Inpatient Quality Reporting (IQR) Program

Support Contractor

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

Presentation Transcript

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Candace Jackson: Hello and welcome to the Hospital Inpatient Quality Reporting Program webinar on the *SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock Version 5.2 Measure Updates*. My name is Candace Jackson, and I will be your host for today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the questions and answers will be posted to our inpatient website, www.qualityreportingcenter.com, generally within 10 business days. If you registered for this event, a reminder email, as well as the slides was sent to your email about two hours ago. If you did not receive that email, you can download the slides at our inpatient website, and again that's www.qualityreportingcenter.com. And now, I'd like to introduce our guest speaker for today, Bob Dickerson. Bob is the Lead Health Informatics Solution Coordinator for the Measures Development and Maintenance team at Telligen. He is a registered Respiratory Therapist with a Master's of Science degree in Health Services Administration from the University of St. Francis in Joliet,

Illinois. Most recently, Bob has been supporting the Centers for Medicare & Medicaid Services with development and maintenance of hospital clinical quality measures. Bob has extensive healthcare process and quality improvement experience, including development and implementation, intervention, processes, and systems in the hospital setting to support national quality measures. His experience includes facilitation and intervention, implementation, data collection, and process improvements related to severe sepsis and septic shock in the hospital setting for the surviving sepsis campaign. Again any questions that are not answered during our question and answer session at the end of the webinar will be posted to the qualityreportingcenter.com website, generally within 10 business day. We do ask that if you submit a question through the chat feature that you be very specific and, if possible, reference the slide number that you are asking about. Please be aware that not all questions submitted through the chat may be answered during the presentation. Thank you again to everyone for joining. Bob, the floor is yours.

Bob Dickerson: Thank you, Candace, and hello, everyone. CMS, the measure steward, and the measure writers have been listening to the feedback related to SEP-1. Recommendations and comments have been carefully considered in relation to published evidence where applicable. Revisions to the measure illustrate the outcome of this review. There are many factors involved in this process that may have limited the ability to implement every change. As such, evaluation feedback and ways to improve upon the measure continue. The fundamental purpose of the SEP-1 measure is to identify opportunities for improvement in patient care that are consistent with published evidence and best practices. This fundamental principle is the basis for consideration of all revisions to the measure endeavoring to maintaining balance with the effort involved in abstracting information for medical record. During this – during this call, we will discuss revisions to the SEP-1 measure in Version 5.2a of the manual and focus on how these changes impact abstraction.

The objectives for this presentation are listed on the slide and focus on identifying and understanding updates to SEP-1 data elements and algorithm flow in version 5.2a of the specifications manual.

This review will focus on algorithm changes and key data elements changes in version 5.2 that primarily impacted abstraction for the majority of cases. There are far too many edits to discuss them all. In particular, we will not cover changes to have minimal or no impact on abstraction or impact only small number of cases. We will also not cover edits that are limited to suggested data sources, inclusion guidelines for abstraction, and exclusion guidelines for abstraction. We will review changes to data elements in the algorithm in the order they appear in the algorithm. Data elements and algorithm inspections to which no changes were made are skipped. I will discuss data on updates, expanded guidance, content currently present to its clarifications added, new guidance, content not in the previous version, and remove the guidance content that has been completely removed from the manual. For a complete listing of changes to the measure please refer to the Release Notes, Version 5.2a that are posted on QualityNet. This slide includes a link to that location. Also available via this link are the SEP-1 additional notes for abstraction for version 5.2a of the specs manual. While there are points where I may reference additional notes for abstraction, we will not be discussing them. The additional notes for abstraction should be used in conjunction with version 5.2a of the specifications manual. They contain additional abstraction guidance that address the situations revealed in your question and comments that need further clarification that unfortunately we received after the timeline for being published in version 5.2a of the specs manual.

So, let's start with Severe Sepsis Present data element. A number of bullet points and examples were added to expand the clinical criteria A, guidance for identifying an infection is suspected or present. Some of the expanded guidance is more than we can discuss in detail, so I encourage you to review the release notes and the data elements in detail. A couple of noteworthy points. Documentation signs and symptoms is not acceptable

for a suspected infection. Nursing or pharmacist documentation that a patient being treated within antibiotic for an infection is acceptable. And, a process is incorporated for consulting other medical resources when identifying whether a condition, not on the inclusion guidelines for abstraction for infections, is indeed an infection. A new piece of guidance addresses when there is documentation or infection suspected, possible or present, and within six hours following that, there is physician/APN/PA documentation, the infection is not present. In these cases, you should disregard the initial documentation with the infections present, suspected or possible.

Expanded guidance for clinical criteria C, signs of organ dysfunction, includes clarification regarding requirements for using respiratory failure as a sign of organ dysfunction. For this, both documentation be acute respiratory failure and a new mechanical ventilation must be present. The additional notes for abstraction further clarify these must both occur within six hours of the other criteria and includes additional terms considered synonymous with acute respiratory failure. To use urine output as a sign of organ dysfunction, there must be documentation that clearly indicates urine output is being monitored hourly.

New guidance for clinical criteria C was added. If there is 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, the criteria should not be used. The additional notes for abstraction further clarify what is meant by inference should not be made. Essentially, explicit documentation, such as INR 1.8, is due to patient being on warfarin is not required. It is acceptable, but not required. As long as the value or reference to it and documentation this is normal, if chronic condition is present, an acute condition a non-infection is present, or the patients are in specific medication that can impact the value, and that is included in the same note it is acceptable. Inferences should not be made if the value is recorded in a separate part of the medical record from the physician documentation. The degree of detail and context of the

documentation can make a difference. For example, if a physician documents the patient is normally hypotensive, then all low blood pressure should be disregarded. If, however the physician documents the low BPs were secondary to heat stroke, then only the low BPs should be disregarded. A new bullet point was added that if a lab value is noted by a physician/APN/PA or nurse as being invalid, erroneous or questionable, it should not be used.

Extended guidance was added to clarify the documentation severe sepsis in a discharge summary should be disregarded. If that is the only time severe sepsis is documented, value 2 (no) should be selected. New guidance was added the use of documentation in pre-hospital records is acceptable to use, as long as it is considered part of the medical record. The pre-arrival documentations need all of the requirements within hospital documentation to be used. New guidance was added that a severe sepsis clinical criteria were met, or there were physician/APN/PA documentations for severe sepsis, and following that there is additional physician/APN/PA documentation indicating severe sepsis not present, and that was within six hours following the initial documentation you should select value 2 (no).

For the severe sepsis presentation date and time data elements, expanded guidance for physician notes was added. If the note states present on arrival or present on admission, this could be traced to a specific time of hospital arrival or hospital admission and can be used instead of the initial note time. Now, if the abbreviation POA is documented, the note time will need to be used, because POA is not clear whether it means present on arrival or present on admission. New guidance was added for patients who added ED with clinical criteria met or arrived with physician/APN/PA documentation of severe sepsis, or there is no triage time, or due to severity of illness, were not triaged. In these cases, use ED arrival date and time. New guidance was added that use of documentation and pre-hospital records is acceptable to use, as long as it is considered part of the medical record and prior arrival documentation meets all of the requirements of in hospital documentation.

The administrative contraindication to care severe sepsis data element originally have three allowable values. Allowable value 2 (yes), which is for cases where there was a witness signed consent form marked refused. Feedback reflected this rarely, if ever, will occur because the elements of care for this data element do not require a specific consent form. The requirements for witness signed form marked refused was removed. This resulted in the removable of allowable value 2 (yes). There are now only two allowable values: one, which is equivalent to yes, and two equivalent to no. Expanded guidance include the nursing documentation of patient refusal is now acceptable. Other expanded guidance indicates broader refusal documentation that would result in blood draws, IV fluids, or IV antibiotics not being administered is acceptable. For example, documentation a patient is refusing all care would be inclusive of all of these elements of care.

For directive for comfort care or palliative Care, Severe Sepsis, guidance indicated discussion of comfort measures was acceptable has been removed. Discussion of comfort measures or palliative care is no longer acceptable as a directive for comfort care or palliative care. This data element has an all-inclusive list of terms in the inclusion guidelines for abstraction that are considered acceptable. As such, terms not on the list are not acceptable. Two new acceptable terms were added, those being withdraw care and withhold care.

So, let's shift gears for a bit and take a look at the algorithm. In previous versions the sepsis discharge time is greater than or equal to zero minutes and less than or equal to 180 minutes would result in a case being excluded. This meant, if the patient was discharged at the time of or through three hours following presentation of severe sepsis, they were excluded. This time frame did not take into account cases where a repeat lactate level was indicated, which needs to be completed within six hours of presentation. The timeframe was adjusted for the patients who were discharged from presentations through six hours following presentation of severe sepsis are now excluded. This better aligns the discharge timeframe with the time requirement for obtaining a repeat lactate.

For the broad spectrum of other antibiotic administration and the date and time data elements, guidance has expanded regarding documentation from more than one source to meet criteria for antibiotic administrations. In essence, all the information comes from a single source allocation in the medical record. Pre-hospital records are acceptable, if they are considered part of the medical record.

For the broad spectrum or other antibiotic administration date and time data elements, guidance was expanded with examples to more clearly explain the antibiotic date and time and its relation to presentation date and time and which dose to abstract. Previous versions indicated the look for earliest dose – earlier doses of the same antibiotics given in the 24 hours prior to presentation. And, there is no time limit for how far to look back. In version 5.2a, new guidance was added to not review for antibiotic doses given more than 72 hours prior to presentations. Since these data elements are only interested in IV antibiotics, other new guidance states to disregard antibiotic doses for which the route is missing or is not documented as IV.

Guidance was expanded in the blood culture collection date and time data elements to indicate blood culture draw attempts are also acceptable considered when determining the earliest blood culture. New guidance was added regarding the timeframe to start abstraction of blood cultures. The intent is to use blood cultures no older than ones drawn 24 hours prior to antibiotic administration. The 48 hours prior to presentation language, is reflective of the oldest possible blood culture, which would be in the scenario for the antibiotic started 24 hours prior to presentation. And, since the oldest acceptable blood culture is one drawn 24 hours prior to the antibiotic, that would make it 48 hours prior to severe sepsis presentation. To help clarify this timeframe, the new guidance indicates that, if antibiotics was started within 24 hours prior to severe sepsis presentation, to begin abstracting for blood cultures 24 hours prior to the first antibiotic dose.

A new data element is being introduced called blood culture collection acceptable delay. This data element will allow a case to meet the intent of

the measure if the blood culture was drawn after the antibiotic administration due to specific circumstances that are considered acceptable delays. There are two allowable values.

The notes for abstraction specify what constitutes an acceptable delay. Surgical cases where pre-op antibiotics were given and the patient subsequently developed severe sepsis when the blood culture was drawn. In this case surgical infection prevention guidelines for pre-op antibiotic prophylactics do not recommend drawing blood cultures. Cases for antibiotics were started in the hospital for a known infection before severe sepsis is present or suspected. And, there are some infection specific guidelines that do not require the blood culture being drawn prior to antibiotics.

Cases for antibiotics were started prior to arrival and a blood culture was not obtained prior to the antibiotic, and then in these cases drawing a blood culture outside of the control of the receiving facility. In situations where physician/APN/PA documentation reflects the antibiotics was started before the blood culture because waiting would result in the delay in starting the antibiotic. While the international guidelines for management severe sepsis and septic shock 2012, upon which SEP-1 is based, provides 45 minutes as an example. We recognize most physicians will not know the exact time of the delay. So, the additional notes for abstraction indicate documentation there was an acceptable delay, a delay that could be detrimental, or reflects the patient is deteriorating rapidly are also acceptable.

This new data element is located in the algorithm on the less than zero minutes branch that comes off the right of the blood culture antibiotic time calculation decision box. So, if the result of this calculation is less than zero minute, meaning the antibiotic was started before the blood culture, the case is directed to the blood culture collection acceptable delay decision box. If value 2 (no) is selected, the case is directed to measure outcome D and does not pass the measure. If value 1 (yes) is selected, the case is directed back into the algorithm and continues to the next data element.

For initial lactate level results, units were added behind the value number in all allowable values. For value one the clause "or if there was not an initial active level collected" was removed because if there is not an initial active level collected the case will not make it this far in the algorithm. The phrase "or there is no result in the chart are unable to determine the results" was moved from value three to value one. So, there is now not a requirement for a repeat, if the result if the result is not known.

We received feedback that it is often clear repeat lactate was drawn, but a draw time is not documented. New guidance was added that their repeat lactate level collection data element and the date and time data element that in this case supporting documentation indicating a repeat lactate was drawn, can be used. Examples of this may include lactate sent to lab, where the account documented lactate received, where the account documented for the lactic result time.

In initial hypotension the description for allowable value 2 (no) was expanded to include cases for the presence of initial hypotension is unable to be determined from the medical record. Now, due to comments indicating there is a lack of guidance regarding the number of low blood pressure value that would be required to identify initial hypotension, expanded guidance was added to indicate a single low pressure value sufficient. We have received comments and concerns regarding initial hypotension being based upon a single low blood pressure. And, the things to keep in mind is that the international guidelines for management severe sepsis and septic shock 2012 indicate that initial fluid resuscitation should be initiated as soon as substance induced hyper profusion is recognized and should not be delayed. And, within this context in the algorithm flow, the patient with severe sepsis and initial hypotension represents the situation for fluid resuscitation should not be delayed. We recognize there are situations for the approach of basing initial hypotension upon a single low blood pressure reading maybe problematic. To deal with the complexity of the situations an alternative approach has not been identified at this point.

New guidance was added to initial hypotension to not use low BP reading if there is physician/APN/PA documentation indicating the low reading is normal due to current condition, due to an acute condition that is not an infection, or due to a medication. The additional notes for abstraction further clarify what is meant by interference that should not be made. Again, explicit documentation, such as the systolic blood pressure of 85 is known for this patient is not required, as long as the low BP reading or reference to it and documentation is normal, a chronic condition is present, and acute condition that is not infection present, or the patients is on specific medication that can impact the BP, and that is included in the same note, it is acceptable. Inferences should not be made if the low BP is recorded in a separate part of the medical record from physician documentation. And, as mentioned during our discussion of update to severe sepsis presence, the degree of detail and context of the documentation can make a difference. New guidance was also added to disregard low blood pressure readings, if there is physician/APN/PA or nursing documentations, the low blood pressure reading is invalid, erroneous or questionable.

New guidance was added to the documentation septic shock data element that if there is physician/APN/PA documentation indicating the patient does not have septic shock within six hours following physician/APN/PA documentation the patient has septic shock, you should select allowable value 2. This data element only needs to be answered for patients that do not have initial hypotension and do not have an initial lactate level greater than or equal to four. If value 2 is selected, abstraction will end. This data element is based solely upon physician/APN/PA documentation indicating the patient has septic shock. And, expanded guidance was added to suggest data source reflection to use physician/APN/PA documentation only.

At this point, patients who continue on the algorithm are in need of fluid resuscitation. And, this brings us to the crystalloid fluid administration data element. To meet this data element, 30 mls per kilogram of crystalloid fluid must be ordered and given. Language was added to the

descriptions of the allowable values that the 30 mls per kilogram must also be completely infused. This change really just moves the point at which determination of whether the full 30 mls per kilogram volume was completely infused from the persistent hypotension element to the crystalloid fluid administration data element, which is more appropriate from an algorithm flow perspective. A new allowable value 4 was added for patients who have an implanted ventricular assist device. And, I'll talk a little bit more about this in a couple of minutes.

In previous versions there was no limit or timeframe associated with how far back from initial hypotension or an initial lactate value greater than four one could abstract crystalloid fluid. The intent was fluid should be included that were associated with these events, but to not put a time restriction because the time may vary greatly depending on the number of factors. Based on abstractive feedback new guidance was added restricting crystalloid fluid abstraction to only those fluids given within six hours of the presence of initial hypotension or the presence of an initial lactate level result greater than four. The additional notes for abstraction further clarify this to include the presence of physician/APN/PA documentation of septic shock. Because of target volume variations from the 30 mls per kilogram based on rounding differences new guidance was added around fraction of pounds or kilogram to the nearest whole number when calculating the volume required for the 30 mls per kilograms. Variations may exist in the volume order compared to abstracter calculated volumes based on numerous other factors. So, new guidance was added that volumes order that are within 10 percent lower than the actual target volume calculated based on weight, are acceptable. If, for example, by calculation the patient's target volume to achieve 30 mls per kilogram is 2550 ml and this infusion order 2500 ml because 2500 ml is within 10 percent of 2550, the 2500 ml volume is acceptable.

New guidance was added to help abstracters in determining whether 30 mls per kilogram was completely infused. What this guidance indicates is the volume order must be equivalent to 30 mls per kilogram, or as we discussed in the previous slides, within 10 percent of that, there must be a

start time at the infusion, and determining this in different situations is detailed in the mls per abstraction, and the infusion end time must be known. An infusion end time could be most easily identified if it is documented. But, if it is not documented, it could be calculated based on the infusion rate documented by nursing. If the nurse documented infusion rate, infusion rate duration from the order can be used. If none of these are documented, you will not be able to determine when the infusion ended. To support the new allowable value, four guidance was added indicating that there is documentation of patient has been planted VAD reflect value four regardless of the volume of crystalloid fluid ordered. As you will see later, if this is deflected, fluid administration is not required to pass the measure.

Guidance was expanded regarding which patient weights to use in relation to the time of the crystalloid fluid order. Weights documented prior to the crystalloid fluid order take priority over weights documented after the order because the weights prior than once the volume ordered is mostly likely based upon. If there are multiple weights prior to the order, use the one closest to the order. If there are no weights documented prior to the order, use the weight documented closest to and after the order. In the event they are both estimated weights and actual weights documented in the same period, before or after the order, the actual weight should be used. As always, do not use ideal weight for purposes of this measure.

Guidance was also expanded in relation to the order requirements. Now, same as in version 5.1, the terms bolus or wide open documented in order are acceptable in place of the weight and infusion duration in the order. However, if the rate infusion duration or infusion end time are not documented in the record, or there is not a way to determine the infusion end time, or whether the full 30 mls per kilogram is completely infused, you will need to select value 2 and the case will not pass the measure. Allowing bolus to wide open the order is consistent with widespread ordering practices. But, if you are not able to determine infusion end time, you cannot identify whether the full 30 mls per kilogram was given. Expanded guidance also includes rewording to make it more clear that the

given rate greater than a 125 mls per hour can count towards the 30 mls per kilogram volume.

New guidance is added to the crystalloid fluid administration data element and date and time data element. The documentation of crystalloid fluids in pre-hospital records is acceptable, if it is considered part of the medical record. So, this allows abstractors to count fluid given prior to arrival towards the 30 mls per kilogram total volume. Keep in mind these fluids are subject to the same requirements to those fluids given in hospitals. There must be an order. Now, this order can consist of a fluid administration protocol on the EMS record that is now part of the hospital record or documentation within a hospital based physician order for crystalloid fluid. And, if that order includes the pre hospital fluids were given and the volume of those fluids given they can be counted. There must be a start time documented, an infusion rate, or infusion end time to determine whether the volume was actually infused. And, the rate must be greater than a 125 mls per hour.

To account for the new allowable value four for patients with VADs, the crystalloid fluid administration decision box was added a second time to the algorithm. If value four is selected, the case goes to outcome category E and passes the measure without the need for administration of crystalloid fluid, and no further abstraction is required.

Guidance is expanded to make it more clear septic shock may be identified based on either the clinical criteria on the data elements or physician APN/PA documentation. The physician/APN/PA documentation of septic shock does not need to be present if the septic shock clinical criteria are met. This is different from the documentation of septic shock data element, which is based solely on physician/APN/PA documentation of septic shock. And, while presentation should be based upon the time vital signs are taken if that time is not available the time there recorded or documented can be used. Expanded guidance was added to disregard documentation of septic shock in a discharge summary. And, if the only documentation of septic shock is present after the discharge time or in a discharge summary choose allowable value 2 (no).

Similar to new guidance in the initial hypotension data element, guidance was added to not use low BP readings if there is physician/APN/PA documentation indicating the low reading is normal due to chronic condition, due to an acute condition that is not infection, or due to a medication. New guidance was also added to disregard low blood pressure reading if there is physician/APN/PA or nursing documentation that is invalid, erroneous, or questionable.

Similar to the severe sepsis present data, new guidance was added indicating the septic shock clinical criteria met or there is physician/APN/PA documentation of septic shock, an addition of documentation indicating septic shock was not present, and that is within six hours following the initial documentation, you should select value 2 (no).

For the septic shock present data element and date and time data element, guidance was expanded to better differentiate that septic shock can be based on two different sets of clinical criteria. Clinical criteria A, septic shock, is based upon documentation supporting presence of severe sepsis and persistent hypotension, which requires two consecutive low blood pressure readings. Clinical criteria B, septic shock is based upon documentation supporting presence of severe sepsis and an initial lactate level results greater than or equal to four mmol per liter.

For the septic shock presentation date and time data elements, guidance was expanded to clarify that for triage time to be used, all clinical criteria must be met prior to or documented during triage. Other expanded guidance clarifies that in situations where there are both clinical criteria met and physician/APN/PA documentation septic shock and the dates or times are different, to use that earlier of the two. The goal is to use the earliest documentation supporting the presence of suspected presence of septic shock. New guidance is added indicating to use the later triage time of situations where there is more than one triage time documented. For example, if there is a triage start time and a triage end time.

Similar to the severe sepsis presentation date and time data elements, new guidance was added to use ED arrival date and time for patients who arrive to the ED with clinical criteria met or physician/APN/PA documentation of severe sepsis that either bypass triage or there is no triage time documented. New guidance was added regarding documentation of septic shock in a sufficient note that does not include a specific time within the note. In these cases, you would use the initial note time. If, however the notes states septic shock present on arrival, you should use the bullet points in the notes for abstraction that provides guidance in abstracting the date and time for cases that arrives for the ED septic shock. Addition of the note to a septic shock was present on admission the release documented and remission date and time should be used.

For the administrative contraindication to care, septic shock, the requirement for a witness consent form marked refused has been removed and there is documentation of patient receivables is now acceptable. Guidance was expanded to allow broader refusal documentation that would result in blood draws, IV fluids, or vasopressors not being administered. And, new guidance with that is that if a patient refuses placement of a central line, that should be considered refusal of vasopressors.

For the persistent hypotension data element, the time and the 30 mls per kilogram is completely infused needs to be determined for the hour within which to look for hypotension following infusion can be identified. Data with this guidance was expanded in relation to determining when the 30 mls per kilograms was actually infused for cases with more than 30 mls per kilogram was actually ordered and given. And, regarding situations where the foods are ordered as a bolus or wide open, now in previous versions, the acceptable crystalloid fluids were listed in the crystalloid fluid administration on persistent hypotension data element. To help simplify future revision and ensure consistent list of acceptable food is maintained, the list was removed to this data month and a note was added referring abstractors the crystalloid fluid administration data element for

acceptable fluid. Consistent with the crystalloid fluid administration, guidance was expanded to round fractions of weight to the nearest whole number for volume calculation.

Also, consistent with the crystalloid fluid administration, guidance was expanded regarding which weight to use for determining target crystalloid volume.

Expanded guidance was added to better help abstractors to determine when to choose allowable value of three. If no blood pressure readings are recorded, or only one is reported, and it was low during the hour following the 30 mls per kilogram, value three should be selected. This is because there is not sufficient information to identify whether persistent hypotension was present.

Expanded guidance was also added to better help abstractors to determine when to choose allowable value two. If there is only one blood pressure reading recorded and it is not low or there are multiple blood pressure readings and only one is low during the hour following the 30 mls per kilogram value two should be selected. This is because there is no evidence persistent hypotension was present.

In consistence with some of the revisions and another data elements, new guidance was added indicating to use the documentation pre-hospital records is acceptable if it's considered part of the medical record, and low blood pressure reading should not be used if there are physician/APN/PA documentations that they are normal for the patient in chronic condition due to acute condition that is not infection or due to a medication.

Expanded guidance in the vasopressors administration data element and date and time data elements indicates that in addition to IV intraosseous is now an acceptable route for vasopressors administration. New guidance consistent with previous data elements indicating the use of documentation in pre-hospital records is acceptable if it's considered part of the medical record.

Now, there are two ways to repeat volume status and tissue perfusion assessment can be completed. The first is by completing all elements of the focused exams. The other is by completing two from the any two of the following four groups. Our discussion will address changes to the data elements that make up the focused exam. These include vital signs review, cardiopulmonary eval, capillary refill exam, peripheral pulse eval and skin exams.

New guidance was added as the data elements that make up the focused exam representing options that are acceptable for demonstrating each was performed. While each data elements still has specific documentation requirements to demonstrate they were performed, revisions include two documentation options that represent exceptions to the more detailed requirements. If there is documentation that a physician/APN/PA has reviewed or performed, or a tested to review and performing a specific focused exam, no further detail is required. The statement indicating the profounder reviewed the exam is acceptable. This exception to the detailed documentation is on each focused exam data element and is acceptable for each, as long as the name of the exam or eval is included in the statement indicating were performed to reviewed it. For example, physician documents “I have completed a capillary refill exam,” this is acceptable and no further detail is required. Other acceptable examples include and are not limited to physician/APN/PA documentation indicating vital signs reviewed, cardiopulmonary valve completed, skin exam performed, peripheral pulse is checked. The other new documentation option is a single statement that can be applied to all focused exam data elements. If there is documentation a physician/APN/PA has performed or tested to performing a physical exam, perfusion assessment, reperfusion assessment, sepsis focused exams, severe sepsis focused exam, or septic shock focused exam, no further details are required. This statement will cover all focused exam data elements and is acceptable for selecting yes for each focused exam data element.

For the date and time data elements of the focused exam, expanded guidance now refers abstractors back to the appropriate performed data element to determine what constitutes or is acceptable for the given data elements. New guidance was added to each of the date and time data elements with the focused exam that there is documentation and a physician note indicating the focused exam element was completed and there is not a time associated with when it was completed to use the initial note time.

Expanded guidance specific to the vital signs review performed detailed requirements was added in reference to the respiratory rate, temperature, heart rate, and blood pressure that make up the vital signs review. They must all be in a single physician/APN/PA entry, but may make use of information for more than one place in the medical record. Clarification was also added regarding the time within which vital signs review must be documented to be more consistent with other focused exam data elements.

In the skin exam performed data element, expanded guidance was added to the detailed requirements. In previous versions, the skin exam required documentation that referenced skin color. Recognizing those skin exam includes other aspects besides color such as skin appearance or condition through revisions, reflect skin exam must include reference skin color appearance or condition.

Now, we've discussed the major revisions for the post exam data elements we'll review revisions to the any two of the following four groups of data elements that count towards the repeat volume status and tissue perfusion assessment. These include central venous pressure, central venous oxygen, cardiovascular ultrasound, passive leg raises, or fluid challenge.

Revisions to the central venous pressure and central venous oxygen data elements are virtually identical, so I'll cover these data elements together. Expanded guidance was added to more clearly defined periods in which to abstract CVP and a CVO2 and which value to select if there are no measurements in the abstraction time window. New guidance includes in the event that there are multiple measurement documented in the time

window to abstract the date and time of the measurement documented latest in the time window. New guidance was also added to make it clear that measurements PICC lines are acceptable since they are central lines that are inserted peripherally.

For consistency, new guidance was added to the date and time data element that if there are multiple measures documented in the time window, to abstract the date and time of the latest measurement.

The last data elements we will discuss today are the fluid challenge performed data element and date and time data elements. To better differentiate fluid challenge from the 30 mls per kilogram crystalloid fluid for fluid resuscitation, the abstraction time window was changed to begin at the completion of the 30 mls per kilogram crystalloid fluid administration and in six hours after septic shock presentation. In the event there are multiple fluid challenges the one latest in the time window should be abstracted.

This concludes the SEP-1 measure version 5.2a update presentation. The slide contains some resources for you. The first is the link to SEP-1 factsheet posted on *QualityNet*. The second takes you to the questions and answers tool on *QualityNet*, where you can search for responses to some existing questions or submit your own. The third line takes you to the page in *QualityNet* for version 5.2a of the specifications manual, release notes, a summary of SEP-1 changes for version 5.2, and the SEP-1 additional notes abstraction for version 5.2 are all located. While this presentation did not cover guidance in the SEP additional notes for abstraction for version 5.2a, these notes need to be used in conjunction with version 5.2a of the SEP manual when abstracting cases for SEP-1.

I want to thank everyone who has submitted questions and feedback to us via *QualityNet*. The questions and comments help identify areas of improvement for the measure that have resulted in the important revisions in version 5.2a that we have covered in this presentation. We are continuing to look at ways to improve this measure and simplify data collection based on your comments and questions. Thank you very much.

Candace Jackson: Thank you, Bob. The information that you have provided today, I am sure will be very beneficial to all who have been listening today. We do have time for a few questions and answers. So, our first question is: slide 30 – and I don't know if we want to go to that slide or not – the question is: 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?

Bob Dickerson: Hi, Candace. This is Bob, and thanks, that is a great question. 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 nurses' documentation of the fluid volume given, and then based on the patient's weight, figure out if they actually received that amount. But, this would suffice for the order part of it.

Candace Jackson: Thank you, Bob. Our next question: 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? And, this is slide 50.

Bob Dickerson: Okay. And, this is again, another great question. So, what has happened in version 5.2a is the options that will allow a physician to indicate that a focused exam has been completed have been expanded. So, 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 is the date and time of the note.

Candace Jackson: Thank you, Bob. The next question: in regards to slide 28, in order to say yes to crystalloid fluid administration is 30 milliliters per kilogram required to be infused when three hours of sepsis presentation time?

Bob Dickerson: Okay, again another great question. In this situation what we are looking at for the 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 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.

Candace Jackson: Thank you. And our next question: 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 OD?

Bob Dickerson: Okay, thanks again. Another great question and 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, they 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.

Candace Jackson: Thank you, Bob.

Bob Dickerson: I hope that helps.

Candace Jackson: Thank you, Bob. Our next question: slide 10, we are told to not infer other causes for 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 ESRD on patients that are currently on dialysis? Same for low platelets on patients currently receiving chemo. These are the two areas we have trouble giving MV to document because it's obvious.

Bob Dickerson: Okay, this – thanks again Candace, this is, again, a really, really good question, and one that we have received a lot of questions about through *QualityNet*. So, the thing with this is the physician does not need to explicitly state, for example, elevated creatinine due to end stage renal disease. On the other hand, we want to be careful about making inferences because not everybody doing chart abstraction is a trained clinical professional that can make the association that an elevated creatinine caused by end stage renal disease. So, the documentation needs to have the either the elevated lab value, or the elevated value; so, in this case, let's say for example, if it actually if the physician documentation actually stated the elevated lab value, and within that same documentation, the physician had that the patient end stage renal disease. The physician has associated or linked to those two. Or, if they made reference to the patient having an elevated creatinine and having end stage renal disease, they have linked to associate those two in the documentation. They don't have to explicitly state that one is caused by the other, as long as both components are in the documentation. The inferences should not be made part is looking at situations where the creatinine is elevated in a lab report and in the physician documentation it states end stage renal disease, but the physician documentation does not make reference to the creatinine being elevated. That's the inference part of it. And, I believe there is some additional explanation on that in the additional notes for abstraction for version 5.2a, which is posted on *QualityNet*. I hope that helps.

Candace Jackson: And, the next question – we have time for maybe one or two more. The next one is: 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, say when the admitting practitioner document likely infection?

Bob Dickerson: Okay, thank you. This is a scenario that we've received questions about in the past. 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 dysfunctions 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.

Candace Jackson: Thank you, Bob. And our next question: is it acceptable for a pharmacist to document an infection?

Bob Dickerson: And, the answer to that one – that's a great question – is yes. In version 5.2a, there has been guidance added that pharmacist documentation that a patient is, for example, being treated for an infection is acceptable. So, if the physician has maybe ordered an antibiotic and the pharmacist documents that that antibiotic is being used to treat pneumonia, for example, or some other infection, that pharmacist documentation can be used.

Candace Jackson: And, I'd like to thank you again Bob for your valuable presentation today. And, that is the end of our question-and-answer session. I would now like to turn the program over to Debra Price for a brief synopsis of the continuing education approval process. Deb?

Deb Price: Yes, thank you Candace. And, as Candace said, we have certain time constraints, so I am going to be going through these slides very quickly. You can contact me, if you have any other problems with continuing

education. This particular webinar has been approved for one continuing education credit.

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And now, I'd like to thank everyone for joining us today. We hope that you learned something, and we want you to enjoy the rest of your day. Good bye.

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