Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) v5.7 Questions and Answers

Presentation Transcript

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Candace Jackson: Hello, and welcome to this *Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) Version 5.7 Questions and Answers* webinar. My name is Candace Jackson, and I'm the Hospital Inpatient Quality Reporting Program Support Contractor Lead from the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting today's event. Before we begin, I would like to make a few announcements. This program is being recorded. A transcript of the presentation, along with a summary of the questions asked today, will be posted to the inpatient website, www.QualityReportingCenter.com, in the upcoming weeks. If you registered for this event, a reminder email and a link to the slides was sent out to your email a few hours ago. If you did not receive that email, you can download the slides at www.QualityReportingCenter.com. This webinar has been approved for 1.5 continuing education credits. If you would like to complete the survey after today's event, please stay on until the conclusion of today's event. After the question-and-answer session, we will display a link to the survey that you will need to complete to receive the continuing education credit. The survey will no longer automatically be available if you leave the event early. If you do need to leave prior to the conclusion of the event, a link to the survey will be available in the summary email sent out one to two business days after the event. If you have questions as we move through the webinar, please type your question into the Ask a Question window with the slide number associated and we will answer as many questions as time allows. Any questions that are not answered during the webinar will be posted to the www.QualityReportingCenter.com website in the upcoming weeks. After the event, if you have additional questions, submit your question through the *QualityNet* question-and-answer tool. Our guest speakers for today are Noel Albritton, Lead Solution Specialist, and Jennifer Witt, Senior Health Informatics Solutions Coordinator with the Inpatient and Outpatient Measure Maintenance Support Contractor.

Today's event will answer SEP-1 abstraction questions and provide rationale for the guidance in version 5.7 of the specifications manual.

At the end of the presentation, you will be able to understand and interpret the guidance in version 5.7 to ensure successful reporting of the SEP-1 measure.

This slide just provides the acronyms that will be used throughout today's presentation.

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

Jennifer Witt: Thank you. Hello everyone and thank you for joining us. For today's presentation, we will be reviewing questions and answers related to abstraction of SEP-1 and reviewing the guidance in specifications manual 5.7. I would also like to point out, before we begin, we will review the guidance then review questions and answers pertaining to the guidance. Yellow highlight is used in some guidance to reflect guidance that has been updated in specification manual version 5.7.

Our first topic for today's presentation will be the *Administrative Contraindication to Care, Severe Sepsis* data element. The guidance on this slide states, "Specific documentation indicating patient or authorized patient advocate has refused the following can be used to select Value 1: Blood draws, IV or IO fluid administration, IV or IO antibiotic." We often receive questions related to this guidance when there is further documentation in the medical record indicating the patient allowed blood draws, IV fluids, or IV antibiotic to be administered at a later time after the patient had already refused them. Let's take a look at a question regarding this scenario.

The question is, "Should you select Value 1, Yes, or Value 2, No, for the *Administrative Contraindication to Care, Severe Sepsis* data element based on this scenario?" Severe sepsis presentation date and time is 2/13/2020 at 1200. RN documentation at 2/13/2020 at 10:30 states, "Patient refused IV fluids." Physician Notes on 2/13/2020 at 12:45, "Discussed need to comply and receive IV fluids and medications, patient agreeable at this time." You would select Value 1, Yes. There is nursing

documentation within the specified time frame indicating that the patient refused IV fluids. You would select Value 1, Yes, in this scenario because the initial refusal of the IV fluids can cause delays, which can lead to missing other timing elements within the measure.

Next, we will review guidance within the *Broad Spectrum or Other Antibiotic Administration* data element. We often see questions pertaining to IV antibiotic administration that occurs greater than 24 hours before severe sepsis presentation. To address those questions, we need to begin with identifying if an IV antibiotic was administered within 24 hours prior through three hours after the severe sepsis presentation time to determine the appropriate value to select for the *Broad Spectrum or Other Antibiotic Administration* data element. The guidance on this slide states, "If the patient started an antibiotic within the 24 hours proceeding or three hours following the *Severe Sepsis Presentation Date and Time*, choose Value 1. If no antibiotic was started within the 24 hours proceeding or three hours following the *Severe Sepsis Presentation Date and Time*, choose Value 2." Let's take a look at a scenario.

The question is, "Should you select Value 1, Yes, or Value 2, No, for the *Broad Spectrum or Other Antibiotic Administration* data element based on this scenario?" Severe sepsis presentation date and time is 1/13/2020 at 1200. MAR documentation: Only IV antibiotic given was Levaquin. Levaquin IV administered on 1/9/2020 at 1500; 1/10/2020 at 1700; and 1/11/2020 at 1800. Select Value 2, No. The patient did not receive an IV antibiotic within the 24 hours prior or within three hours after severe sepsis presentation. As you can see in this scenario, IV Levaquin was administered greater than 24 hours prior to severe sepsis presentation. However, it was not continued, and no IV antibiotic was administered within the 24 hours prior through three hours after the *Severe Sepsis Presentation Time*. Therefore, you would select Value 2, No. Let's review another scenario that is slightly different.

Again, the question in this scenario is, "Should you select Value 1, Yes, or Value 2, No, for the *Broad Spectrum or Other Antibiotic Administration* data element based on this scenario?" Severe sepsis presentation date and

time is 1/13/2020 at 1200. The MAR documentation: Only IV antibiotic given was Levaquin. Levaquin IV was administered on 1/10/2020 at 1500; 1/11/2020 at 1700; and 1/12/2020 at 1800. Select Value 1, Yes. The patient received an IV antibiotic within the 24 hours prior to the *Severe Sepsis Presentation Time*. With an IV antibiotic administered within the 24 hours prior through three hours after the *Severe Sepsis Presentation Time*, you would select Value 1, Yes, and next you will determine the IV antibiotic date and time to abstract. So let's review the *Broad Spectrum or Other Antibiotic Administration Time* data element.

Once we determined an IV antibiotic was administered within the 24 hours prior through three hours after the *Severe Sepsis Presentation Time* and selected Value 1, Yes, for the *Broad Spectrum or Other Antibiotic Administration Time* data element, we next determine the *Broad Spectrum or Other Antibiotic Administration* date and time. Since the guidance for the *Broad Spectrum or Other Antibiotic Administration Date* and *Time* data elements are similar, we will review the time data element guidance provided on this slide. With an IV antibiotic administered in the 24 hours prior through three hours after the severe sepsis presentation time, the guidance on this slide allows you to review IV antibiotic administration up to 72 hours prior to the severe sepsis presentation time to determine the broad spectrum or other antibiotic administration time. Also, the examples provided on this slide are also provided in the data element and make it somewhat easier to identify which IV antibiotic date and time to abstract. Let's take a look at a scenario.

For this scenario, what date and time would you use for the *Broad Spectrum or Other Antibiotic Administration* date and time based on this scenario? Severe sepsis presentation date and time is 1/13/2020 at 1200. MAR documentation: Only IV antibiotic given was Levaquin. The Levaquin IV was administered on 1/10/2020 at 1500; 1/11/2020 at 1700; and 1/12/2020 at 1800. One dose of the IV antibiotic was administered within 24 hours prior to the *Severe Sepsis Presentation Time* and two doses were given more than 24 hours prior. The earliest dose within 72 hours before the *Severe Sepsis Presentation Time* was administered on

1/10/2020 at 1500. We are often asked about the exclusion for this scenario. Cases such as this example, where the *Broad Spectrum or Other Antibiotic Administration* date and time is greater than 24 hours before the *Severe Sepsis Presentation Time*, will be excluded in the algorithm upon reaching the broad spectrum antibiotic timing calculation.

Next, we are going to review guidance in the *Broad Spectrum or Other Antibiotic Administration Selection* data element. Cases only reach the *Broad Spectrum or Other Antibiotic Administration Selection* data element when the broad spectrum or other antibiotic administration time is within three hours after the severe sepsis presentation time. If the broad spectrum or other antibiotic administration time is within three hours after severe sepsis presentation time, then you will need to determine if the IV antibiotic administered was a monotherapy or two-combination therapy antibiotic. The guidance on this slide provides an exception for scenarios where a monotherapy antibiotic or two-combination therapy antibiotics were not administered, but rather an antibiotic was administered based on culture and susceptibility testing. The guidance specifies a requirement which include physician/APN/PA documentation referencing the results of a culture from within five days prior to the antibiotic start time. The physician/APN/PA documentation must identify the date of the culture results to determine the results were within five days of the antibiotic start time, and the physician/APN/PA documentation must identify the causative organism and antibiotic susceptibility. Let's review a question pertaining to this scenario.

"Is the PA documentation below acceptable for selecting allowable Value 1, Yes, for the *Broad Spectrum or Other Antibiotic Administration Selection* data element based on the administration of IV Vancomycin (Vanco) within three hours after severe sepsis presentation?" Severe sepsis presentation date and time is 2/4/2020 at 1400. The PA note on 2/4/2020 at 1410 states, "Abdominal wound cultured on 2/2/2020, starting IV Vanco now." Vancomycin start date and time is 2/4/2020 at 1430. No, the administration of the IV Vanco alone is not acceptable because the PA documentation does not identify the causative organism from the culture

results and its antibiotic susceptibility. As we've reviewed on the last slide, to meet the data element without administration of a monotherapy or two-combination therapy antibiotics, the documentation requirements must be met. When the documentation requirements are not met, such as in this scenario, you would select Value 2, No, for the *Broad Spectrum or Other Antibiotic Administration Selection* data element. Let's review another scenario.

Here is another scenario. "Is the PA documentation below acceptable for selecting Value 1, Yes, for the *Broad Spectrum or Other Antibiotic Administration Selection* data element based on the administration of IV Vanco within three hours after severe sepsis presentation?" Severe sepsis presentation date and time is 2/4/2020 at 1400. The PA Note on 2/4/2020 at 1410 states, "Abdominal wound culture results from 2/2/2020 show MRSA, susceptibility Clindamycin or Vancomycin, start IV Vanco now." Vancomycin start date and time is 2/4/2020 at 1430. Yes, select Value 1, Yes. The PA documentation identifies the date of the culture results, the causative organism from the culture results, and antibiotic susceptibility. The MAR demonstrates a susceptible antibiotic was administered within three hours after severe sepsis presentation.

Next, we'll review guidance in the *Crystalloid Fluid Administration* data element. The guidance states crystalloid fluids or balanced crystalloid fluids that are given to dilute medications may be used towards the target ordered volume. If the volume infused without dilution fluids is the same as the target ordered volume, fluids used for diluting medications do not need to be counted. This guidance does not require the use of crystalloid fluids to dilute medications in cases where the target ordered volume of crystalloid fluids is met without the use of the crystalloid fluids given to dilute medication. Let's review some scenarios related to this guidance.

"For this scenario, should the 200 mL of crystalloid fluids used to dilute the medication count towards the target ordered volume?" Order 2 is 0.9% normal saline, 30 milliliters per kilograms, the weight is 75 kilograms, at 1000 milliliters an hour. Order 2 is Cipro 400 milligrams and 200 milliliters of 0.9% normal saline over 30 minutes. The answer is No. You

do not count the fluids used to dilute the Cipro because the crystalloid fluid volume in Order 1 equals the target ordered volume of 30 milliliters per kilogram. In this scenario, the physician ordered a volume of 30 milliliters per kilogram for the patient. Based on the guidance, you would only use the 30 milliliters per kilogram to meet the target ordered volume and determine when the target ordered volume completely infused. In this scenario, the crystalloid fluids used to dilute the medication can be disregarded as that infusion is not required to be used towards the target ordered volume.

Here's a slightly different scenario that asks, "Should the 100 milliliters of crystalloid fluids used to dilute the medication count towards the target ordered volume?" Patient weighs 75 kilograms, 75 kilograms times 30 milliliters per kilogram equals 2250 milliliters. The orders: The first order is 0.9% normal saline, 1,000 milliliters over one hour. The second order is 0.9% normal saline, 1,000 milliliters over one hour. The third order is 0.9% normal saline, 500 milliliters over one hour. The fourth order is Zosyn 3.37 milligrams in 100 milliliters of 0.9% normal saline over 30 minutes. No, you do not count the fluids used to dilute the Zosyn because the crystalloid fluid volume in Orders 1, 2, and 3 satisfy the target ordered volume. In this scenario, the physician ordered multiple infusions of normal saline, which covered the target ordered volume without using the fluids given to dilute the medication. Therefore, the fluids used to dilute the medications would not be used towards the target ordered volume in this scenario.

Here's another question similar to the last scenario. "Should the 500 milliliters of crystalloid fluids used to dilute the medication count towards the target ordered volume?" Weight is 100 kilograms, 30 milliliters per kilogram equals 3,000 milliliters. The first order is 0.9% normal saline, 2500 milliliters at 1,000 milliliters an hour. The second order is Vancomycin in 500 milliliters of 0.9% normal saline over 120 minutes. Yes, you would count the fluids given to dilute the Vancomycin. The 2,500 milliliters in Order 1 is not within 10% of the target ordered volume, 3,000 milliliters. The 2500 milliliters in Order 1, plus the 500 milliliters in

Order 2 equals the 3,000-milliliter target volume. In this scenario, the patient weighs 100 kilograms which would require 3,000 milliliters to equal 30 milliliters per kilogram. The physician ordered 2500 milliliters of normal saline and 500 of normal saline mixed with the medication. Therefore, the target ordered volume is 3,000 milliliters, since the complete 30 milliliters per kilogram volume was ordered. You would use the crystalloid fluids mixed with the medication because the 2500 milliliters of normal saline ordered is not within 10% of the 30 milliliters per kilogram volume based on the patient's weight. In this scenario, using the crystalloid fluids used to dilute the medication is beneficial as it allows the target ordered volume to be reached. Let's take a look at one more question that we would like you to respond to.

Physician orders Clindamycin in 100 milliliters normal saline over 30 minutes and normal saline, 1800 milliliters in two hours. The weight is 60 kilograms. So that's 30 milliliters per kilogram times 60 kilograms equals 1800 milliliters. Would you count the fluids mixed in Clindamycin towards the target ordered volume? A. Yes? B. No?

Noel Albritton: We'll give you a few more seconds to select an answer. Can you close the polling now? The correct answer in this question is B, No. Do not count the fluids used to dilute the Clindamycin towards the target ordered volume because the physician ordered 30 milliliters per kilogram of normal saline.

Jennifer Witt: Thank you, Noel. Next, we'll move on to reviewing questions related to this guidance from the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element. The guidance states, "Only the earliest physician/APN/PA documentation of an inclusion term documented in the following context suffices." The acceptable contexts are provided, which include a recommendation, order for consult or evaluation, request from the patient, a plan, or a referral. For example, the first context states comfort measures only recommendation. Other acceptable documentation would also include palliative care recommendation or hospice recommended. Acceptable documentation would also include the

physician stating, “I recommend comfort measures” or similar. Let’s review some questions are related to this guidance.

This question asks, “Would you choose allowable Value 1, Yes, or Value 2, No, for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element based on the documentation below?” APN documentation within the time frame: “Comfort care discussed with family.” You would select Value 2, No. Comfort care is an acceptable inclusion term, but it is not used within one of the acceptable contexts noted in the data element. Based on the guidance reviewed on the previous slide, a discussion about comfort care would not be acceptable since the discussion is not provided as one of the acceptable contexts. Let’s review another question.

This question asks, “Would you choose Value 1, Yes, or Value 2, No, for the *Directive for Comfort Care or Palliative Care, Severe Sepsis* data element based on the documentation below within the specified time frame? Physician notes: Consider comfort care. Consult order: Hospice to evaluate. The answer is select Value 1, Yes. Hospice is an acceptable inclusion term and it is used within an acceptable context of an evaluation. Next, we would like you to participate in a question.

Which allowable value would you select if the physician notes within the time frame “referring to hospice”? A, Value 1, Yes. B, Value 2, No.

Noel Albritton: We’ll give you a few more seconds to select an answer. Can you close the polling now? The correct answer for this question is A, Value 1 Yes. Hospice is an acceptable inclusion term and it is used within one of the acceptable contexts noted in the data element.

Jennifer Witt: Thanks, Noel. For the next part of the presentation, I’ll turn it over to you.

Noel Albritton: Thanks, Jennifer. For the *Initial Hypotension* data element, let’s review the guidance on this slide which states, “Hypotensive blood pressures obtained in the operating room, interventional radiology, during active delivery, or procedural/conscious sedation should not be used.” This guidance allows for hypotensive blood pressures to not be used when

documented in one of the areas listed because the procedure the patient is undergoing in those areas has a higher potential to cause the hypotensive blood pressure readings. Therefore, hypotensive blood pressure readings documented while the patient is in one of these areas of the hospital would simply not be used. However, you would continue to review the medical record for hypotensive readings documented outside of these areas to determine if initial hypotension is present. I would also like to point out that only hypotensive blood pressures documented while the patient is in one of these particular areas of the hospital would not be used. Hypotensive blood pressure readings documented in other areas of the hospital not included in the list provided in the guidance would still be acceptable to use for establishing the presence of initial hypotension. Also, to not use the hypotensive readings obtained in these areas of the hospital, or procedural or conscious sedation, the documentation within the medical record would need to clearly indicate when the patient is in one of these areas or procedures. If the medical record does not provide clear documentation indicating when the patient was in these areas of the hospital, or in procedural or conscious sedation, you would use the hypotensive blood pressure reading. Next, we will review a couple of scenarios.

This question asks, “Would you use the hypotensive blood pressure readings to establish initial hypotension?” The OR notes at 1400 “to the PACU.” The PACU vital signs flow sheet has, at 1415, a blood pressure of 83/51 and, at 1430, a BP of 85/54. The answer is Yes. Use the hypotensive blood pressure readings at 1415 and 1430 to establish initial hypotension, because the hypotensive readings were not obtained in the operating room. You would use the hypotensive readings in this case because the hypotensive blood pressure readings were obtained in the PACU and the PACU is not included in the guidance as one of the areas that would exclude the hypotensive readings.

Let’s review another scenario slightly different. This question asks, “Would you use the hypotensive blood pressure readings below to establish initial hypotension?” ED physician notes at 1800, “Chest tube at

bedside, site prepped, added Propofol for sedation due to patient discomfort. ED physician notes at 1825, "Chest tube insertion complete without complication." The vital sign at 1825 has a blood pressure of 87/56. The answer in this scenario is No, do not use the hypotension reading at 1825 to establish *Initial Hypotension* because the patient was receiving procedural sedation, as documented by the physician, and the start and end time were also clearly documented. In this case, you would disregard any hypotensive blood pressure readings obtained between 1800 to 1825.

Next, we're going to review guidance and questions pertaining to the *Persistent Hypotension* data element. The guidance on this slide states, "Hypotensive BPs obtained within the operating room, interventional radiology, during active delivery, or procedural or conscious sedation should not be used. If the patient is in one of these areas during the hour-long window to assess for persistent hypotension, select Value 2." I would like to point out the last sentence of this guidance, which was updated in manual version 5.7. It refers to the patient in one of these settings during the hour-long window to assess for persistent hypotension. If the patient is not in one of these areas listed for the hour-long window to assess for persistent hypotension, blood pressures obtained outside of these areas listed would still be used to establish persistent hypotension. For example, if the patient was in the OR for the first half hour of the hour-long window and outside of the OR for the second half hour, the blood pressures obtained outside of the OR in the second half hour would still be used to determine if the patient has persistent hypotension. Let's take a look at the question.

This slide asks, "Which allowable value would you select for *Persistent Hypotension*?" The patient is in interventional radiology from 0730 to 0930. The hour to assess for persistent hypotension is from 0750 to 0850. Blood pressure readings at 0800 is an SBP of 88 and, at 815, an SBP of 84. The answer in this scenario is select Value 2, No, because the patient was in interventional radiology during the hour-long window to assess for *Persistent Hypotension*.

This guidance for the *Persistent Hypotension* data element states, "If persistent hypotension presentation is more than six hours after the Septic Shock Presentation Time, choose Value 2." In this scenario, persistent hypotension may be present based on the blood pressure readings documented in the hour after completion of the target ordered volume of crystalloid fluids. However, if persistent hypotension was identified more than six hours after septic shock presentation, Value 2 would be selected for persistent hypotension. Let's take a look at a question and scenario based on this guidance.

This question asks, "Which allowable value would you select for persistent hypotension?" *Septic Shock Presentation Time* is 1200. Target ordered volume of crystalloid fluids was completed at 1800. The hour to assess for persistent hypotension is 1800 to 1900. The only BPs documented within the hour are at 1815 of 81/49 and, at 1830, of 84/53. *Persistent Hypotension* presentation would be at 1830 and our *Vasopressor Administration Time* of 1835. In this scenario, you would select Value 2, No, because *Persistent Hypotension* occurred more than six hours after the *Septic Shock Presentation Time*. Here the patient has septic shock and persistent hypotension, and a vasopressor was administered. However, if the case continued through the *Vasopressor Administration* data element, the case would fail due to the timing of the vasopressor administration being greater than six hours after the *Septic Shock Presentation Time*, even though the vasopressor administration was likely based on the hypotensive blood pressure readings at 1815 and 1830. Based on the updated guidance in manual version 5.7, you would select Value 2 for P*ersistent Hypotension* and the case would proceed to the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element, rather than the *Vasopressor Administration* data element.

We continue to receive questions pertaining to this guidance in the *Persistent Hypotension* data element. So, let's review the guidance on this slide, which states, "If one or more blood pressures were documented within the time frame and persistent hypotension is unable to be determined, but a vasopressor was administered, select Value 1." This

guidance applies when there is one or more blood pressures documented within the hour to assess for persistent hypotension. If there are no blood pressures documented during the hour, the guidance on this slide would not apply. Also, we frequently receive questions regarding whether there's a time frame for the administration of a vasopressor to suffice this guidance and select Value 1 for *Persistent Hypotension*. The guidance in the *Persistent Hypotension* data element does not provide a specified time frame for the administration of a vasopressor. Therefore, we are only looking for whether one or more blood pressures were documented in the hour to assess for persistent hypotension, whether persistent hypotension is unable to be determined, and whether the patient received a vasopressor. It is also worth noting, if Value 1 was selected for *Persistent Hypotension* based on this guidance, the case would then proceed to the *Vasopressor Administration* data element where it would be determined if the patient received the vasopressor within six hours after septic shock presentation. Let's review a question pertaining to this scenario.

This question asks, "Which allowable value would you select for *Persistent Hypotension* in the below scenario?" The *Septic Shock Presentation Time* is 1700. The hour to assess for *Persistent Hypotension* is 1930 to 2030. There's blood pressure at 1940 of 99/67; at 2000 of 93/58; at 2025 of 84/50. On the MAR, Levophed IV was started at 2330. In this case, you would select Value 1, Yes, because persistent hypotension cannot be determined based on the single hypotensive blood pressure reading at the end of the hour, but a vasopressor was given. In this scenario, the hour to assess for persistent hypotension ended with a single hypotensive blood pressure reading; therefore, you cannot determine persistent hypotension. However, a vasopressor was also administered. So, based on the guidance we discovered on the previous slide, Value 1 would be selected for *Persistent Hypotension*. Next, we would like you to participate in answering the following question.

Which allowable value would you select for *Persistent Hypotension* if the only reading documented during the hour is a MAP of 61 and no vasopressor was administered? A. Value 1, Yes, hypotension present. B. Value 2, No, hypotension not present. C. Value 3, No, not assessed.

Jennifer Witt: We will give you a few more seconds to select an answer. Can you close the polling now? The answer is C, Value 3, No, not assessed. Select Value 3, No, because there is only one blood pressure documented during the hour to assess for persistent hypotension and it is lower than 65 and no vasopressor was administered.

Noel Albritton: Thanks, Jennifer. We often receive questions related to the guidance from the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element. This data element provides three options for selecting Value 1, Yes, and the guidance on this slide is the first option. It states, "Physician/APN/PA documentation indicating or attesting to performing or completing a physical examination, perfusion assessment, sepsis focused exam, or systems review." Then, it provides examples of acceptable physician documentation. We receive various examples of documentation within medical records. So, let's take a look at a couple scenarios.

This question asks, "Which allowable value would you select for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element based only on the below documentation in the time frame?" Physician notes at 1245: "RN admission assessment and exam reviewed." You would select Value 2, No, because the documentation must indicate a physician, APN, or PA is attesting to performing or completing a physical exam or assessment. Let's take a look at another question.

Also, for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element, this question asks, "Which allowable value would you select for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element based only on the documentation within the acceptable time frame?" The PA notes at 0900, "Review of systems negative except where noted in H&P." You would select Value 1,

Yes, because the PA documentation attesting to performing a review of systems is acceptable.

Next, we'll review several questions related to the *Severe Sepsis Present* data element. The first guidance we'll review states, "Choose Value 2 if within six hours after documentation meeting clinical criteria, or physician/APN/PA documentation of severe sepsis, there's additional physician/APN/PA documentation indicating…" We'll specifically review the third bullet point, which states in manual version 5.7, "The patient does not have septic shock and severe sepsis was met by physician/APN/PA documentation that septic shock was present." In this scenario, if severe sepsis was met by physician/APN/PA documentation of septic shock but, within six hours after the documentation of septic shock, there is physician/APN/PA documentation indicating the patient does not have septic shock, you would select Value 2, No, for *Severe Sepsis Present*. Let's review a question to further clarify this scenario.

This question asks, "Which allowable value would you select for *Severe Sepsis Present* in the following scenario if there is no further physician/APN/PA documentation of severe sepsis and clinical criteria were not met?" The physician documents at 0715, septic shock. Physician notes at 1130, no septic shock. The answer in this case is select Value 2, No, because *Severe Sepsis Present* was met by physician documentation of septic shock, and further documentation within six hours after severe sepsis indicates that septic shock was not present. In this scenario, the patient did not meet severe sepsis clinical criteria, and severe sepsis was not documented by the physician/APN/PA. However, the physician documented septic shock, which would allow Value 1, Yes, to be selected for *Severe Sepsis Present*, but, within six hours of the documentation meeting severe sepsis, there's further physician documentation indicating septic shock is not present. Therefore, you select Value 2, No, for *Severe Sepsis Present* based on the guidance in manual version 5.7. Let's take a look at another similar scenario.

This question, again, asks, "Which allowable value would you select for *Severe Sepsis Present* in the following scenario if there is no further

documentation of severe sepsis and clinical criteria were not met?" A physician documents at 1500, severe sepsis. Physician notes at 1630, no septic shock. In this case, you would select Value 1, Yes, because *Severe Sepsis Present* was met by physician documentation of severe sepsis and further documentation within six hours after does not indicate that severe sepsis was not present. Remember, the updated guidance of version 5.7 states patient does not have septic shock and severe sepsis was met by physician/APN/PA documentation that septic shock was present. In the scenario provided on this slide, severe sepsis was not met by physician/APN/PA documentation of septic shock. It was met by physician documentation of severe sepsis; therefore, you would select Value 1, Yes, for *Severe Sepsis Present*. The reason for this is severe sepsis can still be present without septic shock. However, septic shock cannot be present without severe sepsis.

Next, let's review the guidance related to when not to use SIRS criteria for a sign of organ dysfunction. The guidance in the *Severe Sepsis Present* data element allows for SIRS criteria or evidence of organ dysfunction to be disregarded when documentation by the physician/APN/PA prior to or within 24 hours after the severe sepsis presentation time considers the SIRS criteria or evidence of organ dysfunction to be normal for the patient or due to a chronic condition or medication. We often receive questions referencing whether documentation of a chronic condition alone would suffice to disregard an abnormal value. As the guidance states, the physician/APN/PA documentation must include the abnormal SIRS criterion or evidence of organ dysfunction or include a term referencing or defining the abnormal criteria, and the documentation must include the abnormal criteria as normal for the patient or due to a chronic condition or medication. Therefore, if there is only documentation of a chronic condition or only documentation of an abnormal value, this would not be acceptable to disregard the abnormal value. Let's take a look at some examples.

We often receive questions presenting this scenario. The question asks, "Would you use an elevated creatinine value as a sign of organ

dysfunction based only on the documentation below?" The physician documented chronic kidney disease. Yes, you would use the elevated creatinine value as a sign of organ dysfunction because the physician documentation does not attribute the elevated creatinine to the chronic condition. As the guidance on the previous slide, and within the data element states, inferences should not be made. Therefore, documentation of a chronic condition such as chronic kidney disease alone, would not suffice to disregard the elevated creatinine value. To not use the elevated creatinine, further physician documentation considering the elevated creatinine value to be due to the chronic condition is required. Let's review another question related to this.

This question states, "Would you use the elevated heart rate to meet SIRS criteria based only on the documentation below?" The APN notes A-fib with RVR. Physician documented chronic A-fib. In this case, no, do not use the elevated heart rate because the physician documentation contributes the elevated heart rate to the chronic condition. This scenario presents APN documentation which attributes the elevated heart rate to the condition A-fib. Further documentation in the medical record indicates the condition is chronic for the patient. So, the APN documentation of A-fib with RVR is attributing the elevated heart rate to a chronic condition within the same documentation, as required in the guidance. Therefore, you would not use the elevated heart rate in this scenario. Next, we would like your participation in the following question.

ED physician notes "chronic kidney disease, creatinine 3.2." Would you use the elevated creatinine to meet organ dysfunction criteria? A. Yes, or B. No.

Jennifer Witt: We'll give you a few more seconds to select an answer. Can you close the polling now? The answer is B, No. No, you do not use the elevated creatinine to meet organ dysfunction criteria because the ED physician attributes the elevated creatinine to the patient's chronic condition.

Noel Albritton: Thanks, Jennifer. Next, let's review the *Severe Sepsis Presentation Time* guidance related to documentation of severe sepsis present on admission.

The guidance states, “If the only documentation of severe sepsis being present is in a physician/APN/PA Note that severe sepsis was present on admission, use the earliest time of the following: physician/APN/PA note, an admit order, disposition to inpatient, or arrival to the floor or unit.” This guidance only pertains to cases in which the only documentation of severe sepsis states severe sepsis is present on admission. If the only documentation of severe sepsis in the medical record states severe sepsis was present on admission, then you would use the earliest time of either the physician/APN note, the admit order, disposition to inpatient, or the arrival to the floor or unit to establish a severe sepsis presentation time. Let’s review a scenario related to this guidance.

This question asks, “If the physician documented severe sepsis present on admission, which time would you choose for *Severe Sepsis Presentation Time*: the admit order at 1300; disposition changed to inpatient at 1240; or the arrival time to the inpatient floor at 1330?” In this scenario, select 1240 for the *Severe Sepsis Presentation Time*, because severe sepsis is documented as present on admission and the disposition to inpatient at 1240 is the earliest of the acceptable times documented. I would like to point out, if severe sepsis was documented as present on admission, and the clinical criteria for severe sepsis were also met, you would use the time of the clinical criteria. This is because the guidance on the previous slide regarding severe sepsis documented as present on admission only applies when severe sepsis is only met by the documentation that it is present on admission.

For the *Septic Shock Presentation Time* data element, we’ll review the guidance related to determining the time of the initial lactate level results. When septic shock is met by severe sepsis and an initial lactate level result is greater than or equal to four, the later time of either severe sepsis presentation or the initial lactate level result will be used as the *Septic Shock Presentation Time*. If the initial lactate level result is later than the severe sepsis presentation time, the guidance on this slide defines how to determine the time of the initial lactate level result that will then be used at the septic shock presentation time. To determine the time of the *Initial*

Lactate Level Result use the priority order provided in the data element. The priority source for determining the time of the *Initial Lactate Level Result* is the time of the result from the lab. If the primary source is not available, you would use the supporting sources in the priority order to determine the *Septic Shock Presentation Time* based on the *Initial Lactate Level Result*. Next, we have one more question. We would like your participation in answering.

If the following point of care lactate result times are documented, which time would you choose for the initial lactate level result? A. RN note: POC lactate 4.5 at 1530 note opened time. B. Initial lactate collection time 1730. C. Physician note: POC lactate 4.5 at 1830. D. Flowsheet: lactate 4.5 at 1915.

Jennifer Witt: We'll give you a few more seconds to select an answer. Can you close the polling now? The answer is C. Physician note: POC lactate 4.5 at 1830. Use the time of the physician note 1830 for the *Initial Lactate Level Result* time to establish the septic shock presentation time based on the priority order listed in the data element.

Noel Albritton: Thanks, Jennifer. That concludes our review of version 5.7 questions and answers. We hope this has been helpful. Thanks again to everyone for joining us today. Now, I will turn it back over to Candace.

Candace Jackson: Thank you, Noel, and thank you Jennifer for presenting this information to us today. We will now go head into our live Q&A session. Again, we will not have time to address all questions that have been submitted today, but a synopsis and summary of all questions and responses will be posted to the QualityReportingCenter.com website at a later date. So, we will go ahead and get started would our first question.

That is, "Is the initial lactate, lactic acid, the same lactic acid we would use for determining septic shock or can that value be different?"

Noel Albritton: This is Noel. I can answer that. So, the initial lactic acid or lactate level is the lactate used for determining septic shock. It's the only lactate used for determining septic shock for purposes of the measure. So, the initial

lactate may or may not be the lactate that meets organ dysfunction criteria C for determining severe sepsis, but the initial lactate will be the only one used to establish septic shock by an initial lactate.

Candace Jackson: Thank you, Noel. Our next question: "If the patient meets criteria for severe sepsis in the ED, but the provider documents 'Sepsis not suspected within six hours of that criteria,' are we expected to keep abstracting throughout the rest of the admission for another instance of sepsis criteria? The first provider did not assign credit of any of the aforementioned criteria to another disease process."

Noel Albritton: This is Noel again. I'll answer that. So, if the patient met severe sepsis criteria in the ED and then, within six hours after meeting severe sepsis, the physician documented that sepsis was not suspected, you would select Value 2, No, for the *Severe Sepsis Present* data element. When you select Value 2, No, for *Severe Sepsis Present*, that actually excludes the case. So, you will not continue abstracting for a later severe sepsis presentation time at that point. It would just exclude the case because your earliest presentation was negated at that point.

Candace Jackson: Thank you, Noel. We'll go to a few crystalloid fluid questions. "When calculating the amount of crystalloid fluids to be administered, 30 milliliters per kilogram, or 10% percent, and the physician documents the ideal body weight, does the body mass index have to be noted in the patient's chart, or does the documentation of the patient's height and weight meet the documentation criteria?"

Noel Albritton: This is Noel again. So, to use the ideal body weight to determine a target ordered volume, physician documentation of the patient having obesity or a BMI greater than 30 would actually be required. So, that would have to be documented in the medical record. The abstractor would not be able to use the height and weight and calculate to determine the BMI. The BMI would actually need to be documented by the physician or documentation that the patient has obesity to meet those requirements and use the IBW to determine the target ordered volume.

Candace Jackson: Okay. Our next question related to crystalloid fluids states, "For the data element *Crystalloid Fluid Administration*, what is the difference between Value 2 and Value 3? Is it necessary to have two No answers, since selection of either would fail the measure?"

Noel Albritton: This is Noel again. It's correct. Both Value 2 and Value 3 would fail the case, *Crystalloid Fluid Administration*. However, they provide two different data points. So, Value 2, when you select that, that reflects that less than the target ordered volume was ordered or started for the patient, but they did have some fluids just not enough. Value 3 reflects cases where no fluids were started within the time frame for the patient. So, that's the difference in those two. It provides different information depending on which value you select as the abstractor.

Candace Jackson: Thank you, Noel. We'll go to a few questions in relation to the palliative care data element. First one is, patients who are recommended to receive palliative care, does the palliative care team need to actually perform the consult within six hours or is documentation of a recommendation for such a consult acceptable to choose Value 1?

Noel Albritton: So, for this one, the physician documentation, a recommendation for palliative care, or recommending any of those other acceptable inclusion terms is acceptable for selecting Value 1, Yes. The data element and guidance does not require for the consult to be carried out within that time frame. It's simply looking for that physician documentation that meets the requirements for selecting Value 1.

Candace Jackson: Thank you, Noel. Our next question: "What if the family opts out of comfort care and wants full care despite the physician documenting that they recommended comfort care?"

Noel Albritton: So, similarly, as long as the acceptable physician documentation and the acceptable context and with an inclusion term is documented within the time frame, it would continue to suffice selecting Value 1. There are some guidance in there that talks about if there's conflicting documentation within a different source and that continues to direct you to select Value 1.

So, there, there may be some nuisance to that but, for the most part, you would continue to use that physician documentation that's acceptable to select Value 1 for that.

Candace Jackson: Our next question: "Would you be able to abstract Value 1 if on Saturday the provider documents plan for hospice to see the patient on Monday?"

Noel Albritton: For this one, again, as long as you have the acceptable physician documentation, which in this case would be a plan for hospice, that would suffice selecting Value 1, again, regardless of when the actual consult or hospice actually sees the patient. You're going by that acceptable physician documentation within the time frame, and that will allow you to select Value 1.

Candace Jackson: Thank you and last question here: "Right now for the palliative care comfort care measure or data element, would Value 1 or Value 2 be selected if the documentation reads 'family wants patient kept comfortable?'"

Noel Albritton: So, in this case, you would select Value 2, No, for the *Directive for Comfort Care or Palliative Care* data element. The reason for that is, this particular documentation "Family wants to keep patient comfortable" or similar to that, that's not an inclusion term that's within the data element. So, for this particular data element you have to pay attention to the terms under the inclusion guidelines for abstraction in the data element and only those terms are acceptable. If the documentation, you know, reflects family wants patient kept comfortable, that's not an acceptable inclusion term for selecting Value 1, so Value 2 is selected in that case.

Candace Jackson: Thank you, Noel. We have some questions related to broad spectrum antibiotics. The first one is, "Please outline when the antibiotic selection is not applicable in this measure, for example, IV antibiotic given 16 hours prior to severe sepsis time and then within the three hours after severe sepsis time."

Noel Albritton: Okay. So, for the *Broad Spectrum or Other Antibiotic Administration* data element, that data element is only reached going through the algorithm if

your broad spectrum or other antibiotic administration time is within three hours after severe sepsis presentation. So, if you abstract a broad spectrum or other antibiotic administration time that is in the, you know, 16 hours prior to severe sepsis presentation, then that case will not go through the *Broad Spectrum or Other Antibiotic Administration* data element because the time is not within three hours after severe sepsis. So, the case would continue to go on through the algorithm. The selection data element in that case is just not abstracted in the algorithm. So, and the reason for that is, because the antibiotics were started before severe sepsis, you're not looking for a particular antibiotic. If the only antibiotics were started in the three hours after severe sepsis, then severe sepsis was already present and you're looking for broad spectrum coverage for severe sepsis in that case.

Candace Jackson: Thank you, Noel. Next question: "If a patient received IV antibiotic therapy 32 hours prior to the presentation time, will this patient still be excluded from the sepsis core measure?"

Noel Albritton: In this case, if the only IV antibiotic the patient received was 32 hours before severe sepsis presentation, the case would not be excluded. If the only antibiotic was received 32 hours prior, you would actually select Value 2, No, for the *Broad Spectrum or Other Antibiotic Administration* data element. So, in order to select Yes for the *Broad Spectrum or Other Antibiotic Administration* data element, you have to have an IV antibiotic in the 24 hours prior to severe sepsis to three hours after severe sepsis presentation.

Candace Jackson: The next question: "If IV antibiotics were administered consistently 72 hours before severe sepsis presentation time, would we use the 72-hour time and date, and the case would be excluded?"

Noel Albritton: Yes. So, in this case, if you have antibiotic administration consecutively or consistently from 72 hours prior to severe sepsis through the 24 hours prior to severe sepsis presentation, then you could abstract the earliest antibiotic administration time within 72 hours prior. As the case goes through the algorithm at the broad spectrum antibiotic time calculation in the algorithm, that's where the case would be excluded because your

broad spectrum or other antibiotic administration time would be greater than 24 hours prior to severe sepsis presentation. So, that's where the case would be excluded.

Candace Jackson: Thank you, Noel. Our next question is in regard to slide 16. The question is, "Severe sepsis presentation is on January 15, 2020. The patient was started on IV Ceftriaxone on January 9, 2020 and has continued through January 16, 2020. Would we still use the antibiotic date time on January 9, 2020?"

Noel Albritton: So, in this case, severe sepsis presentation on January 15, the patient was started on IV antibiotics on January 9 and continued through January 16. So, the patient, as long as they received that IV antibiotic in the 24 hours prior to three hours after severe sepsis, then you would abstract the IV antibiotic administration time that is within 72 hours prior to severe sepsis presentation on January 15. So, if the patient received that IV antibiotic in the 24 hours prior to severe sepsis on January 15, then we're probably looking to abstract an IV antibiotic administration time somewhere around January 12, and that would be 72 hours prior to severe sepsis presentation on January 15. You would not abstract the antibiotic administration on January 9, that would be six days prior to severe sepsis presentation, and you wouldn't go back that far. You would only go back the 72 hours prior. Once you select that time, that's greater than 24 hours prior to severe sepsis. That will exclude the case in the algorithm.

Candace Jackson: Thank you. Our next question is on slide 19. The question: "Can it be a pharmacist noting susceptibility?"

Noel Albritton: So, for the guidance on slide 19 or 18, and then the question on slide 19, it requires physician/APN/PA documentation of antibiotic susceptibility. The guidance on slide 18 provides very specific guidance for physician/APN/PA documentation just for that particular scenario, as far as culture, determining antibiotic susceptibility, and the causative organism. So, a pharmacist documentation in that case would not be acceptable.

Candace Jackson: Our next question: "What are the requirements for blood cultures in patients receiving antibiotics prior to severe sepsis times zero?"

Noel Albritton: So, as long as your antibiotic administration time is in that 24 hours prior to three hours after severe sepsis presentation, the case will continue on through the algorithm through the *Blood Culture Collection* data element. You would still have to have a blood culture collection within the specified time frame. If you had, again, if you had IV antibiotic administration times greater than 24 hours prior to severe sepsis presentation, the case would actually be excluded prior to reaching the *Blood Culture Collection* data element, and so you wouldn't have to worry about blood cultures in that situation.

Candace Jackson: Okay. Our next questions relate to initial and persistent hypotension. The first one: "If there is no time entered for the end of a procedure, how long after conscious sedation medication is administered do you stop excluding hypotensive blood pressures?"

Noel Albritton: I'm sorry, Candace, can you repeat that one for us?

Candace Jackson: Sure. "If there is no time entered for the end of a procedure, how long after conscious sedation medication is administered do you stop excluding hypotensive blood pressures?"

Noel Albritton: So, for this guidance, that refers to excluding hypotensive readings during procedural or conscious sedation. The guidance doesn't talk about or doesn't refer to medication administration, you know, as far as say, sedative medications. So, you would only exclude the hypotensive readings that are documented actually during procedural or conscious sedation. So, your medical record will have to be clear in identifying when the patient was in procedural or conscious sedation. So, there's no time frame after receiving a sedation or sedative medication for excluding hypotensive readings. It will depend on your medical record having that end time which identifies when procedural or conscious sedation has stopped.

Candace Jackson: Okay. Our next question is in regard to right around slide 35. I'm not sure if it's initial hypotension or persistent hypotension, Noel. The question: "If Value 2, No, is selected, does the case fail? If so, this isn't fair as blood pressures can't be abstracted when the patient is in the OR, IR, etc."

Noel Albritton: So, I believe this one is slide 35 for persistent hypotension. For persistent hypotension, selecting Value 2 will not fail the case. Selecting Value 2 will identify persistent hypotension as not present and the case will continue through the remainder of the algorithm. Selecting Value 3 for persistent hypotension is where the case would fail the measure at that point. So, selecting Value 2, the case will continue. That's why, if the patient is in the OR, interventional radiology, and those locations during the hours to assess for persistent hypotension, you select Value 2 because they are in those and you can't use those hypotensive readings or blood pressures. So, the case will continue on.

Candace Jackson: Okay. Our next question is in regard to slide 37. "If the vasopressor is given outside of the six hour time window, why would this be Yes? Wouldn't it be No?"

Noel Albritton: So, for slide 37, we're still talking about persistent hypotension. The guidance regards persistent hypotension being unable to be determined, but a vasopressor was administered. The guidance in persistent hypotension doesn't include a time frame for that vasopressor administration. It only talks about persistent hypotension being unable to be determined and a vasopressor was administered. So, in this case, if a vasopressor was given and persistent hypotension was unable to be determined, then you would select Value 1 for *Persistent Hypotension*, and, if the vasopressor was greater than six hours after septic shock, the case will actually proceed to the *Vasopressor Administration* data element. In that case, you would select Value 2 at the *Vasopressor Administration* data element because the vasopressor would not be within the time frame. So, that does get addressed. It's just not in the *Persistent Hypotension* data element.

Candace Jackson: Okay. Our next question: "If not persistent hypotension, I'm assuming they're meaning the patient does not have persistent hypotension. Does the vasopressor need to be initiated within the hour to assess for persistent hypotension?"

Noel Albritton: So, in this case, we're still talking about persistent hypotension being unable to be determined based on the documented blood pressures. So, the guidance in persistent hypotension does not require the vasopressor to be initiated or administered within that hour to assess for persistent hypotension. The guidance only requires a vasopressor to be administered, in that case, to select Value 1 for persistent hypotension. Then, like I said, the case will actually go on to the *Vasopressor Administration* data element, and then you'll evaluate if the vasopressor was administered within the acceptable time frame.

Candace Jackson: Our next question: "I am still confused on the vasopressor guidance. What if there were no blood pressures or only normal blood pressures were documented in the hour window, but a vasopressor was given anyway? Would we answer Yes or No to *Persistent Hypotension*?"

Noel Albritton: So, in this case, there's multiple directions here. So, if no blood pressures were documented within the hour to assess for persistent hypotension, you would select Value 3 for *Persistent Hypotension* at that point. The vasopressor administration would not be relevant because the guidance that talks about persistent hypotension being unable to be determined, but a vasopressor was administered, that guidance only applies when one or more blood pressures were actually documented in the hour. So, if no blood pressures were documented, you would select Value 3 for *Persistent Hypotension*. If there are only normal blood pressures documented during the hour to assess for persistent hypotension, then you would select Value 2. This guidance is all in the data element. So, if there's only normal, you would select Value 2, and the case would continue through the algorithm. The vasopressor administration would also not be relevant in that case because the patient had normal blood pressures. So, the case wouldn't even go to the *Vasopressor Administration* data element, it would go to the *Repeat Volume Status and Tissue Perfusion Assessment Performed*

data element in the algorithm. So, yeah. There's more than just a Yes or No in that case, but I hope that helps.

Candace Jackson: Okay. Thank you, Noel. We'll get a few questions in regarding the reassessment data element, and this is on slide 42. "Is this acceptable documentation for tissue perfusion? The physician documents 'I reassessed patient.' Nothing else is noted."

Noel Albritton: So, yes. The physician documentation within the specified time frame that states "I reassessed patient" would suffice that first option in the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element that allows for physician documentation attesting to performing or completing an exam or reassessment of the patient. So, that would work.

Candace Jackson: Our next question related to slide 44. "Does the focus assessment have to be performed after the IV fluids have been infused?"

Noel Albritton: So, the time frame for the *Repeat Volume Status and Tissue Perfusion Assessment Performed* data element is from the crystalloid fluid administration date and time through six hours after septic shock presentation. So, no, it doesn't have to be after the target ordered volume has completely infused. You're actually going to use the *Crystalloid Fluid Administration Date* and *Time* data elements as your beginning time frame for the repeat volume status data element. So, if you look back in your abstraction and see your crystalloid fluid administration date and time, that will give you the start time for that time frame.

Candace Jackson: We have time for just a couple more questions. "If the physician documents end-stage renal disease on hemodialysis, would you use a creatinine of 6.0 as an organ dysfunction?"

Noel Albritton: No. If there's documentation by the physician that the patient has end-stage renal disease and they are on dialysis, you would disregard the elevated creatinine values. That guidance is in *Severe Sepsis Present* under organ dysfunction criteria C. You wouldn't need further physician documentation in that case, other than the patient is on dialysis and has end-stage renal disease.

Candace Jackson: Okay. Another question in that line: "If atrial fib with rapid ventricular response is noted by the ED physician and there is no other documentation of chronic atrial-fib, would use the rate, if over 100 beats per minute for SIRS criteria?"

Noel Albritton: Yes. So, if the only documentation is A-fib with RVR, you would use the elevated heart rate. In that case, the RVR elevated heart rate is documented with A-fib and that can be acute or chronic, without further documentation, we wouldn't know. So, just based on documentation of A-fib with RVR, we would continue to use the elevated heart rates. If there was further documentation that A-fib was chronic for the patient and then the physician wrote that the elevated heart rate is due to that chronic condition, such as A-fib with RVR, then we would exclude or disregard the elevated heart rate.

Candace Jackson: Thank you, Noel. Again, I would like to thank Noel and Jennifer for their presentation today. This concludes our webinar for the day. Please fill out the survey and we appreciate your responses and your feedback when you do that. So again, we thank you for joining us today. I hope the rest of your day goes well. Thank you.