If the physician documentation stating severe sepsis was present on arrival, and time the query is signed is prior to discharge, and the query is considered part of the medical record, then follow abstraction guidance for patients presenting with severe sepsis on arrival.

Question 173: **If provider only documents the bacteria and not the infection related to the bacteria, do we use this documentation as infection source?**

Exclusion guidelines for infections are as follows: colonization, positive screens, or positive cultures, e.g., methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE), or for other bacteria, without physician/APN/PA documentation referencing an infection.

Question 174: **Do we say no to severe sepsis present if the infection is ruled out later in the patient's stay?**

If an infection is documented as present, suspected, or possible, but within six hours following the initial documentation of the infection, there is physician/APN/PA documentation indicating the infection is not present, disregard the documentation of the infection**.**

Question 175: **If a radiologist in his documentation on a CXR or computed tomography (CT) read documents infection, is this acceptable for infection documentation?**

Because this is physician documentation, it is acceptable. It would not be used if the admitting physician were to document sepsis or infection is not present or has been ruled out.

Question 176: **If an MD diagnoses no septic shock, and then afterwards, an MD diagnoses septic shock, can you still select Value "2," if they are within six hours?**

No, in that case you would select Value "1**."**

Question 177: **If a provider documents in an antibiotic order that the indication is for "severe sepsis or septic shock," do we consider this as documentation as septic shock present?**

Any physician/APN/PA documentation counts for documentation of severe sepsis or septic shock.

Question 178: **If a patient has been admitted for an infection, i.e., urinary tract infection (UTI); however, does not meet severe sepsis criteria until the next day, do I still need to find documentation of suspected or confirmed infection at the time SIRS and organ dysfunction criteria are met? I already know from admission that this patient has an infection.**

All three criteria must be met within a six-hour time window and that includes documentation or evidence of criteria "a."

Question 179: **What if patient meets all measures for severe sepsis but the physician documents no severe sepsis? Is this acceptable to choose Value "2"?**

If there is documentation of clinical criteria being met or physician/ APN/PA documentation of severe sepsis and within six hours, there is additional physician/APN/PA documentation indicating the patient does not have severe sepsis, choose Value "2."

Contraindications

Question 180: **Slide 13: If patient initially refuses, then later consents within a timely fashion, would we still say, "refused"?**

If there is sufficient documentation of a refusal of IV fluids, antibiotics, or blood draws, you can mark refused even if the patient later consents.

Question 181: **Slide 14: Does that mean documentation of discussion for withdraw of care or hospice care is acceptable? For example, MD documents family is discussing withdraw of care at this time; is this case now to be excluded?**

That slide is trying to communicate that no type of discussion is acceptable anymore. Documentation to "withdraw care" is now an acceptable term for the Directive for Comfort Care or Palliative Care data elements.

Question 182: **Do two nurses have to witness for the refusal of care to be acceptable?**

Nursing documentation of patient refusal is acceptable. Two nurses do not have to witness the refusal of care for it to be acceptable.

Question 183: **Regarding on-hospice patient, if the patient is a hospice in admission, will [the case] be excluded for the measure?**

Physician/APN/PA documentation of hospice care that was prior to or within three hours of the presentation of severe sepsis is acceptable. Documentation that is dated prior to arrival or documentation that refers to a pre-arrival period that is not in a state-authorized portable order (SAPO), medical orders for life-sustaining treatment (MOLST), physician orders for life-sustaining treatment (POLST), etc., should be disregarded.

Question 184: **So if there is a consult for comfort care but no order placed/decision made yet that is acceptable and within the time frame of time zero, it may be excluded?**

If the physician has documented they are obtaining, plan to order, or there is an order for a consult for comfort care, this is acceptable.

Question 185: **A consult for comfort care by a palliative care specialist may result in the patient/family deciding no comfort measures only (CMO), that they want full measures/efforts taken for care; thus, a consult would not be a "Yes" to comfort care, is this correct?**

An order for a palliative care specialist would suffice.

Question 186: **Palliative care is not considered the same as comfort care?**

For the purposes of this measure and its allowable values, yes, it is.

Question 187: **Slide 14: Does a consult for palliative care count?**

A consult is acceptable.

Question 188: **If a patient has a consult for palliative medicine entered and/or physician documentation of withdrawal, but not a formal Do Not Resuscitate – Comfort Care (DNRCC) order within six hours of admission, does this count towards exclusion?**

If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is CMO or palliative care, **and** there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is **not** CMO or palliative care, the source that indicates the patient is CMO or palliative care would be used.

Hypotension

Question 189: **Slide 46: How can we determine "persistent hypotension" based on prehospital documentation? Does this mean we would need to know the patient had received 30 mL/kg fluids within six hours prior to arrival?**

Yes, you could only use prehospital records if it is part of the patient's medical record. You would also have to know that the patient received the appropriate fluids.

Question 190: **Slide 26: Hypotension due to hypovolemia – is this acceptable?**

Since the documentation considers the hypotension to be due to an acute condition that is not an infection, i.e, hypovolemia, the hypotensive readings would not be used to meet criteria.

Question 191: **If the documentation states transient hypotension, is that sufficient or does a more specific reason need to be given?**

Unless there is documentation that the hypotensive value is normal for the patient, due to a chronic condition, due to an acute condition that is not an infection, or due to a medication, the hypotensive value could be used. The measure does not provide an exclusion at this time for a single transient low BP.

Question 192: **Does the erroneous hypotension documentation need to be documented within six hours?**

If there is physician/APN/PA documentation indicating the patient does not have hypotension, and it is referencing a specific time period in which there was one or more low BP value(s) recorded, the low BP value(s) should not be used. The documentation must be within 24 hours following the low BP value(s).

Question 193: **Does documentation that low BP is normal have to be specific, i.e., "SBP less than 90 is normal for this patient"?**

The documentation must also include either the BP value or reference to the low BP under consideration. If the value or reference to the value is not included in the documentation, inferences should not be made that the documentation pertains to the abnormal value.

Question 194: **Slide 26: If physician writes, hypotension is not due to sepsis or it is due to gastrointestinal (GI) bleed, is that acceptable?**

Yes, that would be acceptable.

Question 195: **Low BP cannot be taken from the VS flow sheet now, only in MD/nurse practitioner (NP) documentation?**

BP values from the VS flow sheet can be taken to meet criteria for initial hypotension.

Question 196: **Slide 26: This question is in regard to initial hypotension. Should the physician/APN/PA documentation that SBP is normal or related to a chronic condition, is due to an acute condition that is not an infection, or is due to a medication, be six hours prior to or within six hours following severe sepsis presentation? Or can it be anywhere within the episode of care, i.e., no time frame?**

If there is physician/APN/PA documentation indicating the patient does not have hypotension, and it is referencing a specific time period in which there was one or more low BP value(s) recorded, the low BP value(s) should not be used. The documentation must be within 24 hours following the low BP value(s).

Question 197: **Is there a time frame that the documentation needs to be present for the questionable BP readings?**

If there is physician/APN/PA documentation indicating the patient does not have hypotension, and it is referencing a specific time period in which there was one or more low BP value(s) recorded, the low BP value(s) should not be used. The documentation must be within 24 hours following the low BP value(s).

Question 198: **Is CHF considered a chronic condition to exclude BPs?**

The documentation must also include either the BP value or reference to the low BP under consideration. If the value or reference to the value is not included in the documentation, inferences should not be made that the documentation pertains to the abnormal value.

Question 199: **Slide 45: On the additional notes for version 5.1, it was stated, If there are two consecutive low BP readings, followed by one or more normal readings, select Value "2." Is this still an option with this manual update?**

Yes, that is still true.

Question 200: **What if SBP is less than 90 but mean atrial pressure (MAP) is greater than 65; is it considered a hypotension episode?**

Yes, it is.

Question 201: **For persistent hypotension, do the BPs need to be two serial BPs or can you use any two low BPs within the hour after fluid resuscitation has been completed?**

If there are multiple BP readings, but there are not two consecutive low readings, select Value "2."

Question 202: **Does the flow sheet that central venous pressure (CVP) is recorded on still have to have via central venous catheter (CVC) or can we not just use any reading labeled as a CVP?**

Documentation CVP or central venous oxygen saturation (ScvO2) on the CVP flow sheet would be acceptable documentation reflecting the reading was obtained via central catheter.

Question 203: **If two consecutive systolic BPs are less than 90, followed by one that is above 90 within the hour following completion of the 30 mL/kg crystalloid fluid bolus, do we answer "No" to persistent hypotension?**

If there are two consecutive low BP readings, followed by one or more normal readings, select Value "2."

Question 204: **Will a case fail if there is only one BP reading in the hour following fluid bolus?**

No, the case would proceed to initial lactate level result**.**

Program Questions

Question 205: **Our physicians would like to submit a letter related to the elements that they do not agree with, such as, including the differential diagnosis or "possible" in the data element. Can you please tell us where we can send this letter?**

Please follow up and send your letter through the *QualityNet* website for clarification of your question and a more complete response, which is located at https://cms-ip.custhelp.com/app/utils/login_form/redirect/ask.

Question 206: **When are the new guidelines to be used?**

The new guidelines are in agreement with the protocols of care for SEP-1**.**

Question 207: **Where can the additional notes for abstraction be found?**

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775749207

Question 208: **Is the expanded guidance specified in the CMS specifications manual?**

Yes, it is, please find it here:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775749207

Additional

Question 209: **To clarify slides 6 and 7 reference, we are discussing updates to "v5.2," but isn't it supposed to be "v5.2a"? Just want to make sure I'm not missing a manual version somewhere.**

You are correct. The presentation is relevant for the specifications manual, version 5.2a, which replaces v5.2. Information in the presentation is still relevant.

Question 210: **If the provider documents that the patient has ARDS, can we take that as a "Yes" to acute hypoxic respiratory failure?**

Yes, if acute respiratory distress syndrome (ARDS) is consistent with expanded acceptable terms in the *Additional Notes for Abstraction for the Sepsis (SEP-1) Measure, Version 5.2a*. If documented, and there is also documentation of being placed on mechanical ventilation, both within six hours of other criteria, it can be used for organ dysfunction.

Question 211: **Slide 8: What if there is conflicting data among practitioners?**

If one practitioner documents suspected infection and within six hours of this, another practitioner documents no infection, the second documentation can be used to disregard the first documentation.

Question 212: **Has the noninvasive (BiPAP/CPAP) management of respiratory failure been removed?**

No, this is a form of mechanical ventilation and remains in the specifications manual.

Question 213: **On slide 9, you discussed mechanical ventilation. Are BiPAP and CPAP still acceptable, if this is a new issue for this patient?**

Yes, BiPAP and CPAP are still acceptable for mechanical ventilation.

Question 214: **Slide 30: Can we utilize documentation if the MD writes an order for normal saline 30 milliliters per kilogram bolus and nursing documents the total amounts infused?**

So, what would happen in this case, because the physician order is for 30 mls per kilogram, the physician order has the appropriate volume in it. Now, to determine whether or not 30 mls per kilogram were actually given, you would have to rely upon the nurse's documentation of the fluid volume given, and then based on the patient's weight, determine if they actually received that amount. But this would suffice for the order part of it.

Question 215: **Slide 14: Does a consult for comfort care count?**

Yes, this is acceptable because "comfort care" is one of the **only** acceptable terms in the data element.

Question 216: **If the ER practitioner documents no suspicion of infection in the presence of SIRS and organ dysfunction, but the admitting practitioner a few hours later disagrees and documents likely infection, would the time of severe sepsis presentation [be], say, when the admitting practitioner documents likely infection?**

So, keep in mind when you are abstracting for the clinical criteria, it's when the last of the three criteria, either infection, SIRS, or organ dysfunction are met, that marks the severe sepsis present time.

So, in this situation, if the ED practitioner documented no suspicion of infection, we don't have that criteria met. But, if there are SIRS and organ dysfunction, we've got those met. And then, the subsequent documentation by the admitting practitioner states likely infection.

And, if that SIRS, organ dysfunction, and the admitting physician documentation are all within the same six-hour period, that would meet the criteria for severe sepsis.

And, because the last of the criteria is the physician documentation, that would mark the severe sepsis presentation time.

Question 217: **Slide 50: Can the physician/APN/PA document sepsis focused exam completed within documenting each individual element? If yes, would we put the date, time the physician entered to the documentation, or the date, time of each element completed?**

In version 5.2a of the specifications manual, the options that will allow a physician to indicate that a focused exam has been completed have been expanded. If a physician documents that they have completed a focused – sepsis focused – exam, then that would be used. You could use that to select "Yes" for every single one of the data elements that make up the focused exam. And then, the date and time you used for those individual data elements are the date and time of the note.

Question 218: **Is the initiation of the MV, and I am assuming MV is mechanical ventilation, so again, is the initiation of the MV on documentation of acute respiratory failure both in six hours, or if the patient is already on MV initiated greater than six hours before the documentation of acute respiratory failure, is that acceptable for organ dysfunction (OD)?**

When referencing OD, that would be the organ dysfunction part of the severe sepsis criteria, just so that everybody is clear on that.

So, what we are looking at for this is that within six hours, all the criteria must be met. So, for the organ dysfunction criteria, if it's being based on acute respiratory failure, there would have to be both documentation of acute respiratory failure and documentation the mechanical ventilation was started; and both of those would need to be within six hours of the other criteria.

So, let's say, for example, a patient was placed on a ventilator on admission. The next day the SIRS criteria, suspected infection, was documented and the physician documented acute respiratory failure. Because the ventilator was started outside of that six-hour period, you couldn't use that as the sign of organ dysfunction.

Question 219: **Slide 28: In order to say "Yes" to Crystalloid Fluid Administration, is 30 mls per kilogram required to be infused within three hours of sepsis presentation time?**

In this situation, what we are looking at for crystalloid fluid administration is that the 30 mls per kilogram are started within the three hours.

So, the time that you are entering for a crystalloid fluid administration would be the time that the 30 mls per kilogram is started. And, there is guidance within the specifications manual about different scenarios: where it may be ordered as individual boluses, and each of those individual boluses started after each order, or ordered the full 30 mls per kilogram, is ordered in a single order, but had to be given via numerous boluses.

But, the essence of it is, the requirement for the algorithm calculation is that it would be started within the three hours; it does not need to be completely infused within the three hours.

Comments

Question 220: **Slide 8: The infection not present or severe sepsis is allowed, then why is the physician note that writes not sepsis, not acceptable?**

Currently, documentation of not sepsis will result in disregarding documentation of sepsis or possibly disregarding documentation of the infection. We are currently evaluating documentation of not sepsis as a possible consideration for excluding the case from the measure.

Question 221: **So it sounds like we are now having to comb through the pre-arrival information in the chart now, too?**

Prehospital records that are a part of the patient's medical record can be used in certain cases.

Question 222: **Slide 10: Why do the two SIRS, organ dysfunction, and infection not need to align all at the same time (having started in a six-hour window)? We often can have a patient that has an increased respiratory rate as they are being managed on the vent, then that is corrected, patient has then an elevated heart rate (treated with pain medication), then that is resolved, and finally there is a low MAP. All [are] in a six-hour window, but none of them aligning up at the same time. Can you explain why we would be using … that as a start time? Note: Patient infection had already been identified and being treated during the hospital stay.**

Requiring all criteria to align at the same time is not realistic and would result in few cases being eligible for the measure. Six hours was considered a reasonable time frame within all criteria would be met and have a high likelihood of representing severe sepsis.

Question 223: **Why is the word "performed" important? If an exam is documented, isn't it assumed it was "performed"?**

Yes, it is. Documentation doesn't need to use the word "performed."

Question 224: **Our providers are very concerned that for our heart failure patients with sepsis, the fluid volume requirements may overload the patient. Why is there not any allowance for documentation of this issue and lower volumes of fluids be appropriate?**

There is no evidence that heart failure or dialysis patients have any negative outcomes related to the fluid bolus. Rather, there is extensive evidence that these patients benefit from fluid resuscitation and have better outcomes when fluids are administered.

Question 225: **Slide 29: Now we have to figure 10% lower than the recommended volume and say that is okay? Why change now!?! Please repeat that screen.**

The 10% allowance applies to the volume ordered only. This gives some flexibility in that ordered volumes between 10% less than 30 mL/kg through 30 mL/kg are now acceptable. This takes into account calculations based on estimated weights or rounding of volumes while still ensuring adequate volumes of fluids are ordered. The amount infused must be the amount ordered.

Question 226: **If nursing documentation of suspected infection is no longer acceptable, how would all the criteria for severe sepsis be met in triage?**

Physician/APN/PA or nursing documentation referencing an infection, suspected infection, current treatment of an infection, or including the word infection, or form of the word infection, e.g., consider infectious vs. inflammatory process, possible infectious process, suspect infection of unknown source, is acceptable.

Question 227: **If this measure is tied to the order, how is it okay to count this without an order? My question relates to the use of prehospital records.**

In reference to crystalloid fluids, there still needs to be an order for the fluids that meets the order requirements set forth in the Crystalloid Fluid Administration data element. If a sufficient order for prehospital fluids is present, those fluids can be counted toward the 30 mL/kg.

Question 228: **Slide 18: New guidance does not include antibiotics given by IV. Is this an omission?**

Only IV antibiotics are acceptable for this measure.

Question 229: **Why does the persistent hypotension time element start after the initial 30 mL/kg IVF given rather than after completion?**

The hour to start looking for persistent hypotension does begin after the 30 mL/kg is completely infused. The first bullet point in the persistent hypotension notes for abstraction states, "Begin abstracting at the time the 30 mL/kg crystalloid fluid administration concludes…"

Question 230: **If crystalloid fluids are to be started within three hours, then why can't we use the time of the initial crystalloid that was infused in the case of multiple physician orders?**

To ensure that the final infusion, which completes what was ordered, was initiated within the appropriate time frame.

Question 231: **What about high partial thromboplastin time (PTT) in patient on heparin drip or high INR in patient on Coumadin? Our clinical pharmacists manage the anticoagulation. They state therapy goals. Why isn't clinical pharmacist documentation used?**

We are looking into ways to better capture exclusion of INR and PTT for patients on anticoagulants.

Question 232: **If 30 mL/kg of fluid is not appropriate for the patient to receive and the physician documents the reason for contraindication, will this ever be taken into consideration? Example: pulmonary edema, morbidly obese, etc.**

We are currently evaluating the crystalloid fluid guidelines for some conditions to be considered differently.

Question 233: **Will there be additional notes for abstraction for v5.2a? Currently, there are none on *QualityNet*.**

These were posted on *QualityNet* on 1/10/2017:

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228775749207.

Question 234: **Regarding focused reassessment, will there be consideration to allow noninvasive hemodynamic monitoring, e.g., the Cheetah device, to count as one of the interventions to reassess for septic shock?**

Not that we are aware of at this time. Your feedback is appreciated and has been shared with the measure stewards.

Question 235: **I see that ischemic/necrotic/infarcted bowel is listed in the infection sources. I can't find anything that suggests these are caused by infection or that these are infections, but rather they can lead to infections. Should we begin looking for other conditions that can "lead" to infections?**

As part of the current guidelines, you may consider ischemic/necrotic/infarcted bowel as an infection source.

Question 236: **With the last algorithm change, patients without an initial lactate stop at that point, and if they had been on antibiotics greater than 24 hours, they are not excluded – is there any plan to change the algorithm to include this exclusion?**

This will be addressed in the following version.

Question 237: **Slide 53: Is there any consideration to use stroke volume variation (SVV) or stroke volume index (SVI) as tissue perfusion assessment? We have been using these values to guide our sepsis care with great success.**

Not that we are aware of at this time. Your feedback is appreciated and has been shared with the measure stewards.

Question 238: **It sounds like IV fluids administered by paramedics under county protocols still cannot be counted, since those protocols are not part of the medical record. Is that correct? If so, would you please consider allowing prehospital IV fluids without a charted order in an upcoming version update? When we cannot count IV fluids given prehospital, and the expectation is that the full 30 mL/kg be given in the hospital, this creates a safety issue for our patients; we must either give fluids in significant excess of 30 mL/kg to meet measure or fail the measure.**

You are correct. We are looking at ways to account for fluids given prehospital for which documentation may not meet the current requirements for an order.

Question 239: **Ventricular assist device (VAD): Some patients present with acute heart failure (HF) and cardiogenic shock, but do not have a VAD. Typical case is endocarditis patient with severe sepsis/septic shock and heart failure at the same time. Are there other changes coming to accommodate for the acutely ill HF patients?**

Not that we are aware of at this time. Your feedback is appreciated and has been shared with the measure stewards.

Question 240: **There was a revised exception stating that if the causative organism is identified as *C. difficile*, and the patient is receiving oral vancomycin with or without oral or IV Flagyl, we can choose Value "1" for our Broad Spectrum or Other Antibiotic Administration data element selection. However, the specifications manual keeps saying patient has to have IV route antibiotics. Do you know if this will get corrected in the specifications manual?**

There are no plans at this point since any IV antibiotic given in the 24 hours prior is acceptable and IV Flagyl is considered appropriate for patients with severe or complicated *C. difficile*. The measure stewards and CMS are continually evaluating feedback from the measure**.**

Question 241: **Will there be any exclusions for the full 30 mL/kg bolus infusion?**

Exclusions are not currently being considered.

Question 242: **Is there any consideration to using when the first fluid bolus is ordered when multiple orders in the ED are used, to meet the 30 cc/kg? This happens often when the patient presents with a low BP and workup is in progress. The current guidelines skew the abstraction for reassessment.**

Not that we are aware of at this time. Your feedback is appreciated and has been shared with the measure stewards.